Informed Consent for Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working with, or associated with or serving as back-up for Dr. Chad M. Hoffman at Lifestyle Chiropractic & Wellness.

I have had an opportunity to discuss with the Doctor of Chiropractic named above, and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as with the practice of medicine chiropractic carries some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I consent to rely on the doctor's best judgment, exercised during the course of treatment that is in my best interest, based upon the known facts.

I have read, or have had read to me, the above consent. I have also had an 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 conditions(s) and for any future condition(s) for which I seek treatment.

Privacy Notice

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). Signing this consent allows Lifestyle Chiropractic & Wellness to use and disclose my protected health information for:

• Treatment

• Consulting with other health care providers about my case

• The day-to-day healthcare operations of your practice

I understand I can request a copy of your Notice of Privacy Practices, which more fully explains how my PHI may be used and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice and that I may contact you at any time to get the most current copy. I understand that I have the right to request restrictions on how my PHI is used and disclosed but that you are not required to agree to these requests. However, if you do agree you must abide by these restrictions. I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to that date is not affected.

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Print Patient Name Date Signed

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Patient Signature