Hartman Family Chiropractic Consent

Patient Name_____

Authorization to Contact

I authorize this healthcare provider to contact me via telephone, email, and/or postal mail in providing appointment reminders and healthcare information.

Patient Signature _____ Date _____

Clinical Massage Therapy

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension unless it has been medically coordinated. I further understand that massage should not be construed as a substitute for medical examination, full diagnosis, and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. I affirm that I have stated all my known medical conditions, and answered all questions honestly as massage should not be performed under certain medical conditions. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapists' part should I fail to do so. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that any illicit or sexually suggestive comments or actions made by me will result in immediate termination of the session and I am responsible for full payment.If you require any accommodations for your treatment, we will be happy to assist, if possible. Please give us notice before you arrive.

I understand the following rules regarding clinical massage at this location:

RULES

1. Please arrive for your appointment 15 minutes prior to the scheduled start time.
2. If late arrival is inevitable, your service(s) may be shortened in order to keep on schedule. The original treatment time will be charged.
3. Our massage sessions are considered a therapeutic hour and are therefore 52-54 minutes (22-24 for 30 minutes) in length to allow me time to disrobe and prepare for my massage.
4. I agree to provide at least 24 hours notice if I need to reschedule or cancel a treatment. Failure to give notice will result in being fully charged for the service on the card on file.
5. If I am unable to give 24 hour notice, I am allowed to give my massage to a friend or family member with no charge to me.
6. I agree to keep a credit card on file for all future massage payments and cancellation fees.

Patient Signature _____ Date _____

Hartman Family Chiropractic Consent

Patient Name_____

Informed Consent

As a patient coming in to see the doctor of chiropractic, I give the doctor permission and authority for examination and care in accordance with chiropractic testing and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render a patient susceptible to injury even though a procedure was performed correctly. It must be understood by any patient seeking health care that no guarantee of results can be made and that injury, paralysis, or even death may occur from any procedure. By signing this consent for care, I acknowledge the risk or danger and choose to have chiropractic procedures performed. The doctor will not give a chiropractic adjustment or health care if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service.

DIAGNOSIS

Although doctors of chiropractic are experts in musculoskeletal and chiropractic diagnosis, they are not medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition.

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic and traditional medicine. Chiropractic care seeks to restore health through natural means without the use of medicine and surgery. This gives the body maximum opportunity to utilize its inherent recuperative ability. The success of the chiropractic doctor's procedures often depends on the environment, underlying causes, and both physical and spinal conditions. A doctor of chiropractic conducts a clinical analysis for the purpose of determining adjustments and ancillary procedures that may be given in an attempt to restore spinal integrity. Due to the complexities of a patient's overall health, no doctor can promise specific results.

RESULTS

Because there are many variables in regard to a patient's overall health and spinal integrity, it can be difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes, the response is immediate. In other cases, it may be gradual. Occasionally, the results may be less than expected. Two or more similar cases may respond differently to the same procedures. Because of these variables, your progress will be evaluated at every appointment and proper recommendations will be provided based on presentation.

Please discuss any questions and concerns with the doctor before signing this statement of consent.

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Patient Name_____

I have read and understood the foregoing and give my consent to proceed with chiropractic care.

Patient Signature _____ Date _____

Open- Bay Environment
At this office, patients receive adjustments in an open-bay environment with patients within earshot and visibility of one another. As a result, some ongoing routine details of care have the potential to be overheard by other patients and staff.

This environment is used for ongoing care and is NOT the environment used when taking patient histories, performing examinations, presenting reports of findings, or for an initial visit. These procedures are completed in a private, confidential setting.

If you do not wish to receive care in the open-bay area at any time, other arrangements in a private setting can be made upon request.

Patient Signature _____ Date _____

Use and Disclosure of PHI
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By this electronic acknowledgement, I affirm that as a patient of Hartman Family Chiropractic or as the legal guardian of a minor child that is a patient of Hartman Family Chiropractic, that I authorize the practice: (i) to capture photographic or video images of the patient; (ii) to reproduce, use, and disclose the images, with or without the patient's name; (iii) to publicize the fact that chiropractic services were provided to the patient; (iv) to reproduce and publish any testimonials the patient provides regarding Hartman Family Chiropractic (collectively referred to herein as the "information"); and (v) to secure copyright registration for any materials that incorporate the information, at the election and sole expense of Hartman Family Chiropractic. The authorization is given to Hartman Family Chiropractic for disclosures to any persons, without limitation, who may view the information in printed or digital form in promotional materials including social media or internet sites.

PURPOSE:
The purpose of this authorization is to permit the information, including images, to be used for marketing of Hartman Family Chiropractic, and I explicitly consent to the use of information for advertising and marketing activities to promote Hartman Family Chiropractic. I acknowledge and agree that no compensation will be provided for the use of the information.

