LA COSTA CHIROPRACTIC

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Privacy Right Notification Acknowledgement

By signing this form, you are granting consent to La Costa Chiropractic to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at (760) 438-9548.
I hereby acknowledge receipt of the Notice of Privacy Practices.

Signature_____ Date_____
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:
□ Individual refused to sign □ An emergency situation prevented us from obtaining acknowledgment
□ Communication barriers prohibited obtaining the acknowledgment

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic examination, adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me, for whom I am legally responsible, by the doctor of chiropractic named below and /or their licensed doctor of chiropractic, who now or in the future treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.
I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.
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, increased symptoms in the treated area, sprains and strains, dislocation, fracture, or stroke. The possibility of such injuries occurring in associations with adjustment is extremely remote. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.
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.

_____ _____
Print Patient's Name Signature of Patient or Guardian

_____ _____
Date Signed Witness Signature (Office Staff)

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.
Signature _____ Date _____

Michael D. Berry, D.C. James R. Miller, D.C. Lawrence R. Dahl, D.C. Lee A. Wood, D.C., Anthony Salmon, D.C.

Verbal Review Date_____ Doctors Initials_____