Avista Chiropractic
Dr. Jan Bender, Chiropractic Physician
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Consent for Purposes of Treatment, Payment and Healthcare Operations

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat/ice application, electrotherapy, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this office to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications are available upon request. I understand that there is no guarantee or warranty for a specific cure or result

I,______________________________ consent to Avista Chiropractic the use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for Avista's general healthcare operation purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that Avista's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of the consent, "Protected Health Information" means any information including my demographic information, created or received by Avista that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of Avista, but Avista is not required to agree to these restrictions. However, if Avista agrees to a restriction that I request, the restriction is binding on Avista.

I understand I have the right to review Avista's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and Avista's duties regarding the types of uses and disclosures of my Protected Health Information

I have the right to revoke this consent, in writing , at any time, except to the extent that Physician or Avista has acted in reliance on this consent.

I have read and understand the above statements regarding treatment, payment and healthcare operations.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority