Patient Informed Consent

To Chiropractic Adjustment and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and massage, on me (or on the patient named below, for whom I am legally responsible) by Dr. Bonnie Harder, D.C. and/or other licensed doctors of chiropractic who now or in the future work for Holistic Balance Animal Chiropractic (HBAC).

I have had an opportunity to discuss with Dr. Bonnie Harder, D.C. and/or with other office, clinic, or doctor's personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I understand that as part of my healthcare, HBAC originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I understand and have been provided with a HIPAA Statement, Rights and Responsibilities, and Notice of Privacy Practice that provide a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that HBAC reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided or forward a copy in via e-mail at my request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that HBAC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that HBAC has already take action in reliance thereon.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date _____