WHEATON FAMILY CHIROPRACTIC INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment Objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Wheaton Family Chiropractic have been explained to me to my satisfaction, and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

REGARDING: Chiropractic Scoliosis Treatment (Adjustments, Modalities, and Therapeutic Procedures)

I have been advised of the above as well as the standards associated with scoliosis treatment in regards to watching and waiting, bracing and surgery. I have also been informed of the risks associated with not following those standards. I'm also aware that there is no guarantee or promise of any results and I am aware that the scoliosis can still progress. I also understand that a lack of compliance with my Doctor's recommendations regarding the treatment schedule and clinic and home therapies will result in a negative outcome.

After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care and under my free will choose not to follow the standards associated with scoliosis treatment.

______________________________	_______/_______/________	_______ *Witness Initials*
Patient or Legal Guardian's Signature	*Date*	

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully, and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on _______/_______/________ Date

☐ I have been provided a full explanation of when I am mostly likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

MALES/ FEMALES → By my signature below, I understand and give consent to be x-rayed if the doctor deems necessary.

______________________________	_______/_______/________	_______ *Witness Initials*
Patient or Legal Guardian's Signature	*Date*	

INFORMED CONSENT FOR CLEAR SCOLIOSIS TREATMENT

For Cases of Scoliosis at Bracing or Surgical Thresholds of at Risk for Progression

The purpose of this form is to document your understanding of the following.

_______ I understand that scoliosis surgery is recommended when the Cobb angle exceeds 40 degrees, (50–55 degrees in Adults). I understand that on my most recent x-ray, the doctor measured my Cobb angle to be ___________________________________ degrees.

_______ I understand that my CLEAR-certified doctor recommends that I continue any appointments with my orthopedic surgeon. In the event that my CLEAR Doctor has any concerns, he will refer me to the orthopedic surgeon if necessary.

_______ At this point in time, I have chosen not to undergo bracing or surgery, and instead I have made the decision to undergo chiropractic treatment for my scoliosis. I understand that my decision is outside of the established medical guidelines for traditional orthopedic scoliosis management.

_______ I understand that a lack of compliance with my Doctor's recommendations regarding the treatment schedule and clinic and home therapies may result in a negative outcome and may result in dismissal of the patient.

_______ I understand that my decision to delay surgery could result in a greater risk of surgical complication should my Cobb angle continue to progress, and I decide to undergo surgery at a later point in time.

_______ I understand that my scoliosis has a ( ) high ( ) moderate ( ) low risk of worsening over time. I understand that the goal of CLEAR chiropractic treatment is to reduce and stabilize the scoliosis. The goal of bracing is not to correct the scoliosis, but to slow down the rate of progression; this is also a goal of the CLEAR scoliosis treatment. My CLEAR Doctor has informed me that my scoliosis will not be cured. In the event that my scoliosis worsens or any temporary reductions are lost, I agree to hold my chiropractor harmless for providing the treatment that I have chosen to receive.

If you have any questions, please contact your chiropractor before signing this form. Do not sign this form until all of your questions have been answered to your satisfaction.

I authorize the treatment of myself or my child by this Clinic as they deem necessary.

_________________________________   _____-_____-_____
Patient's Printed Name   *DOB*

Patient or Legal Guardian's Signature   _____/_____/_____
Date

CONSENT FOR PHOTOGRAPHY, VIDEOTAPING, OR OTHER IMAGING FOR MEDIA OR EDUCATION PURPOSE

Purpose of Consent: By signing this form, I hereby consent to allow **Dr. Myers and/or Wheaton Family Chiropractic, Max Living, CLEAR Scoliosis Institute** and any associated staff members to use and distribute **my photo and/or video likeness, image, and sound of my voice along with my patient testimonial.**

I hereby grant permission to allow **Dr. Myers and/or Wheaton Family Chiropractic, Max Living, CLEAR Scoliosis Institute** to use **photo, video, and/or audio recordings** of me in conjunction with my patient testimonial. I hereby agree and acknowledge that my photo will be released to the public via public relation efforts of **Dr. Myers and/or Wheaton Family Chiropractic, Max Living, CLEAR Scoliosis Institute**. I further acknowledge and agree that my photo may be used by the media. I understand and agree that these images may be used for: Teaching purposes, which includes being shown to other Doctors, patients and the public. Advertisements by or placement on **Wheaton Family Chiropractic Clinic, Max Living, and CLEAR Scoliosis Institute Website**.

I understand that I am providing the testimonial information to **Dr. Myers and/or Wheaton Family Chiropractic, Max Living, CLEAR Scoliosis Institute** and that my treating healthcare provider will not be providing any protected information to the media or the public, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release **Dr. Myers and/or Wheaton Family Chiropractic, Max Living, CLEAR Scoliosis Institute** from any and all claims for damages of any kind based on the use of my photo, video or information contained in my testimonial.

By signing below I agree and acknowledge that I have read and understand the above Release and agree to all terms described. I am of legal age and freely sign this Release.

______________________________	____-____-____
Patient's Printed Name	*DOB*
______________________________	____/____/____
Patient or Legal Guardian's Signature	*Date*
______________________________	____/____/____
Witness	*Date*

Please provide your contact information:

____
Phone

____
E-mail

____
Twitter Handle

2150 Manchester Rd Suite #100
Wheaton, IL 60187
Phone: (630) 868-8480 Fax: (630) 868-8372

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO: ____
(Name of Facility/Physician/Individual)

____
(Street Address)

____
(City) (State) (Zip)

RE: ______________________________ ______________
(Patient's Name) (Date of Birth)

I, _________________, request that my medical records including any x-rays and reports be released from Wheaton Family Chiropractic to the above stated location.

Signed: ___________________________ Date: _______________

Relationship: __Patient __Spouse __ Parent __Guardian

10/2019