FUNCTIONAL DRY NEEDLING® CONSENT AND REQUEST FOR PROCEDURE

Functional Dry Needling® (FDN) involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension, and will promote healing. This is not traditional Chinese Acupuncture, but is instead a medical treatment that relies on a medical diagnosis to be effective. Your Doctors training was in accordance with requirements dictated by this facility and by the U.S. state of this practitioner's licensure.

FDN is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are *rare* in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: A pneumothorax, injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My Doctor has also discussed with me the probability of success of this procedure, as well as the probability of side effects. Multiple treatment sessions may be required/needed, thus this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form. I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Procedure: I, _____, authorize Dr. J. Alvarez DC to perform Functional Dry

- Needling® for my diagnosis of: Musculoskeletal hypertonia, tendonitis, trigger point, myofascial pain syndrome, strain of the muscle, other: _____
- Causing: referred pain, pain, headaches, decreased muscle function, restricted ROM, painful ROM, other_____

Please answer the following questions:

Are you pregnant? Yes No **If yes, how many weeks?** _____. **Are you immunocompromised?** Yes No

Are you taking blood thinners? Yes No

_____ _____

Patient Name Date

_____

Patient Signature

Doctor Affirmation: I have explained the procedure indicated above and its attendant risks and consequences to the patient who has indicated understanding thereof, and has consented to its performance.

Dr. J. Alvarez DC _____

Dr. J. Alvarez BS, DC, FDN Date

NOTICE OF PRIVACY PRACTICES

This summary discloses how health information about you may be used.

Elevation Chiropractic uses health information about you for treatment, to obtain payment for treatment with your authorization, for administrative purposes, and to evaluate the quality of care that you receive.

Elevation Chiropractic will not disclose any of your information to others unless you tell to do so, or unless the law authorizes or requires us to do so.

Elevation Chiropractic may use your information to provide appointment reminder, information about treatment alternatives or other health related issues.

Elevation Chiropractic may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, government functions in order to comply with workers compensation and laws and regulations.

Elevation Chiropractic will be adjusting your spine and or extremities in an open adjusting room where it is possible for others to be present, near, or by the treatments. As a result it is possible other patients or bystanders will be able to hear information about your particular case. Given such, Elevation Chiropractic will do its best to keep the conversations as directly one on one as possible. You do have the right to request the adjustments and dialogue be kept private, and that request will be honored.

You have the right to request restrictions, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records. You may file a complaint with the privacy officer and or to the Department of Health and Human Services if you believe your rights have been violated. You will not be retaliated against for filing a complaint.

Elevation Chiropractic must maintain the privacy health information provide you with notice of legal duties and privacy practices with respect to your health information abide by the terms of the notice, notify you if it was unable to agree to the requested restrictions on how your information is used or disclosed. Accommodate reasonable request you may make to communicate the health information by alternative means or by alternative locations to obtain your written authorization to use or disclose your health information for reasons other that those listed above and permitted by law.

Any questions or complaints, contact Elevation Chiropractic at 303-521-0130
fax: 720-836-3174

PATIENT SIGNATURE _____ DATE _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment:
The doctor will use their hands or a mechanical device in order to move your joints of your spine and or extremities. You may hear a "click" or "pop" such as the noise when a knuckle is "cracked" and you may feel movement of the joint. Various ancillary procedures such as, but not limited to, hot or cold packs, electrical muscle stimulation, therapeutic ultrasound, exercises, rehabilitation, physical therapies, nutritional advice, and blood labs.

Possible Risks:
As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fracture of bone, muscle strain, ligamentous sprain, dislocation of joint(s) or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury/accident (CVA) or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary treatments could produce skin irritation, burns, soreness, or minor complications

Probability of risks occurring:
The risks of complications due to chiropractic treatments have been described as "rare". The risk of a CVA or stroke has been estimated as one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction do to ancillary procedures is also considered rare.

Other treatment options which could be considered may include the following

- Over the counter analgesics. The risks of these medications include to stomach, liver and kidney's, and other side-effects in a significant number of cases
- Medical care: typically anti-inflammatory drugs, tranquilizers, and analgesics. Risk of these drugs include a multitude of undesirable effects and patient dependencies in a significant number of cases.
- Hospitalizations in conjunction with medical care adds risk of exposure to anesthesia as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated:
Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes.

These changes can further reduce skeletal muscle mobility (limiting range of motion) and may get worse over time if left untreated. This can induce chronic pain cycles. It is quite probable the delay of treatment will complicate the condition and make future rehabilitation more difficult.

This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or with hold your consent to treatment.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to a history, examination, necessary tests and treatments. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment.

Patients Name	Signature	Date