Live Well Chiropractic
11027 SE Kent Kangley Road
Kent, WA 98030
253-630-9395
www.livewellcenter.com

Notice of Privacy Practice Summary

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Live Well Chiropractic uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for payment for administrative purposes, and to evaluate the quality of care that you receive.

Live Well Chiropractic may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Live Well Chiropractic may use your name on their referral or birthday board.

Live Well Chiropractic may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. You have the right to request restrictions, report and retain a copy of your health records, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer Vicki Wood and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Live Well Chiropractic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain you written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints please contact Vicki Wood at 253-630-9395.

_____ _____

Patient Signature Date

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Terms Of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnosis or treat any disease. We only offer to diagnose either vertebral subluxations or neuron-musculoskeletal conditions. However, during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others; OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use procedures to help your body hold the adjustments.

I _____ , have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

_____ _____
(signature) (date)

Consent to evaluate and adjust a minor child:

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

Pregnancy Release:

This is to certify to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised the x-ray can be hazardous to an unborn child.
Date of last menstrual cycle _____.

_____ _____
(signature) (date)