

## Terms of Acceptance/Patient Health Information Consent Form

When a person seeks Chiropractic care and we accept a person for such care it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent confusion.

**Adjustment:** A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well being, not merely the absence of infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease other than the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to locate, analyze and correct vertebral subluxation by specific adjustments.

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 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 to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination 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 what 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 on the use of their PHI. Our office is not obligated to agree with those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for 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. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a 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.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. 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.

**Authorization for Release of Medical Records** I request that payment of authorized Insurance/Medicare/Medicaid benefits be made directly to 1<sup>st</sup> Place Health, LLC for any services provided to me by this medical facility. I hereby authorize the release of all medical information about me to the Health Care Finance Administration or other insurer or agency for purposes of determining medical necessity or processing claims at 1<sup>st</sup> Place Health, LLC. This authorization is in effect until I choose to revoke it. I have the right as a patient to revoke this authorization in writing at any time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the doctors and staff of 1<sup>st</sup> Place Health, LLC have my permission to perform x-ray(s). I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_  
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic, massage, and Rehab care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_