David Bennett, DC
CHIROPRACTOR

**David Bennett, DC**
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# ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY PRACTICES AND CONSENT FOR CARE AND TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by David Bennett, D.C. or other professional staff members who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic Medicine named above and/ or with other office or clinic personnel the nature and purpose of chiropractic treatment, manipulation and other therapeutic procedures. I understand that results are not guaranteed.

I understand and am informed that as with the practice of medicine, the practice of chiropractic carries some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have 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 and for any future condition(s) for which I seek treatment.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have **read** them or **declined** the opportunity to read them and understand the Notice of HIPAA Privacy Practices. I understand that this signed acknowledgment will be placed in my patient chart and maintained for six years.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____