SONORAN CHIROPRACTIC

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic/acupuncture treatments also known as chiropractic adjustments or chiropractic manual manipulations, and any other associated procedures: physical examination tests, physical therapy procedures ect. on me by Dr. Kevin Lowe, DC and/or Dr. Taylor Overmohle, DC including other licensed practitioners such as massage therapists.

Chiropractic treatment, including the spinal adjustment, has been shown to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches, and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

As with all other forms of treatment, manipulation to the spine can cause some unwanted side effects that you should be made aware. A small percent of patients may experience discomfort after treatment ranging from aching and stiffness to soreness depending on the condition being treated and how long you have had it. In rare instances, patients may experience fractures, muscle and ligament sprains and strains as a result of manual therapy techniques. Even more rare, serious neurological damage may result from this type of treatment such as stroke or nerve damage.

At Sonoran Chiropractic, we take every precaution in our diagnosis and treatment to minimize these unfortunate occurrences. Although we offer spinal manipulation with the utmost confidence in its proven benefits, you have the choice not to have this type of treatment. There are other forms of treatment available to you here including, physiotherapy and soft tissue therapy to name a few. Other alternatives include medications and surgery through a licensed provider.

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 procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

It is my responsibility to make it known any condition(s) I am suffering from which would otherwise not come to the attention to the doctor. The doctor is licensed in a special practice and is available to work with other types of providers in your health care regimen.

I am authorizing Sonoran Chiropractic to proceed with any treatment deemed necessary. Furthermore, any risk involving chiropractic treatment will be explained to me upon request. I intend for this consent to cover the entire course of treatment for my present condition for which I am seeking treatment.

I have read the above statements and have had the opportunity to discuss with my treating doctor and have any questions answered. I am of legal age of consent. Please sign below if you understand the described risk and consent to treatment.

_____

Printed Name of Patient

_____ _____

Signature of Patient Date

_____ _____

Signature of Representative/Parent (patients under 18 yrs.) Witness

SONORAN CHIROPRACTIC

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practice provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of you protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
The practice reserves the right to change the privacy policy as allowed by law.
The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? YES/NO
If yes, Please name the members allowed

_____

This consent was signed by: _____
(print name)

Signature: _____ Date: _____