TERMS OF ACCEPTENCE:

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

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

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

Health: a 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 lessening of the body's innate ability to express its maximum health potential.

We **do not** offer to treat or diagnose any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for these findings, we will recommend you seek the services of health care provider who specializes in that area.

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 the vertebral subluxations.**

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

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

I, therefore, accept chiropractic care on this basis.

_____ _____

SIGNATURE DATE

Informed Consent to Chiropractic Treatment

The nature of Chiropractic treatment: The doctor will use his / her hands or a mechanical device in order to move your joint. You may feel a click or pop, such as the noise made when a knuckle is cracked, you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, and therapeutic ultra sound may be used. Also therapeutic procedures such as trigger point release, passive and/ or active stretching, resistance strengthening and balance/ posture exercises may also be utilized to provide the best course of action.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complication could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of neck. A minority of patients may notice stiffness or soreness after the first few days of treatment.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from taking a single aspirin tablet. The risk of cerebrovascular injury of stroke, has been estimated at one in one million to one in 20 million, and can be further reduced by screening procedures. The probability of adverse reactions from ancillary procedures is also considered "rare".

Other Treatments options may include the following: Over the counter medications, medical care and hospitalizations.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

_____ _____ _____

Printed Name Signature DATE

_____

Witness Initials

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

Signature below is acknowledgment that you had access to and / or received, if requested, our HIPAA Notice of our Privacy Practices:

Print Name: _____ Date of Birth: _____ Last four digits of SS #: _____

Signature: _____ Date: _____

The Patient identified above authorizes TurningPoint Chiropractic and Wellness Center (TPWC) to use and or disclose protected health information in accordance with the following:

Specific Authorizations

- I give permission to TPWC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointments, birthday or other occasion cards, general or other health related information, and treatment alternatives.
- If TPWC contacts me by phone, I give them permission to leave a message on my answering machine or voice mail.
- I give TPWC permission to treat me in an open room where other patients may be also be receiving treatment. I am aware that other patients may over hear some of my health related information during the course of treatment. Should I need to speak to a doctor at any time in private, the office will provide a private room for these conversations.
- By signing this form you are giving TPWC permission to use and disclose your protected health information in accordance with the directives listed above.

***This authorization will stay in effect unless I revoke permission in writing*.**

RIGHT TO REVOKE AUTHORIZATION

You may revoke this authorization by mailing or hand delivering a written notice to the privacy official at TPWC. The written notice must contain the following information: your name, social security number and date of birth; a clear statement of your intent to revoke this authorization; the date of your request; and your signature

This authorization is requested by TPWC for its own use/ disclosure of PHI. You have the right to refuse to sign this authorization. If you refuse to sign this authorization TPWC will not refuse to provide you treatment.

A copy of this signed authorization will be provided to you at any time you request.

Name of Patient: _____

Signature: _____ Date: _____

Permission to share health information

By signing below, I am authorizing TPWC to discuss my health information with the following person (s), if necessary. This authorization will remain in effect unless I revoke permission in writing.

Persons authorized to receive information:

1. _____ _____ _____
   Print Name | Relationship to Patient | Phone number & type (C, W, H)
2. _____ _____ _____
   Print Name | Relationship to Patient | Phone number & type (C, W, H)
3. _____ _____ _____
   Print Name | Relationship to Patient | Phone number & type (C, W, H)

Additional Authorizations

I authorize the release of any medical information necessary to process my insurance claim (s) and also certify that all insurance information given to this clinic is correct and complete.

_____ _____ _____
Patient Signature Date Witness Initials

I, _____request that all Insurance Payments that are due to me to be paid to the Doctors office listed below. I further request that as stated in box 12, 13 and 27 of the HCFA claim form that the provider of the service be paid instead of the insurance. This form (reproduced or photocopied) is to be a valid and legally binding form. Please send any /all payments due to me, _____.

TO: Turning Point Chiropractic and Wellness Center
2745 Main Street
East Point, GA 30344
Tax ID #: 04- 3600617

I also understand if for any reason that the insurance company refuses to pay the provider directly or does so incorrectly by error that I am responsible to reimburse the provider for any and all payments. _____
Initials

ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE

I, the undersigned patient, am directing my attorney _____, to pay any outstanding bills out of my settlement, and in effect, protecting any such balance. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration for awaiting payment. And I further understand that such payment is not contingent upon any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment on the current status of my account.

_____ _____ _____
Patient Signature Date Witness Initials

CONSENT FOR TREATMENT OF A MINOR

I, _____, the undersigned party, hereby authorize Turning Point Chiropractic and Wellness Center to administer treatment as necessary to my child _____.

_____ _____ _____
Parent / Guardian Signature Date Witness Initials