Informed Consent

Patient Name: ____
Clinic Name: Medina Family Chiropractic, LLC.
Doctor's Name: Heather A. Martin, D.C., Angela M Hobbs, D.C.
Address: 611 Highway 45 Bypass South, Medina, Tennessee 38355
Phone: (731)783-0602 Fax: 731-783-0604

Treatments that may be administered include:

Spinal Manipulation: The doctor will use her hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "spinal manipulation" or "spinal adjustment". As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costo-vertebral strains and separation. Rare complications include but are not limited to stroke. The most common complication is an ache or stiffness at the site of the adjustment.

We are aware of these complications, and in order to minimize their occurrence, we will take precautions. These precautions include but are not limited to our taking a detailed clinical history of you and examining your any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell us when we take you clinical history.

Cupping: Cupping is a treatment of creating a vacuum in a glass or plastic cup, which is applied to the surface if the skin. After the cups are removed, there may be a slight discoloration of the skin (like a type of bruising). This usually resolves in a few days to a week. Very rarely, a slight burn or blister may appear dur to the heat of the suction.

By signing below, I acknowledge that:
I have read or have red to me the information on this consent form. I understand the possible risks and complications involved. I have had the opportunity to discuss this consent with the doctor. I understand I can request more information at any time if desired. I consent to receiving treatment that involves the above procedures. I understand that I have the right to refuse or discontinue treatment at any time. I understand that this refusal may affect the expected results.

Date: ______________ Name: (printed): ________________________
Signature: ____________________________________
Signature of Parent or Guardian (if a minor): ____________________________________

Notice of Privacy Practices

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agree to allow this office to use their PHI for the purpose of treatment, payment, health care operations, and coordinate of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for that the Insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions of the use of their PHI. Our office is obligated to agree to these restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. A patient may provide written request to revoke consent at any time during care. This would not affect the use of those records of the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, service, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make new notice provisions effective for all protected health information that it maintains. You will be provided with new notice at your next visit following any change.
9. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
10. I understand this authorization is valid from today until I ask for a change in this policy in writing.

Name (printed): ______________________________ Date: ______________

Signature: ______________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Name (printed):_______________________________ Date: __________________

Signature: ____

Parent or Guardian Signature (if a minor): ___________________________________

Parent or Guardian Name (if a minor): ______________________________________

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MATINTAINED FOR SIX YEARS.

Please list below the names and relationships of people to whom you authorize the Practice to release PHI:

Name: ____________________________________ Relationship: ______________

Name: ____________________________________ Relationship: ______________

Name: ____________________________________ Relationship: ______________