Brighton Spine and Wellness

697 Cambridge St., Suite 303, Brighton, Ma 02135

Informed Consent

Chiropractic is system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure any symptoms, disease or condition as a result of treatment in this office. We will always give you our best care and if results are not acceptable, we will recommend another provider whom we feel will assist your condition.

The most common type of adverse reaction to spinal manipulation is some degree of stiffness or soreness that may occur following the first five days of the initial treatment. This is equivalent to the soreness you would experience after initiating a new exercise program. If such soreness occurs after the first one or two treatments, it usually ceases soon. Should the soreness continue after this period, it is your duty to report it to us. Unless you communicate with us, we cannot properly treat you. Other more serious complications could include: fracture, disc injuries, dislocations or stroke, but it has been documented that such complications have only occurred in less than one in one million manipulations. At Simon Wellness, we employ simple clinical tests, which are designed to help identify those persons who may be susceptible to an injury.

Chiropractic treatment: Chiropractic treatment in the office involves the performance of spinal and extremity manipulations or adjustments and muscle therapies for the purpose of correcting subluxations or joint position errors that may be causing your pain or condition. Please note that chiropractic adjustments may involve leaning against your body. It also involves doing muscle work on your body at various body parts or along the various parts of your back and spine. If at any time you feel uncomfortable, please inform Dr. Simon and his staff immediately so that any changes can be made to your treatment plan if necessary.

For your comforts, all patients may request, during both examinations and adjustments, that a responsible adult third party; staff member, adult family member, adult friend or other person of the patient's choice be present in the room at all times.

By my signature below, I request and consent to the performance of chiropractic care including, but not limited to examinations, adjustments, and supportive procedures, including various types of therapeutic modalities and exercises. Certain supportive modalities may be suspended in the following cases, pacemaker, pregnancy, prosthesis cancer, metallic implant, etc. I consent that the licensed chiropractic doctors associated with this office, who now or in the future treat me, will use their own well-educated judgement in caring for me. I have had the opportunity to discuss with the treating chiropractic doctors and other office personnel, the nature and purpose of the chiropractic adjustments and other procedures.

I understand that in the practice of chiropractic as in the practice of medicine there are some risks. I do not expect the doctors to be able to anticipate and explain all risks and complications. I wish to rely on the doctors to exercise their judgement during the course of the procedures which the doctors feel at the time, based upon the known facts, will perform accordingly in my best interest.

I intend this consent form to cover the entire course of treatment for my present reasons for care and for any future conditions for which I may seek treatment at this office. I have read or have had read to me this consent form. I have had the opportunity to ask questions about the information contained herein. By my signature below I understand and give permission for examination and treatment in this office.

Print Patient's Name	Date Signed
Signature of Patient or Guardian	Relationship of Guardian/Representative
Witness	Date Signed
Informing Doctor's Signature	Date Signed