ALDANA CHIROPRACTIC

CONSENT FOR EXAMINATION AND TREATMENT

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate tests, diagnosis, and analysis. The procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through healthcare procedures from whatever he/she is suffering from: latent pathological defect, illnesses, or deformities, which would otherwise not come to the attention of the physician. I agree to settle any claim or dispute I may have against or with any of these person or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.
I have read and understand the foregoing:

____ ________________________
Patient's Signature Date

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ____ DOB: __________________

I acknowledge that I have reviewed the Notice of Privacy Practices of Aldana Chiropractic.
(Please initial on of the following options and sign below.)

__________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can Request a copy at any time and the Privacy Notice is posted in the office.

__________ I wish to receive an electronic copy of the Privacy Notice. My email address is as follows: ____

____ __________________
Signature of Patient/Guardian Date

For women only: X-Ray Questionnaire

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary, we would like to confirm that you are not pregnant at this time.

Name: ____ Date of last menstrual period: _________________

_____ No, I am definitely not pregnant at this time.

_____ There is a possibility that I may be pregnant at this time.

_____ Yes, I am definitely pregnant at this time.

_____ I request that x-ray films be taken because: ____

Patients Signature: ____ Date: ____________________________