

CONSENT TO TREATMENT

Healthcare providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to treatment.

There are some risks that may be associated with treatment, in particular you should note:

- a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;
- b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
- c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall wellbeing. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

- a. The condition that the treatment is to address;
- b. The nature of the treatment;
- c. The risks and benefits of that treatment; and
- d. Any alternatives to that treatment

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care and with _____ (healthcare providers name).

Dated this _____ day of _____ 20_____

Patient signature (or Legal Guardian)
Print Name: _____

Signature of Witness
Print Name: _____

Body in Balance Healthcare
5472 Watkins Drive Suite C
Jackson, MS 39206

**Consent to the Use and Disclosure of Health Information for Treatment, Payment, or
Healthcare Operations**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Legal Representative Witness

Date Notice Effective Date or Version

_____Accepted _____Denied

Signature_____

Date: _____

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