Mitchell Chiropractic & Acupuncture Center, P.C.

501 W. Havens Ave. * Mitchell, SD 57301 * 605-996-1078

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How we may use and disclose health information

Described as follows are the ways we may use and disclose your health information. You may revoke such permissions at any time by writing to our privacy officer.

- Treatment
- Payment
- Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services:
- Individuals Involved in Your Care or Payment for Your Care
- Research- Under certain circumstances
- Special Situations: As required by law. We will disclose Health Information when required to do so by international, federal, state, or local law.
- Business Associates
- Organ and Tissue Donation
- Military and Veterans
- Worker's Compensation
- Public Health Risks
- Health Oversight Activities
- Lawsuits and Disputes
- Law Enforcement
- Coroners, Medical Examiners, Funeral Directors
- National Security, Protective Services, and Intelligence Activities
- Inmates or Individuals in Custody

To avert a serious threat to health of safety we will disclose Health Information when necessary to prevent a serious threat to your health and safety or to the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Your Rights:

- Right to Inspect and Copy
- Right to Amend
- Right to an Accounting of Disclosures
- Rights to Request Restrictions: We are not required to agree with your request
- Right to Request Confidential Communication
- Right to a Paper Copy of this Notice:
- Changes to This Notice
- Complaints: You will not be penalized for filing a complaint

By signing my name below, I acknowledge receipt of a copy of this notice, my understanding, and my agreement to its terms. This notice is effective _____. This notice will expire seven years after the date upon which the record was created.

X_____
Patient Name Printed

X_____
Date

X_____
Patient Signature

_____
Authorized Provider Representative

_____
Personal Representative Printed

_____
Personal Representative Signature

_____
Relationship to Patient

_____
Name of person(s) who MCAC may disclose my Health Information to

Informed Consent to Chiropractic Treatment

Chiropractors are required by law to obtain your informed consent before starting treatment.

I, _____, do hereby give my consent to the performance of conservative noninvasive
(Patient/minor's name)
treatment to the joints and soft tissues, I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy, ultrasound, hot packs, TENS unit, exercises, and other therapeutic modalities may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Join Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a one million to once in ten million treatments.

Physical therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precaution, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Tests have been performed on me to minimize the risk of complications from treatment, and I freely assume these risks.

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I agree to performance of procedures by my doctor and such other persons of the doctors choosing.

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over the counter mediations, exercises, and possible surgery.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment for myself or my child.

_____ _____

Date Patient or Parent/Guardian Signature

_____ _____

Date Mitchell Chiropractic & Acupuncture Representative