Ogawa Chiropractic, Inc.

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Ryoichi Ogawa D.C.

Alice Holm Ogawa, D.C.

Informed Consent to Chiropractic Care

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy, exercises and diagnostic x-rays may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures. Risks include, but are not limited to, dizziness, fractures, joint/disc injuries, strokes, dislocations and sprains.

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctors choosing.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ _____

Signature of Patient (parent/guardian if minor) **Signature of Doctor**

_____

Date

Acceptance as Patient

I understand and agree that the doctors of Ogawa Chiropractic, Inc. have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

_____ _____

Signature of Patient (parent/guardian if minor) **Date**

Notice of Privacy Practices ~ Acknowledgement

Ogawa Chiropractic, Inc. keeps a record of the health care service we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Our ***Notice of Privacy Practices*** describes in more detail how your health information may be use and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices and the opportunity to review it.

_____
Signature of Patient or legally authorized individual

_____ _____ a.m. / p.m.
Date Time

_____ _____
Printed name if signed on behalf of the patient Relationship to patient

This form will be retained in your medical record.