## PATIENT HEALTH INFORMED CONSENT

The patient understands and agrees to allow Susquehanna Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information (PHI), we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

PATIENT'S SIGNATURE _____ DATE _____

GUARDIAN'S SIGNATURE _____ DATE _____

## INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficially and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient, by a physician at Susquehanna Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

PATIENT'S SIGNATURE _____ DATE _____

GUARDIAN'S SIGNATURE _____ DATE _____

## CONSENT TO TREAT A MINOR

(I)(We), the undersigned, parent(s)/person having legal custody/guardianship do hereby authorize the physician at Susquehanna Chiropractic and whomever they may designate as an assistant, to administer care as deemed necessary to my child.

MINOR'S NAME _____ DATE _____

GUARDIAN'S SIGNATURE _____ DATE _____