

INFORMED PATIENT CONSENT

I understand that if I am accepted as a patient of Dr. Loftus and Sussex Chiropractic, S.C., I am authorizing them to proceed with any further treatment that may be necessary. Furthermore, any risks involving chiropractic treatment will be explained to me upon request.

PATIENT SIGNATURE _____

DATE _____

PARENT/GUARDIAN SIGNATURE AUTHORIZES CARE OF MINOR _____ DATE _____

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Please check the following specific items you give us permission to use:

_____ To use your name on our referral board.

_____ To Send advertisements of special events.

_____ To use your email for future conversations or newsletter type of correspondence.

E-mail address _____

_____ To leave messages on voice mail, answering machine or with a family member.

Patient's Signature _____

Date _____

Guardian's Signature Authorizing Care _____

Date _____