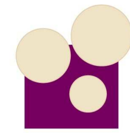
Fitzwilliam Health Clinic




# Patient Consent Form

**Dr. Gemma Bailey DC, Bsc (Hons) Chiro** **Dr. Patrick Ryder M Chiro**

Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there may be some risks associated with such treatment.

In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques.

b) Doctors of chiropractic, medical doctors and physical therapists using manual therapy treatments for neck problems are required to explain that there have been rare cases of injury to a vertebral artery associated with this treatment. Such injury has been known to cause stroke, sometimes with serious neurological injury. The chances of this happening are extremely remote, approximately 1 per 1 million treatments.

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 me caused by spinal adjustments or chiropractic treatment.

Chiropractic treatment , including spinal adjustment, has been the subject of international 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.

Chiropractic 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.

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I consent to appropriate physical examination by my chiropractor.

I acknowledge that I have been advised of and that I understand the nature, effect and potential risks of chiropractic treatment.

I consent to the Chiropractic treatments recommended to me by my Chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future Chiropractic care.

Patient Signature _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
(Guardian consent required if patient aged under 16)

Patient Name (Please Print) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date _ _ _ _ _ _ _ _ _ _ _ _

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## Data Protection Information

Pursuant to the Data Protection Acts 1998 and 2003, we are required to advise patients of our Data Protection Policy.

**POLICY**

As part of a patient's records, this Clinic retains information for the purposes of consultation for treatment, recording treatments and payments and use by third party medical practitioners and third party payers such as health insurance companies.

All paper files and information contained within a patient's records may be electronically scanned and stored on computer file for as long as the relevant patient remains a patient of this Clinic, and for a period of at least 8 years thereafter. Paper records will be retained for the same period.

All information held both in paper and electronic formats will be accessible only by the staff of this Clinic, who are directly involved in the data entry and processing of patient records. Other than for the purposes stated here, information will not be released except with the patient's written consent, or as required by law.

**CONSENT**

I the undersigned acknowledge that I have read the above Data Protection Policy and hereby give consent to the maintenance of my / the patient's records for the purposes outlined within the said Policy.

Patient Name _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Parent / Guardian Signature _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
(Guardian consent required if patient aged under 16)