PATIENT CONSENT

Communication Authorization

Acknowledgment Of Receipt Of Notice Of Privacy Practices For Protected Health Information

I acknowledge that the doctor(s) at FirstMove Performance Health acts in strict accordance with the federal privacy regulations (HIPPA). I understand that I may request, at any time, my own copy of the Doctor's Notices of Privacy Practices for Protected Health Information.

Print Name:_____Signature:_____Date:_____

I hereby give my permission to the Doctor (or staff) to contact me with appointment reminders or health related information. If this contact is made by phone and I am not home, a message will be left on an answering machine, or with whomever answered the phone. I acknowledge that contacts may also be made by email, text message, or postal mail.

Print Name:_____Signature:_____Date:_____

I hereby request and consent to the performance of physical examination, chiropractic adjustments, and other chiropractic procedures which include other manual therapy techniques, various methods of physiotherapy, and the ordering of diagnostic imaging studies, on me by the Doctor(s) affiliated with FirstMove Performance Health. I understand that in Chiropractic Treatment, as in Traditional Medicine, there are risks associated including fractures, disc injuries, stroke, sprain/strains, sore muscles. I do not expect the Doctor(s) at FirstMove Performance Health to anticipate all potential risks or complications. I rely on the Doctor to make the best clinical judgement during the course of all procedures, based on the facts known, and is in my best interest.

I have read and comprehend the above consent, and understand I can speak with my Doctor(s) about any concerns I have related to potential risks or any other health concerns I may have at that time. By signing below I agree to the above, and understand this consent will cover the entire course of treatment for my present condition, and for any future condition(s) for which I seek treatment at FirstMove Performance Health. If the patient named below for whom I am responsible for is under the age of 18, I hereby authorize treatment under the same conditions as noted above.

Print Name:_____ Signature:_____Date:_____