RATCLIFF
CHIROPRACTIC

Consent to Exam and Treat

The doctors and staff at Ratcliff Chiropractic would like to welcome you to our practice. People go to Chiropractors for a variety of reasons. Some go for symptom relief of pain or discomfort (relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (corrective care). Still others want whatever is malfunctioning in their bodies brought to the highest state of heath possible with Chiropractic care (comprehensive care). Your doctor will weigh your needs and desire when recommending your treatment program.

I hereby authorize the Doctor(s) to treat my condition as they deem appropriate. The doctor(s) will not be held responsible for any pre-existing medically diagnosed conditions, nor any medical diagnosis.

The undersigned consents to any examination (x-ray and otherwise) including, but not limited to, physical orthopedic and neurological evaluation, visual inspection, palpation, exercise stress test, electromyography (EMG) and photography.

The undersigned also consents to observation of therapeutic or diagnosed procedures by staff personnel or medical personnel in training as permitted by the attending practitioner and allowed by clinic policy. Treatment procedures that may be used in your treatment include, but are not limited to, manipulative therapy, joint mobilization, myofascial release, trigger-point therapy, ultrasound, diathermy, electrical therapy, traction, muscle stretching, hydrocollator therapy, cryo-therapy, nutritional supplementation, rehabilitative exercise, and massage.

Cases will be managed with all due concern and with the evaluation of response to previous care provided. Home care instructions will be given as appropriate to enhance your treatment program. Compliance with the recommendations for home care and follow-up care is necessary for resolution of your complaint.

Because of modern techniques and equipment, examination and therapeutic procedures carry with them a low risk of complication. Even though problems seldom arise during these procedures, risks must be recognized and considered. Any procedure intended to help may also do harm. While examination and therapeutic procedures used in this clinic are considered remarkably safe and effective, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate our patients. Complications reported in the literature include but are not limited to pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, bleeding, fracture, fainting, irregular heartbeat, heart attack, spinal cord damage, nausea, burns, soft tissue injury, stroke, dizziness, or weakness. No guarantee or warranty for a specific cure or result is implied by the acceptance of your case. All patients respond differently to the treatment procedures. Each case must be evaluated separately.

If you do not fully understand the above or have questions about anything mentioned in this document, please do not sign it until these matters have been resolved with further discussion.

I have read the above explanation of treatment and diagnostic procedures used in this clinic and have myself decided that it is in my best interest to submit to these procedures.

Printed Name_____Date:_____

Signature_____

Witness_____

Notice of Privacy Practices Acknowledgement Form
And
Permission to Release Medical Information

Patient: _____Date: _____

Ratcliff Chiropractic has a comprehensive policy to preserve your confidential medical information also called "protected health information". This Notice of Privacy Practices is available for you to read and review in the lobby of our office. A printed copy of the notice is also available to you if requested.

I hereby acknowledge that this information has been made readily available to me, and I have had the opportunity to review the information contained therein.

Patient's Signature Date

Family/Significant Other Signature Date

In addition, I hereby have given my permission for my Protected Health Information to be released, when necessary, to the following individuals, who are also my emergency contact(s):

Name Relationship to Patient

Date of Birth Phone Number

Name Relationship to Patient

Date of Birth Phone Number

Name Relationship to Patient

Date of Birth Phone Number

This information may include, but is not limited to, confirmation/changes of appointments, testing results, medication changes, progress reports, etc. I may withdraw this permission at any time by informing the Ratcliff Chiropractic Office staff in writing.