Informed Consent to Treat:

Please read this entire document prior to signing it. It is very important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment: Dr. Joseph Jaime, D.C., D.A.C.B.S.P.®, A.T.C., may use his hands or a device to manipulate the area(s) being treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment may also include activity advice, exercise, electrical stimulation, or other types of manual and passive therapy. Dr. Joseph Jaime, D.C., D.A.C.B.S.P.®, A.T.C., will recommend treatment that is most appropriate for your condition.

Possible Risks: Chiropractic treatment is safe and the majority of patients experience improvement. Approximately, 30% of patients experience slight pain in the treated area, possibly due to a minor strain of muscles, tendon, or ligament. When this occurs, the pain is brief and self-limiting over the next few days. Temporary minor pain may also occur with exercise, heat, cold, electrical stimulation, or other manual and passive therapies. Possible skin irritations, burns, or electrical shocks may occur with thermal or electrical therapy but are rare. Some soft tissue treatments may produce local discomfort, reddening of the skin, and superficial tissue bruising/soreness during and post treatment.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many factors can adversely affect one's health, including: previous injury, mediations, osteoporosis, cancer, and other illnesses, disease, or conditions. When complicating factors are present, chiropractic treatment may be associated with serious adverse events such as fractures, dislocation, or aggravation of existing injuries. Dr. Joseph Jaime, D.C., D.A.C.B.S.P.®, A.T.C., is aware that symptoms of stroke or cerebrovascular injury exist and will assess for the symptoms and signs, and will alert patients to seek medical care, if appropriate. The incident of stroke with neck adjustments is exceedingly rare (1 in 1 to 5 million) and while current research does not refute a causal relationship, it strongly suggests associated strokes are already in progress at the start of the visit rather than the result of the care provided.

Please inform Dr. Joseph Jaime, D.C., D.A.C.B.S.P.®, A.T.C., of all medications you are taking, including blood thinners, and any surgeries you have had, and any other medical conditions, including osteoporosis, heart disease, numbness, cancer, stoke fracture, or previous injury.

Other Treatment Options: Do nothing and live with it, over-the-counter medications, acupuncture, medical care, injections, surgery and many others. Most treatments have potential benefits and also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment.

DO NOT SIGN BELOW UNTIL ASKED BY YOUR DOCTOR

My signature below confirms that I have read the paragraphs above and that I understand what Dr. Joseph Jaime, D.C., D.A.C.B.S.P.®, A.T.C., has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. In addition, I have told Dr. Joseph Jaime, D.C., D.A.C.B.S.P.®, A.T.C., about my medical history regarding the above-specified complicating factors, if any.

Patient's Name	Date
Patient's Signature (Parent/Guardian sign if minor)	Clinician Signature / Date

PODIUM SPORTS PERFORMANCE

Visual / Vestibular Assessment:

At times, assessment of how your visual (eye motions) and vestibular (head motions) systems may be helpful in finding solutions for your current complaints. Due to the high energy demand these systems may have on your nervous system, various sensations such as being light-headed, dizzy or nauseated, fatigue, and similar symptoms may be experienced. Proper hydration, nutrition, rest, and other recovery methods will aid in minimizing these effects. Nonetheless, please let us know if you have had changes within vision (ex. surgeries, cataracts, etc.) or vestibular (ex. concussions, head trauma, history of motion sickness, etc.), or if you would like to delay/opt out of this assessment opportunity altogether. Dr. Joseph Jaime, D.C., D.A.C.B.S.P.®, A.T.C., will communicate to you when this evaluation method would be suggested, so opportunities to ask questions are always welcomed.

Patient Name: _____ Date: _____

Patient/Guardian Signature (if patient is a minor): _____

Parent/Guardian Name: _____

Consent to Photograph, Film, Videotape for Testimonial Release:

I hereby consent to the participation in interviews, the use of quotes, and the taking of photographs and movies/video (where applicable). I hereby confirm that my testimonial concerning my health condition is true and accurate to the best of my knowledge. I also release this information, along with my photograph or video, with the right to edit, use, and reuse said products in part or in its entirety, for the purpose of in-office patient/ athlete education or any other type of advertisement by the Dr. Joseph Jaime, D.C., D.A.C.B.S.P.®, A.T.C., and their corporations, including but not limited to: website, direct mail, social media, internet promotions, etc. I also release Dr. Joseph Jaime, D.C., D.A.C.B.S.P.®, A.T.C., and their corporations, from all claims, demands, and liabilities whatsoever in connection with the above.

Patient Name: _____ Date: _____

Patient/Guardian Signature (if patient is a minor): _____

Parent/Guardian Name: _____

ON THE GO SPORTS CHIRO PODIUM SPORTS PERFORMANCE

Consent To Treat A Minor:

Name of Minor: _____

Name of Responsible Party: _____

Relationship to Minor: □ Mother □ Father □ Other: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Occupation: _____

Business/Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

I, the parent or guardian of _____, a minor, the age of _____, do hereby consent, authorize and request Dr. Joseph Jaime, D.C., D.A.C.B.S.P.®, A.T.C., to administer such treatment deemed advisable. I agree to hold Dr. Joseph Jaime, D.C., D.A.C.B.S.P.®, A.T.C., free from harmless from any claims and suites for damages or complications that may result from such treatments.

Patient/Guardian Signature: _____ Date: _____