EXPIRATION AND REVOCABILITY:
If the patient is signing on his or her own behalf, this authorization expires when the patient informs the practice that he or she is no longer a patient of Hartman Family Chiropractic. If the

Hartman Family Chiropractic Consent

Patient Name_____

patient is signing on behalf of a minor child, this authorization expires when the patient reaches the age of majority, but the authorization remains valid for protected health information already used or disclosed until revoked by the patient who has attained majority. However, I understand that protected health information already used or disclosed prior to any revocation may no longer be protected. I understand that I may revoke this authorization at any time by notifying Hartman Family Chiropractic by certified mail, return receipt requested, but that revocation will only affect uses and disclosures initiated after the date the notice is received by Hartman Family Chiropractic. Upon receipt of the notice of revocation, Hartman Family Chiropractic will make reasonable efforts to remove protected health information from social media platforms over which it has control but cannot guarantee removal from all sites. I understand and explicitly acknowledge that the Internet allows for wide sharing and forwarding of information and that Hartman Family Chiropractic cannot control all re-disclosure of information.

NO EFFECT ON TREATMENT:
This authorization is voluntary. I understand that Hartman Family Chiropractic cannot condition treatment of the patient on whether I sign this authorization and that my decision not to sign will not influence or affect my treatment in any way.

I recognize and agree that this electronic acknowledgement is the legal equivalent of my manual signature.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By this acknowledgement, I affirm that as a patient of Hartman Family Chiropractic or as the legal guardian of a minor child that is a patient of Hartman Family Chiropractic, that I authorize the practice: (i) to capture photographic or video images of the patient; (ii) to reproduce, use, and disclose the images, with or without the patient's name; (iii) to publicize the fact that chiropractic services were provided to the patient; (iv) to reproduce and publish any testimonials the patient provides regarding Hartman Family Chiropractic (collectively referred to herein as the "information"); and (v) to secure copyright registration for any materials that incorporate the information, at the election and sole expense of Hartman Family Chiropractic. The authorization is given to Hartman Family Chiropractic for disclosures to any persons, without limitation, who may view the information in printed or digital form in promotional materials including social media or internet sites.

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NO EFFECT ON TREATMENT:
This authorization is voluntary. I understand that Hartman Family Chiropractic cannot condition treatment of the patient on whether I sign this authorization and that my decision not to sign will not influence or affect my treatment in any way.

Patient Signature _____ Date _____

Verification of Payment
I understand that I am responsible for payment of all services received by this healthcare provider and any questions or concerns regarding insurance coverage will be resolved based on agreements between myself and my insurance carrier(s).

Our doctors and staff desire to assist our patients with insurance coverage for chiropractic services. In order to avoid misunderstandings, please read the following statements carefully:

1. The insurance company has an obligation to the PATIENT and not the doctor.

2. The doctor cannot state or guarantee what services the insurance company will assist with or the amount of coverage.

3. As a courtesy for the patient, the office will complete insurance forms and attempt to estimate insurance coverage. This does not relieve the patient of their obligation to the doctor, nor does it imply that the fee for services is thereby settled. The patient alone is obligated to provide payment of services rendered to the doctor. This includes insurance deductibles, co-payments, and any services rejected by the patient's insurance company.

I hereby instruct and direct my insurance company to pay by check or electronically mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise

Hartman Family Chiropractic Consent

Patient Name_____

payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic.

Patient Signature _____ Date _____

Verification of Privacy

I acknowledge that Hartman Family Chiropractic & Wellness Center's "Notice of Privacy Practices" has been provided to me. I understand I have a right to review this prior to signing this document. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations at Hartman Family Chiropractic & Wellness Center. The Notice of Privacy Practices is also provided on request at the main desk of this practice and also located online at www.hartmanfamilychiro.com. This Notice of Privacy Practice also describes my rights and this office's duties with respect to my protected health information.

Hartman Family Chiropractic & Wellness Center reserves the right to change the privacy practices that are described in the current Notice of Privacy Practices. I may obtain a revised version by accessing the website, calling the office, and/or requesting a revised copy be sent in the mail or available at my next appointment.

Patient Signature _____ Date _____

Verification of X-Rays

This is to certify that to the best of my knowledge, I am not pregnant and Hartman Family Chiropractic has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Patient Signature _____ Date _____

Verification of Information

I verify that to the best of my knowledge all information I have provided is thorough and accurate.

Patient Signature _____ Date _____

Hartman Family Chiropractic Consent

Patient Name_____

Consent to Treat a Minor

Being the parent or legal guardian of this patient, I have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care. I recognize and agree that this electronic acknowledgement is the legal equivalent of my manual signature.

Signature of Parent/Guardian _____ Date _____

Printed Name of Parent/Guardian _____