

LifeSport Chiropractic

MEDICAL RELEASE FOR CARE

I understand that chiropractic, sports medicine, and massage are done with my best interests in mind. Most common issues between provider and patient are in the area of strain-sprains, close proximity of provider-patient body space, and injuries to bones from bone softening disorders in the elderly. Commonly occurring, **there is a risk** of bruising, swelling, and aches that accompany the breaking up of scar tissue in muscles, soft tissue, and joints. It is common to feel sore after such procedures. There are additional rare risks associated with sports medicine care including tape and adhesive spray allergies, symptoms associated with treatment without knowledge of **blood clotting disorders, collagen disorders, and bone weakening disorders**. Please notify the staff if such disorders exist.

Care at this office for muscular or sports medicine reasons might cause irritation of current or prior injuries however our care is with my best interests in mind. Without the ability to do x-ray or advanced diagnostic studies on site, I understand that LifeSport staff does the best they can in any emergency situation or clinical office setting and as the patient/athlete in this situation and they will do their best to refer me out for such advanced imaging and care might be halted until results from such studies are given.

Due to the incidence of lawsuit in the medical realm for patients unsatisfied with care, I understand that my care will not begin at this office without a formal written release and I agree to do so. **I release Dr. Lisa Erikson and LifeSport Chiropractic LLC from any side effects associated with care** including but not exclusively pertaining to bruising, soreness, headaches, aggravation of unknown or unstated additional disorders listed above, and strain-sprains from tensing during care while manipulation of the spine.

I understand that this clinic is for basic injury care, sports medicine, chiropractic and muscle aid and is not to be used instead of the emergency room. I understand that my Doctor's recommendations are stated in person and also written on my patient notes and that failure to continue to recommended referrals for advanced imaging or associated testing/consults are at my own risk. As a patient engaging in this relationship with the provider(s) at this clinic, I agree that I am willing to forgo these risks and agree to not pursue financial compensation from providers and associated clinics for any side effects or malpractice issues stated above.

If you feel that you have an issue with care, please discuss it with us immediately before beginning care at our clinic.

Signature of Patient: _____

Signature of Parent (If Patient is under 18) _____

Date: _____