Bodyworks Chiropractic Center Inc.

HIPPA Consent for Personal Health Information Disclosure

(*"I" and "my" refer to the patient, and "Chiropractor" refers to Dr. Hall and Bodyworks Chiropractic)*

- I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.
- My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.
- I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document**.**
- Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Informed Consent to Chiropractic Care

As in the practice of medicine, in the practice of chiropractic care there are some risks including, but not limited to: sprain/strain, dislocation, fractures, stroke, disc injuries, and bruising. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke, but there are reported cases of stroke associated with many common neck movements, in sports, exercise, and even in every day activities. Furthermore, the apparent association is noted very infrequently. However, in the rare case of possible stroke being caused by an adjustment it may cause serious neurological impairment, including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote. Various studies estimate the incident of this type of stroke being associated with an adjustment between 1:3,000,000 and 1: 38,000,000.

It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, 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 upon the facts then known, is in my best interests. Treatments offered in this office include: chiropractic adjustments, mechanical traction, electric stimulation, manual therapy, massage therapy, spinal decompression, prolozone therapy and ice.

If you choose not to receive conservative chiropractic care for your condition, you may experience:

- possible worsening of symptoms
- musculoskeletal degeneration
- higher probability of developing a chronic condition that may require more aggressive treatment later.

You may take over the counter or prescription medication for your condition, and be subject to the side effects and risks inherent to those substances. *Please consult your medical doctor regarding those risks and side effects.*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient(s) named below, for whom I am legally responsible) by Dr. Hall and/or his preceptor and/or other trained chiropractic assistants.

I have read, the Informed Consent to Chiropractic Adjustments and Care. 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 form to cover the entire course of treatment for my present condition (or that of my dependent) and any future condition (s) for which I seek treatment in this clinic.

By signing you understand and agree with all the above

_____ _____ _____

Signature of Patient or Guardian Print name of Guardian Date signed

Print Name of Patient _____ Witness _____