12242 Queenston Blvd., Suite G
Houston, TX 77095
832.479.8846
drclaudiavarga@yahoo.com
www.lifetimewellnesschiropractic.com

Lifetime WELLNESS CHIROPRACTIC

ACKNOWLEDGEMENT FORM

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Lifetime Wellness Chiropractic "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Lifetime Wellness Chiropractic's Notice of Privacy Practices prior to signing this document. Lifetime Wellness Chiropractic has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Lifetime Wellness Chiropractic. The Notice of Privacy Practices for Lifetime Wellness Chiropractic is also provided on request at the front desk of this practice and on Lifetime Wellness Chiropractic's website at lifetimewellnesschiropractic.com. **This Notice of Privacy Practices also describes my rights and Lifetime Wellness Chiropractic's duties with respect to my protected health information.**

Lifetime Wellness Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Lifetime Wellness Chiropractic website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

initial

Consent to Treat

Chiropractic examination (history, examination, neurothermal scanning) and therapeutic procedures (including but not limited to spinal and/or extremity adjustments, heat/cold application, acupuncture, manual muscle therapy, electrical muscle stimulation, and therapeutic exercises) are considered safe and effective methods of care. However, any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice Lifetime Wellness Chiropractic, to inform the patients about them. Additional diagnostics such as advanced imaging, laboratory tests and/or outside medical referral may also be ordered as needed.

Complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, bruising, and temporary worsening of symptoms. More serious complications such as fractures and stroke are extremely rare. Additional information on side effects and complications can be explained by your treating doctor upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required.

I consent to the provisions of care. I understand that this care may include treatment, special tests, exams, evaluations, and rehabilitation. I understand that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.

initial

This authorization shall remain effective unless revoked in writing by the undersigned.

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Consent to Acupuncture Treatment

I consent to being treated with acupuncture needle procedures as part of the chiropractic care rendered to me by Lifetime Wellness Chiropractic. I have been informed of the potential risks of the procedures, which are similar to those of an injection procedure or needle immunization procedure.

I understand that only sterile packaged single use needles will be used and that standard clean needle technique will be followed. The procedures have been explained to me and I understand them to my satisfaction.

initial

Consent to Treatment (Minor)

I hereby request and authorize Lifetime Wellness Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

initial

If you were referred by a healthcare practitioner, would you like us to send reports and updates to your Referring Provider? **Yes or No**

If Yes, please list your referring provider: _____

Patient/Guardian: _____ Date: _____

Witness: _____ Relationship: _____