INFORMED CONSENT

PATIENT NAME ____

Clinic Name: **Active Body Chiropractic & Rehabilitation, PLLC**

Doctor's Name: **Sarah Arnold, DC**

Address: 9428 S. Elwood Ave Ste 102 Jenks, OK 74037

Phone: 918-296-0525 Fax: 918-296-0526

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

DATE ______________________________

____
Printed Name

____
Doctor

____
Signature

____
Signature of Parent or Guardian (if a minor)

____
Doctor's Signature

Privacy Statement

In general, the HIPPA privacy rule gives individuals the right to request confidential communications or that a communication of private health information be made by alternative means, such as sending correspondence to the patient's office instead of their home. Occasionally our office will send out greeting cards, reminder postcards, call you regarding an appointment, etc. Please let us know which form(s) of communication you would prefer to be contacted by. If you would like to see our full privacy policy, please visit the front desk and ask for a copy. By signing this form, I am acknowledging that I have been notified of the Privacy Practices utilized in this office. I may be contacted in the following manner (check all that apply):

Home Telephone_________________
___OK to leave a detailed message
___Leave message with call back number only

Work Telephone______________________
___OK to leave detailed message
___Leave message with call back number only

Cell Phone___________________________
___OK to leave detailed message
___Leave message with call back number only

Written Communication:
___OK to mail to home address
___OK to mail to work/office address
___OK to fax to this number_____________
___OK to email to _____________________

Other:_______________________________
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Patient and/or Guardian Name (Print):________________________________ Relation:_________________

Patient and/or Guardian Signature:____________________________________ Date:____________________