



INFORMED CONSENT

PATIENT NAME: _____

Clinic: Simply Southern Chiropractic Center

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We will use our 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 complications 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 oculosympathetic 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.

We are aware of these complications, and in order to minimize their occurrence we will take precautions. These precautions include but are not limited to our 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 must tell us when we take your clinical history.

We may also employ other techniques in order to help alleviate your symptoms, including, but not limited to, electric stimulation (“stim”), IASTM (instrument-assisted soft tissue mobilization), and massage therapy tables. Electric stimulation complications include, but are not limited to, burns to the skin. IASTM complications include, but are not limited to, bruising and muscle soreness to the treated area and the area immediately surrounding the treated area. If you begin to feel burning to the skin during electric stimulation, please alert an SSCC employee immediately.

I understand my referring physician requests my radiographs interpreted by Tracey A. Littrell, BA, DC, DACBR, DACO, CCSP®, a chiropractic radiologist certified by the American Chiropractic Board of Radiology. I authorize the release of any medical information necessary to process this claim.

DATE: _____

Printed Name

Signature

Signature of Parent or Guardian (if a minor)