

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Chiropractic Wellness Center, Inc., have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

	1		Witness Initials
Patient or Authorized Person's Signature	// Date	┘┗━━	

REGARDING: X-rays/Imaging Studies

FEMALES ONLY \rightarrow please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

□ The first day of my last menstrual cycle was on _____- (Date)

 \Box I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.





HIPAA Personal Health Information Release Authorization

I, _____, hereby authorize Chiropractic Wellness Center, Inc to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

O Spouse	Name:
O Significant Other	Name:
O Parent/Legal Guardian	Name:
O Child(ren)	Name(s):
O Any Specified Person	Name:
v 1	

O Information is not to be discussed with or released to anyone.

Restrictions:

O No Restrictions

O Only discuss my appointment time with the above-named individual(s).

O Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).

O Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call	O my home	O my work	O my cell phone
Phone Numbe	er:		

If unable to reach me:

O you may leave a detailed message

O please leave a message asking me to return your call

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I understand I may terminate this consent at any time by giving written notice to [Insert Practice Name]. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: _____ Date: _____

5209 Forest Drive, Suite C, Columbia, SC 29206 Drshellyjones.com Dr. Shelly Jones 803-771-9990 doc@drshellyjones.com

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff. **Keep this page for your records.**

YOUR RIGHTS:

- To inspect or obtain a copy of your records, usually within 30 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
- 2. To ask for amendments to your health information you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- 3. To request confidential communications (contact you in a specific way or send mail to a different address).
- 4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
- 5. To receive an accounting of disclosures (those with whom we've shared your information).
- 6. To receive a paper copy of the extended detail Notice of Privacy Practices.
- 7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- 8. To file a complaint if you feel your rights are violated

USES AND DISCLOSURES:

- 1. Treatment purposes use your health information and share it with other health care providers who are treating you.
- 2. Run our organization use and share your health information to run our practice, improve your care, and contact you when necessary.
- 3. Bill for your services use and share your health information to bill and get payment from health plans or other entities.
- 4. Inadvertent disclosures an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
- 5. Help with public health and safety issues in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
- 6. For health research purposes.
- 7. Comply with the law share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- 8. Work with a medical examiner or funeral director share health information with a coroner, medical examiner, or funeral director in the event of a patient's death.
- 9. For workers' compensation claims, law enforcement purposes or with a law enforcement official, and other government requests including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
- 10. Respond to lawsuits and legal actions share health information about you in response to a court or administrative order, or in response to a subpoena.
- 11. Emergency in the event of a medical emergency we may notify a family member.
- 12. Phone calls and/or emails we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
- 13. Change of ownership in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

COMPLAINT:

If you wish to make a complaint about how we handle your health information, please contact our privacy official using the information noted above. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

U.S. Dept. of Health and Human Services, Office of Civil Rights 200 Independence Avenue, SW, Washington DC 20201 877-696-6775 www.hhs.gov/ocr/privacy/hipaa/complaints/

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued ...

Please complete the following where indicated and return to our front desk staff.

Patient initials: _____ - retaining page 1 of 2

I hereby acknowledge I have read and received a copy of Chiropractic Wellness Center Privacy Practices Notice.

I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.

I am aware an extended detail version of this "Notice" is available to me upon request.

At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature:	Date:				
Print Name:					
If not signed by the patient, please indicate relationship:					
Parent or guardian of minor patient					
Guardian or conservator of an incompetent patient					
Beneficiary or personal representative of deceased patient					
Name of Patient: For Office Use Only					
Signed form received by:					
Reason acknowledgment not obtained:					
Efforts to obtain:					
PATIENT'S NAME: H	R#:	DATE:			