Terms and Consent

X-RAY Consent (for women of childbearing age)

I am pregnant: ( )Yes ( )No

Date of last menstrual period: ____

To my knowledge I am not pregnant and I understand the doctor feels that the information to be gained from this examination is important to my health. I therefore wish to have this x-ray examination performed now.

Patient signature: ____ Date:________

Guardian signature: ____ Date: ________

Patient HIPAA Consent

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define 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 charges 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 and 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, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. 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 disclosed.

Date: ____________________ Print Patient Name: ____

Signature:_____________________________________ Relationship to Patient: ____________________

Authorization for Care

I hereby authorize doctors and staff at LifeGiving Chiropractic to treat my condition as deemed appropriate. At LifeGiving Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of LifeGiving Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. Our goal is to provide you with the best care possible. Should we feel that we cannot help you, we will refer you to another provider who we feel can further assist you.

Date: ____________________ Signature: ____