Inner Banks Chiropractic

We provide adjustments or manual manipulations through the gentle application of a targeted movement where and when indicated by a licensed Doctor of Chiropractic to improve motion of the body's spinal column and extremities.

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 an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

However, there are some risks associated with chiropractic adjustments, including, but not limited to the possibility of sprains, dislocations and fractures. In addition:

1. While very 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:

2. There are reported cases of stroke associated with neck movements including adjustments of the upper cervical spine. Current 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 a stroke may cause serious neurological impairment and result in injuries including paralysis.

The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and surgical procedures given for the same treatments.

By signing this Informed Consent, I acknowledge that I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments), the benefits, risks and alternatives to chiropractic treatment. I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

I agree and consent to assessment and treatment. I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.
I have read and agree to the terms, statements & policies above

INFORMED CONSENT

I consent to the chiropractic treatments offered or recommended to me by my Doctor of Chiropractic, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care received from Inner Banks Chiropractic

Patient Signature_____ Date _____

Witness Signature_____ Date _____

PRIVACY NOTICES/INFORMATION

Inner Banks Chiropractic

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY INNER BANKS CHIROPRACTIC AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact your local facility.

Who Will Follow This Notice?

1. Inner Banks Chiropractic
2. Doctors of Chiropractic who provide services; and
3. All employees and subcontractors of Inner Banks Chiropractic.

We understand that medical information about you and your health is personal and we are committed to protecting this information. When you receive chiropractic treatment from us, a record of the treatment you receive is made. Typically, this record contains your treatment plan, your history and physical, any x-ray and test results that you provide to us, and billing record. This record serves as a:

1. Basis for planning your treatment;
2. Means of communication for or between Inner Banks Chiropractic clinic doctors and staff, the doctors and staff IBX Chiro if any, that you wish us to share them with; and a
3. Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES We are required by law to:

1. Maintain the privacy and security of your medical information;
2. Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
3. Abide by the terms of this notice; and
4. Notify you if we are unable to agree to a requested restriction.

The Methods in Which We May Use and Disclose Medical Information about You

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

1. For Treatment. We will use and disclose your medical information to provide, coordinate, or manage your chiropractic treatment at this clinic or any other clinic where you seek treatment. For example, we may share your information with your primary care physician or other specialists upon request.
2. For Payment. We will use and disclose medical information about you so that payment for the treatment you receive may be collected from you or another party.
3. For Health Care Operations. We may use and disclose medical information about you for our office operations. These uses and disclosures are necessary to run the clinic in an efficient manner and provide that all patients receive quality care. For example, your medical records may be used in the evaluation of services, and the appropriateness and quality of chiropractic treatment we provide. Chiropractic services will be provided in an open room where other patients are also receiving care. Other persons in the office may overhear some of your protected medical information during the course of care. Should you need to speak with the doctor at any time in private, a place for these conversations will be provided upon request. To the extent permitted by law, we may use cameras or other recording devices in our clinics. Any clinics having cameras or recording devises will have a notice posted at the clinic informing you of the use of such devices.
4. For Contacting You. We may use your address, phone number, e-mail and clinical records to contact you with notifications, text messages, birthday and holiday related messages, billing inquiries, information about treatment alternatives, or other health related information. If contacting you by phone, we may leave a message on your answering machine or voicemail.
5. Appointment Reminders. We may use and disclose medical information to remind you of an appointment, if applicable.
6. As Required by Law. We will disclose medical information about you when required to do so by federal or state laws or regulations.
7. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
8. Lawsuits and Disputes. If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
9. Law Enforcement. We may release medical information if asked to do so by a law enforcement official in response to a court order or subpoena.
10. Electronic Disclosure. We may use and disclose your medical information electronically. For example, your medical information is maintained on an electronic health record. If another provider requests a copy of your medical record for treatment purposes, we may forward such record electronically.

DISCLOSURES REQUIRING AUTHORIZATION

1. Marketing. Marketing generally includes a communication made to describe a health-related product or service that may encourage you to purchase or use the product or service. We will obtain your written authorization to use and disclose your medical information for marketing purposes unless the communication is made face-to-face, involves a promotional gift of nominal value, or otherwise permitted by law. All other uses and disclosures of your information for marketing purposes require your written authorization. You have the right to revoke such authorization in writing.

Inner Banks Chiropractic

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding medical information collected and maintained about you:

1. Right to Inspect and Copy. The right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to us. You can also ask to see or get an electronic copy of health information we have about you. Ask us how to do this.

2. Right to Amend. If you feel that medical information maintained about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by us or The Joint Corp. To request an amendment, your request must be made in writing and submitted to us. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by Inner Banks Chiropractic

3. Right to an Accounting of Disclosures. To request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations. To request this list you must submit your request in writing to us. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free.

4. Right to Request Restrictions. To request a restriction or limitation on the medical information we, other The Joint clinics, or The Joint Corp. uses or discloses about you for treatment OR payment. You also have the right to request a limit on the medical information we. disclose about you to someone who is involved in your care or the payment for your care. Neither we. are required to agree to your request, but should any of us agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions you must make your request in writing and include (1) what information you want to limit; (2) whether you want to limit our use and/or disclosure; and (3) to whom you want the limits to apply.

5. Right to Revoke an Authorization. There are certain types of uses or disclosures that require your express authorization. For example, we may not sell your information to a third party for marketing purposes without first obtaining your authorization. If you provide authorization for a particular use or disclosure of your medical information, you may revoke such authorization in writing by contacting us. We will honor your revocation except to the extent that we have already taken action in reliance of the specific authorization.

6. Right to Receive a Copy of this Document. You have a right to obtain a paper copy of this document upon request.

CHANGES TO THIS NOTICE

We reserve the right to change our practices and to make the new provisions effective for all medical information we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting us.

I understand and agree to the patient privacy notice that was presented to me. I also acknowledge that a copy will be made available if I request one.

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(Patient Printed Name)

_____ _____

(Patient or Legal Guardian Signature) (Date)

_____ _____

witness/ Employee Signature}