• Patient Consent Form

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (the below mentioned patient, which I am legally responsible) which are recommended by Alys Smith, D.C. and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for Dr. Alys Smith, D.C.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts she knows, are in my best interest.

I will exercise my right to discuss with the doctor and/or his office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures in order to have all my questions answered to my satisfaction prior to treatment. I further understand that the results are not guaranteed.

I have read, or have had read to me, the above explanation of chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) of which I seek treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Patient's Signature: _____ Date: _____

Signature of Patient's Representative: _____ Relation: _____

• Patient Privacy Disclosure

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing below. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but, if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Consent. Dr. Alys Smith DC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations (including but not limited to verifying insurance benefits and confirming appointments).
- Dr. Alys Smith DC has a Notice of Privacy Practices and that the patient has the opportunity to review the notice.
- Dr. Alys Smith DC reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but Dr. Alys Smith DC does not have to agree with those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Dr. Alys Smith DC may condition treatment upon the execution of this Consent.

Signature of Consent: _____ Date: _____

This consent is signed by (printed name): _____ Relation: _____