

BACK 2 BACK CHIROPRACTIC
INFORMED CONSENT TO CHIROPRACTIC CARE & PRIVACY NOTICE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me or on the patient named below, for whom I am legally responsible.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of the spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptoms, disease or condition as a result of treatment in the clinic. I understand that the chiropractor will use his or her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he or she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with similar cases.

I have had an opportunity to discuss 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, fractures, disc injuries, strokes, dislocation and sprains.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health, history, symptoms, examination and test, diagnosis, treatment, and any part for future care or treatments. 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 Notice of Information Practices that provides 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 the Practice 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 a 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 the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already take action in reliance thereon.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. 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 conditions(s) for which I seek treatment.

NAME _____ Signature _____ DATE _____

Office Use Only Below This Line

() Nature & Purpose of Adjustment
() Patient's Authorization to Treat

Other _____

Informed Consent Consultation

() Treatment Risks () Alternative Treatment Options

X _____ Date _____

Dr. Derik Baltich D.C.

Authorization for the Release of Protected Health Information

Back 2 Back Chiropractic 206 Joe V Knox Ave, Suite C, Mooresville, NC 28117
Phone 704-799-1999 Fax 704-663-8225

Patient Name _____ Date of Birth _____

List those facilities and/or doctors you have seen for this same problem or condition.

Facility / Doctor _____ Phone _____

Facility / Doctor _____ Phone _____

Facility / Doctor _____ Phone _____

I request and authorize the entities and individuals listed above to release my protected health information to Back 2 Back Chiropractic Group PLLC.

Please send: Treatment Notes & Imaging Reports regarding _____.

Signature X _____ **Date** _____

I authorize Back 2 Back Chiropractic to obtain my protected health information.

Fax Records To: 704-663-8225

OR

Mail To: Back 2 Back Chiropractic, 206 Joe V Knox Ave, Suite C, Mooresville, NC 28117

The Following Section is OPTIONAL

I request and give consent for Back 2 Back Chiropractic and the doctors and staff to release and discuss my protected health information (PHI) with the following individual(s). Please Circle

My Spouse My Parent(s) My Children My Employer My Attorney The
Media Coach Family Other

List Individuals: _____

X _____ **Date** _____