Greer Chiropractic Center, PA
215 W Poinsett St
Greer, SC 29650
864-877-5795

CONSENT FOR TREATMENT AND PRIVACY

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) by the doctor of chiropractic named below and/or licensed doctors who now or in the future work 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 name below and/or with other office or clinic 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 judgement 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 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-mentioned 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)

_____

(Witness signature)

COMPLIANCE ASSURANCE NOTIFICATION FOR PATIENTS

To our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without and thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

2. Please list the family members or significant other, if any, whom we may inform about your medical condition only in a emergency:

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

4. Please indicate if you want correspondence from our office sent in a sealed envelope marked "Confidential".

Yes_____ No_____

5. Please print the telephone number, if any, where you want to receive call about appointments, lab and x-ray results, or other health care information if other than your home phone number.

6. Can confidential messages (i.e. appointment reminders) be left on your answering machine or voicemail?

Yes_____ No _____

7. If you do not have voicemail, can a confidential message be left at your place of employment?

Yes _____ No _____

Patient Name _____

(Guardian if under 18)

Witness _____