INFORMED CONSENT FOR FUNCTIONAL NUTRITION SERVICES

Pursuant to this Patient Care Agreement ("Agreement"), I/we authorize the professionals and staff at Ballard Family Chiropractic to administer such Chiropractic, health care and/or nutrition services, treatments and procedures for me or my/our children as they deem appropriate and necessary under the applicable circumstances. I/we understand that they will recommend an integrative program that may include conventional health care, nutritional therapies, homeopathy, functional medicine and other elements of integrative medicine. I/we acknowledge and agree that in connection with any births or adoptions, the doctor/patient relationship shall begin with the first physical examination and not at birth.

I/we understand that if any explanations as to benefits and/or risks and dangers of the recommended treatments or services are unclear, it is my responsibility to ask for clarification before giving my consent. I/we understand that there have been and can be no warranties, representations or assurances of successful outcomes for me or my children. Nevertheless, I desire to pursue integrative medical treatment or nutrition services for myself or my children after reviewing the information herein and receiving answers to any questions related to this agreement. As a patient or parent seeking medical, health care and/or nutrition services, I/we understand that I/we are ultimately responsible for selecting and approving recommended treatments and services (or rejecting recommended treatments/services) for me or my children.

I/we will report to Ballard Family Chiropractic any matters arising out of treatments or services and schedule a consultation to conduct appropriate follow-up. I/we will promptly seek medical attention from Ballard Family Chiropractic or another medical facility if any of us experience any unanticipated effects associated with treatments and services or if I/we or my children's condition worsens. If a medical emergency arises, I/we will call 911 or visit the nearest hospital emergency room.

Patient Signature: _____ Date:_____

FINANCIAL POLICY

Please read each statement and initial.

- I understand that I am personally financially responsible for all services rendered to me or my child. _____
- I agree that all fees will be paid at the time of service unless arrangements have been made in advance with Ballard Family Chiropractic. _____
- I understand if I carry a balance, a card must be kept on file with an authorization for a monthly payment as agreed upon with Ballard Family Chiropractic._____
- I understand if my balance exceeds $500 care may be suspended until financial arrangements have been made. _____

Patient Name: _____ *Date:*_____

To receive text appointment reminders, initial here_____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, 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 changes 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 & 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.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

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 or disclosed. I also allow use of my personal email address for office communication.

Patient Name: _____ *Date:* _____