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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I, ____________________________(print name), hereby request and consent to the performance of chiropractic procedures, including a comprehensive exam, diagnostic testing, physical therapy techniques, massage or manual therapy, adjustments or manipulation, and acupuncture on me which are recommended by the doctors at West University Wellness, P.C., and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by or associated with West University Wellness, P.C.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Although these complications are rare, they include but are not limited to, muscle sprain/strains, dislocations, fractures, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Although our patients are screened for indications that they are candidates for chiropractic manipulation to the best of our ability, I do not expect the doctor to be able to anticipate all risks and complications during the course of the procedure(s). Therefore, the doctor based upon the facts then known, will act in the best interest of the patient. I understand that I can terminate treatment at any time, even during the course of any of the chiropractic procedures listed above.

______________________________ ______________________________

Signature of patient Date

______________________________ ______________________________

Signature of patient's representative Date
(If minor)

<u>West University Wellness, P.C.</u>

Health Care Authorization Form

Patient's Name: ____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **West University Wellness** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

Open Room Authorization

______ (Initial) I give **West University Wellness** permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of my care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

Authorization of Treatment

______ (Initial) I hereby authorize **West University Wellness** to treat my condition, as they deem appropriate through the use of chiropractic manipulation, physical modalities and/or acupuncture. **West University Wellness**, including its doctors and staff, will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis. I agree that I am ultimately responsible for all bills incurred by me at this office.

Acknowledgement of Receipt of
Notice of Privacy Practices

______ (Initial) I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

• The right to review the notice prior to signing this consent.
• The right to object to the use of my health information for directory purposes.
• The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

____ ________________

Patient/Guardian Signature Date