Your Family Chiropractor

Dr. Tom K. Jensen

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Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any question please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Your Family Chiropractor, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There will be a $20 fee charged for all appointments that are missed or canceled within three hours of the scheduled visit.

Consent to Evaluate and Treat a Minor:

I, ________________________________ being the parent or legal guardian of ______________________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to who may we do so?

Spouse: ____

Children: ____

Others: ____

May we leave messages on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

I, _______________________________, have read and fully understand the above statements.

Acknowledgement

I have received the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy.

Print Name: ____

Signature: ____ Date: ___________________________