

DISCLOSURE AND CONSENT

CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: *You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains, and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intent this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

To be completed by the Patient: Print Name: _____

Date Signed: _____ Signature of Patient: _____

To be completed by the patient's representative, if necessary, e.g. if the patient is a minor or physically or legally incapacitated:

Print name of patient: _____

Print name of patient's representative: _____

Signature of patient's representative: _____ Date Signed: _____

As: (relationship or authority of patient's representative) _____

To be completed by doctor or staff:

Witness to patient's signature: _____ Date: _____

Translated by: _____ Date: _____