



# INTEGRATIVE HEALTH INSTITUTE

Good health enables empowered, authentic living.

## Osteopathic Medicine- Informed Consent

**PLEASE NOTE THAT THIS FORM MUST BE SIGNED  
PRIOR TO YOUR 1<sup>ST</sup> APPOINTMENT**

Doctors of osteopathy who use manual therapy techniques are required to advise patients that there are or maybe some risks associated with such treatment. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strain or sprains as a result of manual therapy techniques;
- b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Further more, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;
- c) There are 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 adjustments or chiropractic treatment.

Osteopathic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Osteopathic care contributes to your overall well-being. The risk of injuries or complications from chiropractic 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, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent. I consent to the osteopathic treatments offered or recommended to me by my osteopath, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Patient Name: (Please print name): \_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

The vision of the Integrative Health Institute is to provide true integrative medical services. Given our commitment to this best-patient practice, we will communicate with your other medical providers at the clinic to ensure that you are receiving true complementary care. This will be done with respect for all privacy laws and any restrictive stipulation you may have placed on this communication. Please speak to your practitioner if you would like more clarification on this process.

I welcome professional dialogue regarding my case between members of my medical team at the Integrative Health Institute: Yes I No Signature: \_\_\_\_\_



**INTEGRATIVE  
HEALTH INSTITUTE**

## **Credit Card on File: Billing Authorization Form**

Client's Name: \_\_\_\_\_

Name as it Appears on the Credit Card: \_\_\_\_\_

Type of Credit Card: MasterCard | Visa

CardNumber: \_\_\_\_\_

Expiration Date: (month/year) \_\_\_\_\_

Security Code: (last 3 numbers on back of card) \_\_\_\_\_

I, \_\_\_\_\_ authorize Integrative Health Institute to process the above credit card as "Signature on File" for any balance due on my account.

\_\_\_\_\_  
Cardholder's Signature

\_\_\_\_\_  
Date