INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and any other procedures, including examination tests, diagnostic x-rays and adjustments necessary to help with my condition. Furthermore, I consent to treatment by any chiropractor working for, or serving as a fill-in for my regular chiropractor named below.

I understand that, as with any health care procedure, there are certain risks involved. Some of the risks or complications which may occur during a chiropractic adjustment include, but not limited to; muscle strains, fractures, disc injuries, and costovertebral strains and / or separations. In a small percentage of the population there have been injuries to the arteries in the neck resulting in or contributing to stroke. In some of these incidents the manipulative procedures were performed by untrained people such as massage therapists, beauticians, and even medical doctors not adequately trained in the science of chiropractic.

By signing below, I state I have weighed the risk involved in undergoing treatment and have myself decided that it is in my interest to undergo chiropractic care recommended. I hereby give consent. I intend this consent form to cover the entire course of treatment for my present condition and for any other future conditions for which I seek care.

Doctor of Chiropractic: *Garrett C. Irene D.C.*

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE

_____ _____

Print Name **Date**

_____ _____

Signature **Date**

_____ _____

Witness Signature **Date**

HIPPA

INDIVIDUAL AKNOWLEDGMENT OF PRIVACY PRACTICES

At Heights Family Chiropractic we take your care very serious and want what is best for you at all times. Under the Health Insurance Portability and Accountability Act (HIPPA), your health care provider may share your information face-to-face, over the phone, or in writing.

A health-care provider may share relevant information if:

- You give your provider permission to share this information

OR

- You are present and do not object to sharing the information

If you would like us to share information (i.e. appointment dates/times, current balances, etc.) please list the person's name and we will be happy to abide by this. I authorize Heights Family Chiropractic to release my healthcare information to the following:

1.) _____
2.) _____
3.) _____

Appointment reminders and private health information will be communicated to you only in the manners in which you have given specific written authorization and you have the option to opt out of any of those methods at any time by notifying our office. Email and standard SMS/text messaging are not confidential methods of communication and may be insecure.

I give permission to contact me, relative to appointment reminders only, by the following methods:

Cell Phone #:_____ ☐ Verizon ☐ AT&T ☐ Straight Talk ☐ Cricket

By signing this form, I am indicating that I have been provided a copy of Heights Family Chiropractic's Notice of Privacy Practices related to health information. I understand that the Notice is subject to change, and I may obtain a current notice by contacting Heights Family Chiropractic. The doctor and staff of Heights Family Chiropractic will follow the above directions until notified in writing of change.

_____ _____

Patient/Authorized Signature **Date**

I am the: ☐ Patient ☐ Guardian ☐ Other _____