

# SnyderChiropracticCare

For better health & wellness

## Consent for Chiropractic Treatment

State law requires us to obtain your consent prior to your chiropractic treatment. What you are being asked to sign is simply a confirmation that we have discussed your contemplated treatment and that we have given you sufficient information upon which to make a decision whether to have the treatment and any choice as to the type of treatment of your own free will. We will discuss with you the common problems or undesired results that sometimes occur. We wish to inform you, not alarm you. If you wish, however, we can go into more elaborate details of more unlikely problems. If you do not, that is also your privilege. Please read the form carefully. Ask about anything that you do not understand. We will be pleased to explain it.

I hereby authorize and direct **Dr. Patrick Snyder**, with the associate(s) or assistant(s) of his choice to perform the following chiropractic procedures on

\_\_\_\_\_, my \_\_\_\_\_ as we have agreed upon.  
**Patient Name** Relationship, if minor

- The nature and purpose of the treatment to be performed by the physician are: Chiropractic Adjustment/Therapy.
- These treatments are expected to accomplish: increase range of motion and decrease muscle spasms.
- The reasonably known risks of the treatments are: initial stiffness and discomfort.
- Details of this treatment and alternative methods of treatment have been explained to me. I have been advised that, although good results are expected, each situation/person reacts differently to the treatment; therefore, the outcome of the treatment has no guarantee as expressed or implied.
- The doctor has explained to me the most likely complications that may occur from this treatment and I understand them. I have also been told the less likely complications, even if rare, that could occur.
- I hereby authorize Dr. Patrick Snyder and his associates/assistants to provide additional procedure(s) as they deem reasonable and necessary including, but not limited to, x-rays/therapy.
- I hereby affirm and state that I have read and understood this consent and that all blanks were filled in prior to my signature.

**Date** \_\_\_\_\_ **Signature** \_\_\_\_\_

The patient is unable to execute this consent for the following reason(s): \_\_\_\_\_

Witness \_\_\_\_\_

I certify that I have personally reviewed all the blanks on this form and explained them to the patient or his/her representative before requesting the patient or his/her representative to sign this form.

Physician Signature: \_\_\_\_\_

## Memo to our Patients Regarding HIPAA

As you may know, a new law has been passed that relates to how we may use your personal health information. We have always been in the forefront regarding patient confidentiality; and, for years, have been very careful with how we share your information with other people and have tried to protect your privacy. So, you will probably not notice that this law will affect our interaction that much.

We are required by law to have to sign a statement that you have received a copy of your rights under the law. This is called the "Notice of Privacy Practices".

Please sign and date this page indicating that you have been allowed to read the "Notice of Privacy Practices" and were offered a paper copy if so desired.

**Print Patient Name** \_\_\_\_\_

**Signature of Patient or Guardian** \_\_\_\_\_

**Date** \_\_\_\_\_