CHIROPRACTIC INFORMED CONSENT FOR CARE

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or the patient names below for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future perform any chiropractic services on me while employed by, working or associated with or serving as back-up for the doctor of chiropractic names below, including those working at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as with all healthcare practices, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare options, in the practice of chiropractic there are some risks to care including, but not limited to, muscles spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations, and sprains. 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 that time, based upon the facts then known, is in my best interests.

I further understand that chiropractic adjustments and supportive care is designed to reduced and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for care are final and no refunds will be issued. However, prorated fees for unused, prepaid visits will be refunded if I wish to cancel care.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered over the counter analgesics and rest, medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and pain killers, physical therapy, steroid injections, bracing, and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options. Further, I understand the doctor's in this office are not claiming to treat any disease or condition, but are simply correcting vertebral subluxations.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of my care in this office for the present and any future visits.

Name of patient: _____

Signature of patient: _____

Name of guardian & relationship to patient: _____

Guardian signature: _____

Date: _____

Doctor of Chiropractic name: _____

Signature of Doctor of Chiropractic: _____

Date: _____

Livin' Well Family Chiropractic

PRIVACY NOTICE ACKNOWLEDGEMENT

We at Livin' Well Family Chiropractic are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient/guardian. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Livin' Well Family Chiropractic's *Notice of Privacy Practices for Protected Health Information.*

_____	_____
Patient Name Printed	Date
_____	_____
Patient Signature	LWFC Representative
_____	
Guardian Name Printed	
_____	_____
Guardian Signature	LWFC Representative

Livin' Well Family Chiropractic
Dr. Marley Smith DC & Dr. Heather Smith DC
5231 Yellowstone Rd
Cheyenne WY 82001