St. Joseph Chiropractic

Dr. Robert Marrow, DC/ Dr. Ryan Marrow, DC

INFORMED CONSENT TO CHIROPRACTIC TREATMENT/ HIPAA RELEASE FORM

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) by the chiropractic physician(s) Dr. Robert Marrow, DC / Dr. Ryan Marrow, DC and/or anyone working in this office authorized by the chiropractic physician(s).

I further understand that such chiropractic services may be performed by the Physicians of Chiropractic named here: Dr. Robert Marrow, DC/ Dr. Ryan Marrow, DC and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Robert Marrow, DC/ Dr. Ryan Marrow, DC 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 and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physicians to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physicians to exercise judgment during the course of the procedure which the physicians feels are in my best interests at the time, based upon the facts then known.

I have received or reviewed the privacy practice notice for St. Joseph Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (My Application for Care) on my first visit, whenever that may have occurred. I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement. I have also received a personal copy of St. Joseph Chiropractic’s office policies and procedures. I have read and clearly understood the policies and will abide by them accordingly.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

|  |  |
| --- | --- |
| To be completed by the patient: | To be completed by the patient’s  representative, if necessary, (eg: if the patient is a minor or is physically or mentally incapacitated) |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Patient’s Name  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Patient  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name of Patient  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name of Representative  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Representative  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date |

This form should be maintained in the patient’s health record.

4102 Sunset Blvd. Steubenville, OH 43952

740-283-3365—office/ 740-283-3375—fax