STEVENS CHIROPRACTIC
& ACUPUNCTURE CLINIC

Informed Consent for Examination and Treatment

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physiotherapy, diagnostic x-rays, acupuncture, on me (or the patient named below, for whom I am legally responsible) by Dr. Stevens and his staff.

I believe I have been given opportunity to discuss with clinic personnel the nature and the purpose of the above services. I understand the results of the treatment and payment by my insurance is not guaranteed and I agree that services and procedures not covered by my insurance plan are my responsibility.

I understand and am informed that, as in the practice of medicine, there are some risks to chiropractic treatment and acupuncture. These include, but are not limited to: fractures, disc injuries, strokes, TIAs, dislocations, sprain, strains, bruises, infections.

I understand and do not expect that the doctor would be able to anticipate and explain all of the risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon his on site assessment of the facts known to him/her is in my best interest.

I have read, or have had read to me, the above consent form. 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 as well as for any future condition(s) for which I seek treatment.

Confidentially and Security of Your Personal Record and Information

HIPAA

We take our responsibilities of guarding your private information seriously. We will only use the information you provide us with to treat you and process your insurance claims. As such, you have certain rights as listed below.

1) **You have a right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you as long as we maintain the protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protect health information that is subject to law that prohibits access to protected health information.

2) **You have the right to request a restriction on your protected health information**. Your request must site the specific restrictions requested and to whom you want the restrictions to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protect health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

3) **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable request. We may also condition this by asking you for information as to how payment will be handled for this service. We will not ask for an explanation for this request. Please make this request in writing. Please address it to our office in care of the compliance officer.

4) **You have the right to receive an accounting of certain disclosures we have made, if any, of you protected health information.** This right applies to a disclosure for purposes other than treatment, payment or healthcare operations. Upon your request, we will provide with an account as such we deem reasonable.

5) **Complaints.** You may file a complaint with us or the United States Office of Civil Rights. To make a complaint to us, please do so in writing by addressing it to our office at 327 Douglas Avenue, Yankton, SD 57078 in care of the compliance officer.

I hereby by acknowledge that I have read and agree to the above Informed Consent and HIPAA statements

Signature _____ **Printed Name**_____ **Date** _____