



AGREEMENT AND AUTHORIZATION TO TREAT

Alternative Health & Chiropractic Wellness, 7 Brendan Way, Suite C, Greenville, South Carolina 29615 - (864) 331-9484

The nature of chiropractic treatment: The doctor may use his/hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise made when a knuckle is “cracked,” and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, and therapeutic ultrasound may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include but are not limited to fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, injury to intervertebral discs, injuries to nerves or spinal cord, and/or cerebrovascular injury (stroke). A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare,” about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare.”

Other treatment options, which could be considered, may include the following: Over-the-counter analgesics, medical care, hospitalization, and/or surgery. Each of these procedures carry with them “significant” risks, to include irritation to key body systems (stomach, liver, kidneys, etc.), multitude of undesirable side effects and drug dependence, exposure to virulent communicable diseases, iatrogenic (doctor) induced diseases, complications from the surgery, adverse reaction to anesthesia, as well as an extended convalescent period.

Risk of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.

Risk of mixing medications and/or supplements: There are risks associated with mixing medications and/or supplements. I understand that I must notify Dr. Kramer immediately of any medications (prescription, over-the-counter, or other) and/or any supplements (vitamins, minerals, herbs, homeopathic remedies, ergogenic aids, steroids or the like) that I am currently taking, or may begin taking at a later date, so that he may assist me in identifying possible contraindications or adverse reactions which may result from the combination of said medications and/or supplements. Providing Dr. Kramer with this information will also reduce the risk for unfavorable combinations with any vitamin, mineral, or herbal supplement that he may recommend.

Keep all parties informed: It is critical that all parties working with me on my health be made aware of any other treatment programs (inclusive of medications, supplementations, therapies, etc) for which I may be participating; I will assume the full responsibility of keeping all parties informed. I realize that by not keeping those individuals who are working with me on my health aware of my changing health situation and any treatment plans for which I may be participating could inadvertently lead to combinations of therapies, supplements or medications which may place me at undue health risks or possible injury.

Reasonable expectations: I do not expect Dr. Kramer to be able to anticipate and explain all risks and complications, and I wish to rely upon him to exercise judgment during the course of the procedure which he feels at the time, based upon the facts then known to him, are in my best interest.

Pay for services and supplements/supplies: Payment is expected at the time of service. I understand that health and accident insurance policies are an arrangement between an insurance carrier and the patient. At the conclusion of your visit, you will be provided with a super-bill which is suitable for filing with most insurance carriers. If you need assistance in the preparation of any reports and/or forms necessary to file for collections with your insurance carrier, we will be happy to assist. I further understand that any insurance payment forwarded to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services and supplements rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if my care is suspended or terminated at this office, any outstanding charges for professional services and/or supplements rendered to me will be immediately due and payable.

I have read, or have had read to me, the above Agreement and Authorization to Treat. I have also had an opportunity to ask questions about its content and have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing chiropractic and/or holistic health treatments at this office. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have freely decided to undergo treatment at this office, and hereby give my full consent to the treatment recommendations as outlined on the Treatment Recommendation Sheet.

Print Name

Signature

Date

WITNESS:

Print Name

Signature

Date