HIPAA Notice to Our Patients

I consent to the use or disclosure of my protected health information by Genesis Chiropractic for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Genesis Chiropractic. I understand that analysis, diagnosis or treatment of me by Genesis Chiropractic may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Genesis Chiropractic is not required to agree to restrictions that I may request. However, if Genesis Chiropractic agrees to a restriction that I request, the restriction is binding on Genesis Chiropractic.

I have the right to revoke this consent, in writing, at any time, except to the extent that Genesis Chiropractic has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or medical health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of Genesis Chiropractic's "Privacy Notice to Our Patients" and understand that I have a right to review the Privacy notice To Our Patients prior to signing this document. The Privacy Notice to Our Patients describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations at Genesis Chiropractic. The Privacy Notice to Our Patients for genesis Chiropractic is available in the waiting room. This notice also describes my rights and duties of Genesis Chiropractic with respect to my protected health information.

Genesis Chiropractic reserves the right to change the privacy practices that are described in the Privacy Notice to Our Patients. I may obtain a revised notice of privacy practices by calling the office of Genesis Chiropractic and requesting a revised copy to be sent in the mail or by asking for one at the time of my next appointment.

Name: _____ Date: _____

Signature: _____

Informed Consent to Chiropractic Treatment

The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have had the following unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____	_____	_____
Printed Name of patient	**Signature**	**Date**

WITNESS:

_____	_____	_____
Printed Name of Witness	**Signature**	**Date**