Chiropractic Consent Form

HIPAA

The undersigned does hereby acknowledge that he/she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic examinations, adjustments, and any other associated procedures on me by _____.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose, and risks of chiropractic care and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines. I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

PHOTO CONSENT

We are PROUD of our patients and the progress they make while under our care! There's nothing we enjoy more than CELEBRATING our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others, right?

If the moment arises, we would love to share your photo, story, or progress on our Social Media page(s) or website in the interest of showing others that "real people" visit our office and are smiling while they're here – and most importantly, getting results!

Please check the box that applies to you:

- ☐ Sure! You can use my picture on the Straightahead Website and Social Media (i.e. Facebook, Instagram, etc.) pages, as long as I look good in it!
- ☐ No thanks! I'll pass for now.

X-RAY RELEASE AND CONSENT

It is not unusual for our office to take digital x-rays in the process of determining how we can best help you. Please select from the following:

- ☐ Sure! Do whatever you feel is necessary to come up with the best care plan for me (and, NO, I am certainly NOT pregnant).
- ☐ No thanks! I'll pass for now, as I am pregnant or have another medical condition which contradicts me being exposed to x-ray.

I attest that the information on this form, and those preceding, is true and accurate to the best of my knowledge.

_____

Printed Name of Patient

_____

Signature of Patient Date

_____

Signature of Representative (if patient is a minor or has disability) Date