NEXUS
HEALTHCARE

CONSENT TO EVALUATION AND TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, acupuncture meridian therapy either with or without needles, and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the staff of Nexus Healthcare. I understand and I am informed that, in the practice of chiropractic and acupuncture that there are some risks to examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. When acupuncture with needles is performed, adverse effects can include, but not limited to some slight bruising, slight bleeding or infection. I do not expect the doctor to be able to anticipate and explain all risks and complications, 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 on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

OUR PRIVACY POLICY

Nexus Healthcare is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with Nexus Healthcare may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare.

By signing below, I have read, or have had read to me, the above consent to evaluation and treatment statement, that I am aware of the privacy policy, and that I certify that my medical information above is correct to the best of my knowledge.

_____ _____

Signature of Patient or Guardian Date

_____

Printed Name

14785 Jeffrey Rd., Ste 102, Irvine, CA. 92618
(949)-829-3138

Jonathan Lin, D.C., L.Ac., CCSP®
Jim Chung, D.C., L.Ac.