MN SPINE AND SPORT
MOVE BETTER. FEEL BETTER. LIVE BETTER.

Consent for Examination and Treatment

I hereby request and consent to an examination and treatment. I understand that the treatment may include, but are not limited to therapeutic exercises, forms of manipulation, acupuncture, manual therapy, ice, heat, electric stimulation, therapeutic laser, PEMF, spinal decompression and ultrasound.

While the chances of experiencing complications are small, there have been case reports including, but not limited to soreness, inflammation, soft tissue injury, dizziness, burns, strains, separations, and temporary increase in symptoms. Very rare reports include disc injury, fractures, vertebral artery dissection and stroke. Some patients may feel sore following the first few days of treatment.

I do not expect Dr. Schreiber to anticipate all risks and complications and wish to rely on his best judgment during the procedures that are in my best interests based on the facts known at that time. Dr. Schreiber will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to Dr. Schreiber's attention, it is your responsibility to inform the Doctor.

Other available treatment options include: over-the-counter analgesics and rest; medical care and prescription drugs, such as anti-inflammatory, muscle relaxers and pain-killers; hospitalization; and surgery. If you choose one of the aforementioned options, there are risks and benefits that you may wish to discuss with your primary care physician.

I have been informed that I have the right to refuse any portion of treatment and been given the opportunity to ask questions that pertain to my treatment. I have read, or been read to, the above consent and by signing below, I agree to the above-named procedures. I understand that there always may be an unexpected complication and no guarantee can be made concerning the outcome of treatment. I intend that this consent form to cover the entire course of treatment and for any other condition(s) that I seek future treatment.

_____ _____

Name **Date**

_____ _____

Parent of a minor **Date**

_____ _____

Dr. Scott Schreiber **Date**

_____ _____

Witness **Date**

SS 2/16/19