Cromshaw Chiropractic & Wellness Medicine
304 Village Road, Leland, North Carolina 28451
P: (910) 371-2525 F: (910) 371-5922

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, direct my treatment, and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Patient / Guardian Signature: _____ Date: _____

Personal Health Information Authorization

In accordance with our "Notice of Privacy Practices," we may disclose your personal health information to a family member, relative, friend or other person identified by you. Please list the names below of ALL persons you would permit to have such access to your personal health information.

Name _____ Relationship_____
Name _____ Relationship_____
Name _____ Relationship_____

When calling to discuss medical information, we prefer to speak directly with the patient unless it is an emergency. Any person calling for you should be able to identify your date of birth, physician name, and problem/procedure performed. This enables us to further protect your privacy. This authorization will continue until revoked or terminated by the patient in a written revocation received by Cromshaw Chiropractic Center.

Patient / Guardian Signature: _____ Date: _____
Patient's Name: _____ Date of Birth: _____

For Women ONLY - Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant and the doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ___/ __/____ Patient's Signature: _____ Date: _____

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records or a summary or narrative of my protected health information, to the facility listed below.

Patient Name; _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows

☐ Complete Records ☐ X-rays and Radiology Reports ☐ History & Physical ☐ Other _____

Release my protected health information to the following directly associated in my medical care:

Cromshaw Chiropractic Inc
PO Box 1378 / 304 Village Rd NE
Leland, NC 28451
Phone: (910) 371-2525 Fax: (910) 371-5922

Patient / Guardian Signature: _____ Date: _____

AUTHORIZATION OF CARE

I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me.

The Doctor and/or staff will not be held responsible for any health conditions or diagnoses, which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature: _____ Date ____ / ____ / ____

Patient's Name Printed _____
If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship _____

I herby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts:

Guardian Signature _____ Date ____ / ____ / ____

INFORMED CONSENT

REGARDING Chiropractic Adjustment, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, hold certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments, all other procedures provided at Cromshaw Chiropractic Inc have been explained to me to my satisfaction, and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

_____ ____ / ____ /____

Patient or Authorized person's Signature Date

Witness