

NORTHLAND IDD

RELEASE FORM

Dear Patient,

The treatment you are undergoing has been clinically proven to reduce symptoms related to lumbar disc herniations, degenerative disc disease, and posterior facet syndrome by 86%.

During the course of your treatment, it is not uncommon to have an increase in the following symptoms:

- INCREASE IN LOWER BACK PAIN
- INCREASE IN THIGH, CALF, ANKLE, AND FOOT PAIN
- INCREASE IN NUMBNESS AND TINGLING DOWN THE LEG

Initial _____

Your initial reduction in symptoms may not be noticed until your 12th visit for treatment.

Initial _____

Your responsibilities as a patient to maximize the pace of treatment and longevity of results are the following:

- 20 VISITS (5 DAYS A WEEK FOR 4 WEEKS)
- IF YOU MISS A SESSION AND DO NOT CALL 24 HOURS IN ADVANCE, NORTHLAND IDD RETAINS THE RIGHT TO CHARGE A \$50.00 CASH FEE.
- DAILY REPORTS TO THE THERAPISTS
- HOME ICING MAY BE NECESSARY IF PAIN INCREASES AFTER DAILY THERAPY (20 MINUTES ON 60 MINUTES OFF)
- 6-12 WEEKS OF STRENGTHENING AND CONDITIONING FOLLOWING 20 THERAPY SESSIONS
- ADDITIONAL VISITS MAY BE REQUIRED IF DETERMINED TO ENHANCE PROGRESS

Initial _____

I understand the above listed requirements and I acknowledge the possibility of having an increase of my current symptoms during the first part of my care as listed above. I DO AGREE for Northland IDD to perform treatment and the secondary therapeutic applications necessary for this treatment program.

Print Name _____

Signature _____

Date _____

Northland IDD
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