Bennett Family Chiropractic, LLC

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Bennett Family Chiropractic, LLC have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

***FEMALES ONLY→** *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and/or I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized person's Signature Date

SMB,DC 9/2012

BENNETT FAMILY CHIROPRACTIC, LLC

HIPAA PATIENT COMMUNICATION FORM

It is the office policy of Stephanie Bennett, DC not to release confidential medical information regarding your treatment to family members or friends, except for parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below.

By signing below, you authorize the following people to receive information regarding your treatment:

List names (please list relationship such as spouse, parent, boyfriend, fiancé, girlfriend, sister, brother, etc)

_____

_____

_____

_____

How may we contact you?

Can we say we are calling from:

☐ Bennett Family Chiropractic

☐ The Doctor's Office

Home Phone _____

_____ DO NOT leave a message

_____ Leave a brief message

_____ May leave a detailed message

Cell Phone _____

_____ Do not leave a Message

_____ Leave a brief message

_____ May leave a detailed message

***WHICH PHONE NUMBER WOULD YOU LIKE PRIMARY _____ ***

Who would you like us to contact in case of an emergency?

Name _____ Relationship _____

Phone Number _____

If you wish to add names later on, please confirm in writing with our office.

Patient Printed Name _____

Patient Signature _____

Parent/Guardian Signature _____

Today's Date _____