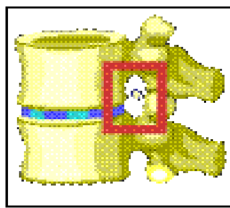
PATIENT INFORMATION

Changes to the law now require all practitioners who manipulate the spine to warn patients of material risks. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke symptoms (approx 1 / 5.85 million, Haldeman, et al. Spine vol 24-8 1999). Whilst this has never occurred in this clinic we are still required to warn. If such procedures are required as part of your treatment you will be fully tested beforehand in advance, as has always been our practice.

Other very slight risks include strain/injury to a ligament or disc < 1 /139000 in the neck or < 1 / 62000 in the low back. (Dvorak study in Principles & Practice of Chiropractic, Haldeman. 2nd Ed)

Chiropractic care of spine-related conditions are internationally recognised as being far safer than dealing with pain management medications and many other alternative interventions. (A Risk Assessment of Cervical Manipulation, JMPT, 1995. & Magna Report, Ontario Ministry of Health 1993)



CONSENT TO CARE

Chiropractic care is recognised as being an effective and safe form of treatment for many conditions. In this clinic we specialise in a unique & integrative CBP (chiropractic Biophysics) system of spinal correction using traction & specific exercises. However, you must also understand and be informed that there are risks associated with all health care procedures.

Please read the following carefully:

1) I acknowledge that the treating doctor has discussed with and explained to me the rare risks associated with my proposed care which includes although are not limited to muscle & joint soreness or strains, nausea and dizziness, fractures, disc injuries, stroke (or like episodes) and an exacerbation and/or aggravation of my underlying conditions.

2) I have the opportunity to discuss with the doctor and ask questions about the nature, extent and purpose of the proposed chiropractic care and that I have been given sufficient time to make decision giving consent for the care to proceed.

3) I acknowledge that I am aware of and understand the potential risks. I appreciate that results are not guaranteed.

4) I do not expect the practitioner to be able to anticipate all potential risks & complications associated with the proposed care.

5) **FOR FEMALES ONLY** It is my responsibility to inform the treating practitioner at the earliest possible instance that expected / unexpected pregnancy is suspected or confirmed. The doctor reserves the right to terminate or modify treatment.

6) I hereby grant my consent to the performance of the proposed chiropractic examination & treatment by **€ Dr. Henry Lin / € Dr. Shalene Cho** and/or any other chiropractor working in this clinic. I also understand that treatment may involve body parts that may not be directly related or close to my primary symptoms.

7) I understand that I can withdraw consent at anytime.

Patient's Signature   Name (Printed)

______________________________   ______________________________

(Parent or Guardian to also sign if patient is under 18 yo)

Dated:

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Doctor's Signature:

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<u>YOUR PRIVACY & CONFIDNETIALITY</u>

At SpinoConcept we respect your privacy and by law we are required to keep your personal history and clinical records confidential.

However, in the process of offering the best solution and care possible for your condition/s other staff members (including other doctors and doctor's assistants) must also have access to some of your information. Such information is **strictly restricted for use by our staff within the clinic premise only**.

We have purposely set up the semi-open-plan treatment bays and rehab areas to facilitate our unique system of care. Please notify the front desk staff or doctor's assistant if you have special needs. Initial consultation and examinations that may require exposure of body parts are carried out in private rooms.

Please sign to inform us of your consent.

Signature: _______________________