KOOISTRA CHIROPRACTIC

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

ADDRESS
2855 Byron Center Ave.
Wyoming, MI 49519

1680 East Paris Ave.
Grand Rapids, MI 49546

PHONE
616-532-2518

FAX
616-532-2696

WEB
drkooistra.com

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or chiropractor at Kooistra Chiropractic and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor at Kooistra Chiropractic, including those working at the clinic or office listed below or any other office or clinic.

I have or will have had an opportunity to discuss with the doctor of chiropractic the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. 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 upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Patient's Name: _____ Date: _____

Signature of Patient: _____

KOOISTRA CHIROPRACTIC

Acknowledgment of receipt of HIPPA privacy notice

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and accreditation.

_____

Patient Print

_____

Patient Signature

_____

Date

For Office Use Only
We attempted to obtain written Acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because: ☐ Individual refused to sign ☐ Communications barriers prohibited obtaining the Acknowledgement ☐ An emergency situation prevented us from obtaining Acknowledgement ☐ Other (Please Specify)_____ _____ _____ Staff signature Date