

INFORMED CONSENT REGARDING TREATMENT

Welcome!!! I appreciate your trust and the opportunity to be of service to you. I enter our relationship with optimism and an eagerness to work with you. Because treatment is a collaborative effort, we will work most productively and comfortably together when we mutually agree upon and understand the nature of the treatment experience. This set of agreements is designed for you to have informed consent regarding your treatment. It is divided into four parts: the treatment process, your rights as a patient, my fees and your written consent. Please feel free to note questions which come to you mind so we can discuss them.

Part I: The Process of Neuromuscular Reeducation

Participating in Neuromuscular Reeducation can result in a number of benefits to you, including neurological, musculoskeletal, visceral and emotional changes. Working towards these benefits, however, requires effort and can result in discomfort. Change will sometimes be easy and quick, and sometimes will be slow and frustrating. It is also possible that there may be times when treatment produces no discernible benefits or change.

- Bruising, tenderness and discoloration may occur in some cases. Post treatment stiffness is almost always present and can be relieved by exercises you will be given. Appropriate nutrition to relieve any possible pain or inflammation will also be recommended as needed.
- One out of five or six patients will have emotional reactions. These are sometimes associated with remembering the feelings from the time of the traumas that are being moved out of the tissues. This can simply be exact memories about the details of the trauma incidents, to the more rare (and severe) reactions that are reliving some traumatic event (less than one out of fifty emotional reactions). Remember that these emotional reactions may happen with any treatment.

Part II: Patient's Rights

As a patient it is important to realize that you have rights. More specifically, you are informed of the following rights:

1. You have the right to a confidential relationship with me. Within certain legal limits (see # 4 below), information revealed to me during the course of treatment will be kept confidential and will not be revealed to any agency or other person without your written permission.
2. You have the right to know the contents of your records at any time, and I have the right to provide you with complete records or a summary of their contents.
3. At your request, my part of your records can be released to an agency or person you specify.
4. You have the right to ask questions about any of the methods used in the

course of your treatment. I will explain my approach to you at any time.

5. You have the right to choose **NOT** to receive treatment from me. I will provide you with the names of other qualified professionals you might prefer.
6. You have the right to terminate treatment with me at any time without financial or moral obligations other than those you have already incurred. In turn, I have the right to discontinue treatment with you under the following conditions:
 - a. When I believe the treatment with me is no longer beneficial to you.
 - b. When I believe that you will be better served by another professional or you can benefit from treatment that I cannot provide.

Part III: Fees

1. In any professional relationship, payment for services is an important issue. Your responsibility for assuring that services are paid for demonstrates your seriousness, sincerity and commitment.

Part IV: Consent for Treatment

I, _____, agree to enter Neuromuscular Reeducation treatment with Garry G. Bracken, Doctor of Chiropractic, and I authorize and request that Dr. Bracken carry out a chiropractic examination and treatment procedures which now, or during the course of my care as a patient, are advisable. I understand that the purpose of these procedures has been explained to me. My signature here attests to the fact that I have read, understand, asked any relevant questions and agree to abide by the points presented above.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

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