Quality of Life Chiropractic
6910 FM 1488 Suite 3; Magnolia, TX 77354
17099 Walden Rd Suite 100; Montgomery, Tx 77356

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I _____ (Name of Patient) hereby request and consent to the performance of chiropractic treatment (also known as chiropractic adjustment or chiropractic manipulative treatments) and any other associated procedures: physical examination, test, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic of Quality of Life Chiropractic and/or other assistants and/or licensed practitioners in this practice.

I understand, as with any health care procedures, that there are certain complications which may arise during chiropractic treatment. Those complications include but are not limited to fractures, disc injuries or exacerbation, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral (rib) strains and separations.
Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complication including stroke, although these occur 1 out 10 million cases (less than .00001%) in other words very rare.

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 judgment during the course of the procedures(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have an opportunity to discuss with the Doctor of Quality of Life Chiropractic and/or with office personnel the nature, purpose, and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments. By signing below, I state that I have been informed and weighted 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 the treatment. I intend for this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment at Quality of Life Chiropractic.

<u>SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE</u>

x_____ _____/_____/20__
Signature of Patient Date

x_____ _____/_____/20__
Signature of Representative (if patient is minor or handicapped) Date

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HIPAA Information and Consent Form the Health Insurance Portability and Accountability Act (HIPAA)

Provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years.

This form is a "friendly" version. A more complete text is posted in the office at the Front Desk (see binder)

WHAT THIS IS ALL ABOUT:

- Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services.
- HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.
- Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

WE HAVE ADOPTED THE FOLLOWING POLICIES:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. . It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____(Signature) on the Date _____20___ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.