Lane Family Chiropractic
960 Main St.
Delta CO 81416

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic imaging by the doctor named above.

I understand that I will have the opportunity to discuss with the doctor of chiropractic named above and/ or with the office of clinic personnel the nature and purpose of the chiropractic adjustments procedures. I understand that results are not guaranteed.

Lane Family Chiropractic may use your information to provide appointment reminders, information about treatment alternatives or other health related issues.

I understand and am informed that as in the practice of medicine, and the practice of chiropractic there can be, although minimal, some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complication, and I wish to rely on the doctor to exercise judgment during the course of procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Our policy requires payment in full for all services rendered at the time of service, unless other arrangements have been made with business manager. If account is NOT paid within 20 days of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

No show appointments or cancellations less than 24 hours are subject to cancellation fee of $60.00.

I have read the above consent. I have also had the opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature _____Date_____
(Patient Representative, indicate relationship if signing for patient)

Parent or Guardian _____Date_____

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Patient Health Information Consent Form/HIPAA

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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**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 to 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.
8. No show appointments or cancellations less than 24 hours are subject to cancellation fee of $60.00.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature Date

Doctor Signature Date

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