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KAISER PERMANENTE®

HRN Label

Center for Complementary Medicine

CONSENT FORM FOR CHIROPRACTIC CARE

Chiropractic focuses on the nervous system and the spinal cord. During chiropractic treatment, the doctor will use his/her hands or a mechanical device in order to align your spine and improve the body's ability to control and coordinate its many functions. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, strains, dislocations of joints, or injury to discs, nerves or spinal cord. Stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment.

The risks of complications due to chiropractic treatment have been described as "rare". The risk of stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures.

I, _____, understand the hazards and potential dangers involved in treatment by means of chiropractic. I believe that this treatment is in my best interest and I understand that no guarantee of results has been made.

I understand that it usually requires a series of chiropractic treatments to significantly change a condition and receive benefit.

My Signature indicates that I have read and fully understand the above information regarding the consent to this procedure. I have had the opportunity to ask questions about any matter which I did not understand, and I have received satisfactory explanations to my questions. My signature below authorizes this procedure.

_____ _____

Patient/Authorized Representative Signature | Relationship to Patient | Date

Practitioner Statement: The patient (or patient's representative) and I have discussed this procedure, the risks and alternatives to this procedure. To the best of my knowledge, the patient (or patient's representative) understands this procedure and consents to it.

_____ _____

Practitioner Signature | Practitioner Printed Name | Date

Cancellation Guidelines:
The staff of the Kaiser Permanente Centers for Complementary Medicine strives to provide excellent service to our patients. In order to do so, please give us a 24-hour notice of cancellation when you are unable to keep a scheduled appointment. We would be happy to reschedule your appointment for you. You could be charged a fee for failure to show for your appointment.

*Initials*_____

After-hours questions:
The Kaiser Permanente Centers for Complementary Medicine does not have after-hours availability. If you have general questions about our services, please call the main number for your ***preferred*** location and leave a message. Your call will be returned the next business day. If you are having medical symptoms that need immediate attention, please call your primary care physician or specialty care physician. If you believe it is an emergency, please call 911.

Acknowledgement of Financial Responsibility: *Initials*_____
I understand that I am financially responsible to the Center for Complementary Medicine for services provided if not a covered benefit by my Kaiser Permanente plan. I am also responsible for payment of services at the Center for Complementary Medicine if my employment status has been altered or my insurance terminated.

*Initials*_____

If **Non-Kaiser Permanente member:** ***Primary Care Physician*** and Phone Number _____

Emergency Contact Name and Phone number: _____