Informed Consent to Care and Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. V. Moore.

I have had an opportunity to discuss with the Dr. Moore 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 in the practice of medicine and all healthcare, in the practice of chiropractic there are 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, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, 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.

Print Patient Name _____Signed _____

If patient is a minor:
Parent/Guradian Name_____Signed_____

Notice of Privacy Practices

Protecting your confidential health information is important to us. It is our desire that you understand that the HIPAA (Health Portability and Accountability Act) laws were written to protect the confidentiality of your health information and that we are committed to ensuring that your health information will not be shared with anyone who does not require it.

- We will use your health information only for purposes of providing diagnosis and treatment.
- We may share your health information with physicians, referring specialists or any other health care professional only at your request.
- We may also share your information with family and/or friends, but ONLY at your request.
- We will remind you of a scheduled appointment, contact you for follow-up appointments and inform you of treatment options or other services that may be of interest to you.

These communications are an important part of our philosophy of partnering with our patients to be sure that you receive the best information and support that we can provide. Other than what is stated above or where Federal, State, or local law requires, we will not disclose your health information without your written authorization. ***You may revoke authorization in writing at any time. You have the right to obtain a copy of this notice from us at any time***