COMPREHENSIVE CHIROPRACTIC CLINIC • Michael J. Hughes, D.C., DABCO
610 W. Michigan Ave., Jackson, Michigan 49201
517-784-9101

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- While rare, some patients may experience short term aggravation of symptoms, rib fractures, or muscle and ligament strains or sprains as a result of manual therapy techniques.

- There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.

- There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or Chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from Chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my Chiropractor the nature and purpose of Chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the Chiropractic treatments offered or recommended to me by my Chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future Chiropractic care.

Patient Signature (or Legal Guardian)	*Signature of Witness*
Patient name (please print)	*Witness name (please print)*

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by COMPREHENSIVE CHIROPRACTIC CLINIC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of COMPREHENSIVE CHIROPRACTIC CLINIC. I understand that Michael J, Hughes, D.C. may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my protected health information for the above state purposes. *(My signature on this document is evidence of this consent.)*

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. COMPREHENSIVE CHIROPRACTIC CLINIC is not required to agree to the restrictions that I request. However, if COMPREHENSIVE CHIROPRACTIC CLINIC agrees to a restriction that I request, the restriction is binding on COMPREHENSIVE CHIROPRACTIC CLINIC and Dr. Michael J. Hughes, D.C .

I understand I have a right to review COMPREHENSIVE CHIROPRACTIC CLINIC'S Notice of Privacy Practices prior to signing this document. COMPREHENSIVE CHIROPRACTIC CLINIC'S Notice of Privacy Practices 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 COMPREHENSIVE CHIROPRACTIC CLINIC. The Notice of Privacy Practices of COMPREHENSIVE CHIROPRACTIC CLINIC is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and CHIROPRACTIC CLINIC'S duties with respect of my protected health information.

COMPREHENSIVE CHIROPRACTIC CLINIC 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 calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, at any time, except to the extent that COMPREHENSIVE CHIROPRACTIC CLINIC or Dr. Michael J. Hughes, D.C. has taken action in reliance on this consent.

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Patient or Personal Representative Signature *Date*