INFORMED CONSENT FOR TREATMENT

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including and not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. I wish to reply on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

By signing below I agree to the above and allow the Doctor, affiliated with Ballard Family Chiropractic, to perform such. This consent will cover the entire course of my treatment.

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.* _____
- *I agree that all fees will be paid at the time of service unless arrangements have been made in advance with Ballard Family Chiropractic.* _____

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 (HIPPA), 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 assurance 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 (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE: