# INFORMED CONSENT FOR CHIROPRACTIC AND ACUPUNCTURE

**TO THE PATIENT:**
You have a right as a patient to be informed about your condition and the recommended use of acupuncture or chiropractic adjustments (and other chiropractic procedures) to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I _____ hereby request and consent to the performance of acupuncture (including needling, moxa and cupping), chiropractic adjustments and other chiropractic procedures, including various models of physical therapy, on me (or the patient named below. For whom I am legally responsible), by Dr. Steven Schram. I have had the opportunity to discuss with Dr. Schram my diagnosis, the nature and the purpose of acupuncture, chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of acupuncture or chiropractic there are some risks to exam and treatment including, but not limited to:

_____ **Chiropractic-**fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain.

_____ **Acupuncture**-bruising, organ puncture, infection, local tenderness, drowsiness.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions, and all of my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. 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.

**To be completed by the patient:**

_____
Print name

_____
Signature date

_____
witness to patient signature date

**To be completed by the patient's representative, if necessary, eg, if the patient is a minor or incapacitated:**

_____
Print name of patient

_____
Name of patient's representative

_____
Signature of patient's representative

# Patient Health Information Consent Form

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. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Dr. Steven Schram to use their patient Health Information (PHI) for the purpose of treatment, payment healthcare operations, and coordination of care. As an example, the patient agrees to allow Dr. Schram office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment. Dr Schram also explicitly requests the permission to send a thank you letter to the person that referred you.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, our staff has been trained in the area of patient record privacy and Dr. Schram has been designated a privacy official to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with Dr. Steven Schram about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment payment and health care operations, Dr. Schram *has the right to* refuse to give care.

I have read and understand how my Patient Health Information will be used and I Agree to these policies and procedures.

Name _____ Signature_____ Date_____