Frederick Chiropractic Wellness Center
Dr. Deborah Morrone
425 E. Patrick Street, Frederick, MD 21701 • 301-695-0032 • 301-695-3911 fax
www.frederickchiro.com

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.
I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

____________________________	_________________________
Patient Name (printed)	Relationship to patient
____________________________	________________
Patient or Legal Guardian Signature	Date
_____________________________	________________
Witness Signature (office staff)	Date

Frederick Chiropractic Wellness Center
Dr. Deborah Morrone
425 E. Patrick Street, Frederick, MD 21701 • 301-695-0032 • 301-695-3911 fax
www.frederickchiro.com

NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. Our practice has the right to accept or deny your request.
Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.
You may inspect and receive copies of your records within 30 days of a written request. There may be a reasonable cost-based fee for photocopying, postage and preparation.
You may request changes to your records, in writing. Our practice has the right to accept or deny your request.
We maintain a history of protected health information disclosures that is accessible to you upon written request. Such requests will be fulfilled within 60 days.
In the future, we may contact you to provide appointment reminders or information about treatment alternatives, or other health-related benefits and services that may be of interest you.
You have the right to request confidential communications by alternative means or to an alternative location (i.e., you may request that you be contacted in a specified place or manner).

Notice regarding chiropractic care being provided in an "open-door" adjusting environment
It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. As a result patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open door" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization.

If you choose not to be adjusted in an open-door adjusting environment other arrangements will be made for you; let the front desk know when you arrive for your appointment. Your decision will have no adverse effect on your care or on your relationship with our staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.
You may file a complaint about privacy violations by contacting our Office Manager.

Name ______________________________Signature _______________________________D ate_____________

The effective date of this Notice of Privacy Practices is March 15, 2009

Frederick Chiropractic Wellness Center
Dr. Deborah Morrone
425 E. Patrick Street, Frederick, MD 21701 • 301-695-0032 • 301-695-3911 fax
www.frederickchiro.com

PATIENT AUTHORIZATION

Name ________________________________ **Email Address** _________________________

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information, your decision will have no adverse effect on your care or relationship with Frederick Chiropractic Wellness Center, Inc. Your email/contact info will never be shared with 3rd parties. **By initialing below, you authorize the following:**

Appointment Reminders and Scheduling Related Matters __________
This office may use your name, address, telephone number, or email for the purpose of contacting you to remind you of scheduled appointments, re-evaluations, or other health care and scheduling related matters.

Preferred method(s) of contact: Email Home phone Work phone Cell phone

Contact Regarding Chiropractic and Health Related Information __________
This office may use your name, address, telephone number, or email for the purpose of contacting you to advise you about health related meetings, workshops, and products. You will also be placed on our mailing list for our bi-monthly e-newsletter. You may unsubscribe to the newsletters anytime by going to www.FrederickChiro.com.

Others Involved in My Healthcare

Frederick Chiropractic Wellness Center, Inc. and Dr. Deborah Morrone MAY discuss all aspects of my healthcare with:

___________________________________ _________________
Print Name Relationship

___________________________________ _________________
Print Name Relationship

___________________________________ _________________
Print Name Relationship

As the patient, you may also request that any part of your Private Health Information (PHI) not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

____ Date: ______________
Signature of Patient or Legal Representative

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow up to 30 days for change in our system to be completed.

Thank you!