



CONSENT TO PROCEDURES

Changes to the law now require all practitioners who manipulate the spine to warn patients of the material risks. In extremely rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms, approx 1 in 5.85 million (Neck manipulations, Haldemen, etal. Spine Vol 24-8 1999). Whilst this has never occurred in this practice, we are still required to warn the patient. If any adjustments (manipulations) are required you will be tested beforehand, as has always been our practise. Other very slight risks include strain/sprain to a ligament or disc in the neck which occurs less than 1 in 13 900 or lower back, that occurs 1 in 62 000. (Dvorak study in Principles and Practice of Chiropractic, Haldeman 2nd Ed.) Chiropractic adjustments of the spine are internationally recognised as being far safer in dealing with neck and lower back pain than medication and many other alternatives. (A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993)

In addition to this, Drs. Matthew and Sharith Sippel may determine that my condition may respond to Biomesotherapy/Biopuncture. In this case, saline solution will be inserted into important trigger points, pain points or acupuncture points. As with any procedure that punctures the skin, infection is a risk. The skin around the injection site can remain red and itchy until the next day. Rarely, it might aggravate some pain.

If you have any questions related to the treatment you are about to receive, please speak to the chiropractor.

I also acknowledge that Coast to Country Chiropractic offers Massage services for relaxation and relief of muscular tension and discomfort. I understand that massage increases circulation and may leave me feeling sore afterwards due to the release of lactic acid.

I agree to drink at least 0.5 Litres of water after each massage to help minimise this detoxification reaction. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

- This consent form is for all treatments for the same and related symptoms
- I have had explained to me any terms in this consent form that I do not understand
- I have informed the Chiropractor of any treatments I do **NOT** wish to receive
- I have informed the practitioner of any concerns I have about the effect on my health that I am concerned about before undergoing the procedures.

I UNDERSTAND THAT IF I FAIL TO KEEP AN APPOINTMENT WITHOUT GIVING 24 HOURS NOTICE OF CANCELLATION, I WILL BE REQUIRED TO PAY A \$45 ADMINISTRATION FEE.

The alternatives to the treatment are: No treatment / Medicine / Physiotherapy / Other _____

I have discussed the above information with the chiropractor/massage therapist and give my consent to treatment.

Patient's NAME (or legal guardian's) _____

Patient's SIGNATURE (or legal guardian's) _____ Date: _____

Chiropractor's NAME _____

Chiropractor's SIGNATURE _____ Date: _____

Massage Therapist's NAME _____

Massage Therapist's SIGNATURE _____ Date: _____