Healing Hands Chiropractic Inc.
3054 B Berkmar Dr, Charlottesville, VA, 22901 Tel (434) 409-0564

TERMS OF ACCEPTANCE

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

CONSENT TO TREATMENT

1. I,_____, authorize the performance upon myself of the
   Patient name
   Following procedure (s): Physical Therapy Modalities, Manipulation of the Spine and extremities Massage and Exercise instruction/therapy.

2. I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unknown conditions, that the above named doctor associates, or assistants may consider necessary or advisable in the course of my health care.

3. The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to my satisfaction by the above named doctor, associates, or assistants.

4. I acknowledge that no guarantee or assurance of the results that may be obtained from the procedure has been given by the named doctor, associate, or assistant.

Signed:_____ Date:_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alterative means, such as sending correspondence to the individual's office instead of residence. Please note your preferences by checking an option from the communications in writing and telephone columns.

Communication in writing:

☐ Send to home address
☐ Send to Office address
☐ Fax to _____
☐ Email _____

Communication by telephone:

☐ O.K. to leave a detailed message
☐ O.K. to leave a call back number only
☐ O.K. to call work number_____

By my signature below, I acknowledge receipt of the Notice of Privacy Policies.

Patient Signature:_____Date:_____