Dr. Robert DeVincentis
Intracoastal Chiropractic Clinic
14255 Beach Blvd, Suite A * Jacksonville FL 32250

Consent for Treatment

Medical doctors, chiropractors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedure may consist of manipulation/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to one in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Tests will be performed on me to minimize the risk of any complications from treatment and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

Patient's Signature:_____ Date:_____

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Alternate Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medications can be used to reduce pain or inflammation.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy.

Surgery: Surgery may be necessary for joint stability or serious disk rupture.

Non-Treatment: I understand the potential risks of refusing or neglecting care may include increase pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this Authorization For Treatment.

_____ Printed Name of Patient
_____ Signature of Patient
_____ Signature of Witness
_____ Date

PATIENT STATUS AT TIME OF INFORMED CONSENT PROCESS

Based on my personal observations, medical history and direct conversation with the patient, I conclude that throughout the consent process the patient was orientated X 3, coherent and lucid, proficient in understanding English language or assisted in understanding by an interpreter.

I certify that the above accurately describes the above named patient's status during the informed consent process on the patient's first visit.

_____ _____
Date Signature of Doctor