McClure CHIROPRACTIC
www.McClurechiropractic.com

HIPAA CONSENT FORM

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 begin any health care operation we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, and public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

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. Patients have right to file a formal complaint with our privacy official about any possible violations to of these policies and procedures. If the patient refuses to sign this consent for purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

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

Print Patient Name:_____ **Date** _____

Signature:_____ **Relationship to Patient**:_____

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Informed Consent for Chiropractic\Physiotherapy Treatment

The nature of 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 may also be used.
Possible Risks: 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.
Probability of risks occurring: 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".
Risks of remaining untreated: 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.

Patient/Guardian Signature:_____**Date:**_____

Informed Consent for Needle Acupuncture Treatment

Please take time to read this form, which will provide you with some basic knowledge about needle acupuncture treatment.
While receiving needle acupuncture treatment, please feel free to communicate with your practitioner what you experience during the needling process, as this will enable the practitioner to adjust needles and the points selected to maximize your comfort during the treatment. If you experience dizziness, nausea, a cold sweat, shortness of breath, or faintness during treatment, please let the practitioner know immediately. This is known as needle shock, and while its occurrence is extremely rare, it helps to let the practitioner know if you experience any of these symptoms so that the needles can be removed.
These symptoms go away immediately after needles are withdrawn, and are generally caused by anxiety when receiving acupuncture for the first time. Other possible side effects of needle acupuncture treatment may include local bruising, mild pain in the area treated, brief generalized fatigue, tingling or numbness.

Everyone responds to treatment differently therefore, we cannot guarantee the outcome of treatment. Some individuals experience total or partial relief of their pain or symptoms after the first few treatments. Others notice steady, gradual improvement. In some cases, no relief is felt at all until after several days go by. Occasionally, some people notice that their pain actually seems to be worse before it gets better. Let us know how you responded to the previous treatment at the time of your follow-up visits, so that your treatment plan can be adjusted accordingly. By signing this informed consent, you (the patient) acknowledged that you have read the information above carefully and are giving consent for treatment.

Single-use, sterile, disposable needles are used in this clinic

I have read and understand the above statements.

Patient/Guardian Signature:_____**Date:**_____

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Consent of Treatment of Minor Child

I (we) being the parents, guardian or custodian of the minor being_____, age _____,do hereby authorize, request and direct the doctor's office as shown above, its doctors and staff to perform examinations, and any treatment that in their judgment, is deemed advisable or required. It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests and treatments as will be needed while said minor shown above is under care in the office until legal age is attained. As legal parent/guardian I realize full responsibility for all charges and payments due.

Patient/Guardian Signature:_____**Date:**_____

_____ _____

Witness **Date**