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Laurel Street Chiropractic & Rehab
Privacy Practice, Consent to Treat, & Release Form

Please take a moment to carefully read and sign where indicated:

The Chiropractic visit, Therapeutic/Vichy Massage you are about to receive is designed to address your needs within the scope of practice of the healthcare provider's experience and training. Any information you provide is helpful in allowing you to receive the full benefit of these services. Any information which you volunteer (written or verbal) is confidential.

I consent to treatment and release the Chiropractic Physician, and/or Massage Therapist from any and all liability due to injury or other causes resulting from the scope of treatment given to me.
I further understand that massage/bodywork should not be performed under certain medical conditions; I affirm that I have stated all my known medical conditions and answered all questions honestly. I further agree to keep my healthcare providers updated as to any changes in my medical profile and I understand that there shall be no liability on the part of the Chiropractic Physician, and/or Massage Therapist should I forget to do so.

I understand that I will have the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. 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 the time, based on the facts then known; is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

Massage/Active Therapy Appointment Cancellation Fee:
We have many people waiting and needing appointments, so we ask that you give cancellation notice 24 hours prior to your scheduled appointment time. If you do not contact us within 24 hours, you will be solely responsible for paying the ***$60 cancellation fee*** **if we cannot fill your reserved time.** Insurance will not pay this fee. _____ initials

Massage/Active Therapy rates are typically charged for by the hour. **Please be courteous** to our Massage Therapists they only have five or six appointments a day; and to our other patients by arriving for your appointment on time.

It is also understood that any illicit or suggestive remarks or advances made by me will result in termination of my appointment and I will still be liable for payment of the scheduled appointment.

I am aware Laurel Street Chiropractic & Rehab operates under the HIPAA privacy guidelines. I have read and agree to all of the above.

_____ Print Name

_____ Member of Doctor's Staff

_____ Signature of patient/or Representative

_____ Date Signed

_____ Date Signed