Marconi Chiropractic and Wellness
1002 MLK Jr Way Tacoma, WA 98405 (253)750-3381

CONSENT FORM & ACKNOWLEDGEMENT OF PRIVACY RIGHTS

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat, ice application, traction, laser, x-ray 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 clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which maybe associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5-2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects and complications is available upon request.

Acupuncture

The scope of practice for an East Asian medicine practitioner in the state of Washington includes the following: Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians; Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; Moxibustion; Acupressure; Cupping; Dermal friction technique; Infra-red; Sonopuncture; Laserpuncture; Point injection therapy (acupuncture); and Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; Breathing, relaxation, and East Asian exercise techniques; Qi gong; East Asian massage and Tui na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and Superficial heat and cold therapies. Side effects may include, but are not limited to: Pain following treatment; Minor bruising; Infection; Needle sickness; and Broken needle. The patient must inform the East Asian medicine practitioner if the patient has a severe bleeding disorder or pace maker prior to any treatment.

Cupping, which involves localized suction with small glass cups, may be used to stimulate healing and promote circulation. This technique leaves temporary local bruises that typically resolve within 4-5 days.

Massage is a safe and effective method of treatment, but it is not without risk. During certain techniques, patients may experience moderate local pain as muscles are stretched and manipulated. Patients may also experience slight muscle soreness after treatment.

I, _____ consent to the following examination and therapeutic treatment procedures as necessary to facilitate my diagnosis and treatment.

I, _____ consent to Marconi Chiropractic and Wellness (MCW) use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for the purposes relating to the payment of services rendered to me, and for MCW's general healthcare operations 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 MCW diagnosis or treatment of me maybe conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by MCW, 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 MCW, but that MCW is not required to agree to these restrictions. However, if MCW agrees to restriction that I request, the restriction is binding on MCW.

I understand I have a right to review MCW Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice'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 MCW has acted in reliance of this consent.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself, or unless law requires it. I understand that I may look at my record and can request a copy by paying the appropriate fee. I understand my medical record will be kept no more than 10 years after the date of my last treatment.

_____ _____
Signature of Patient/Personal Representative/Guardian Date

_____
Description of Personal Representative's Authority