MT. PLEASANT CHIROPRACTIC & REHAB, LLC

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read the below and if you have any question please feel free to ask one of our staff members.

INFORMED CONSENT

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by the physician at Mt. Pleasant Chiropractic & Rehab, LLC, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

_____ _____

Signature Date

PATIENT CONSENT TO X-RAY/ PREGNANCY RELEASE

I authorize the performance of diagnostic x-ray examination of myself which the above doctor or his associate may consider necessary or advisable in the course of my examination and treatment.

_____ _____

Signature Date

WOMEN ONLY: This is to certify to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child. Date of Last Menstrual Period _____

CONSENT TO EVALUATE AND TREAT A MINOR: I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

MEDICAL RECORDS & COPIES OF X-RAYS

By law, our office retains your *original* medical records and x-ray film. If you require *copies* of your x-ray films, each duplicated x-ray costs $5.00.

I understand medical records and x-ray films are the property of Mt. Pleasant Chiropractic & Rehab. I also understand that I may request copies of these records. Copies of x-ray films are an additional fee of $5.00/film.

_____ _____

Signature Date

ACKNOWLEDGEMENT/COMMUNICATIONS

I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy.
Upon request I will be given a copy.

_____ _____

Signature Date

May we leave messages on any answering device, i.e. home answering machines or voicemails? Yes ❑No ❑
In the event that we would need to communicate your healthcare information (confirming or changing an appointment), to whom may we do so?
Spouse: ☐Y☐N Children: ☐Y☐N

Due To HIPAA regulations, we will be calling you by your FIRST name. We respect your privacy and do not mean to be disrespectful. The use of your first name is less informative to others than the use of your last name. Please inform someone at the front desk if this is not acceptable to you.