Kalaheo Wellness Center

KALAHEO SPINE AND WELLNESS CENTER

PATIENT INFORMED CONSENT

I, _____, the undersigned, consent to care at this office. I understand that I have the opportunity to discuss any questions or concerns with the chiropractor/other treating provider/office personnel, and the nature/purpose of chiropractic adjustments and progressive wellness treatments. I hereby consent to treatments on me (or on the patient above, for whom I am legally responsible) by the Doctor of Chiropractic and/or the treating provider's at Kalaheo Wellness Center. I also understand that as is with all healthcare treatments, results are not guaranteed, there is no promise to cure, and that there are some risks. Risks include but are not limited to; aggravating and/or temporary increase in symptoms, muscle spasms, fracture, disc injuries, strokes, dislocation, and sprains. I do not expect the chiropractor/treating provider to be able to anticipate and explain all risks and complications, and I wish to rely on the chiropractor's/treating provider's judgment, based on the facts then known, is in my best interests.

DISCLAIMER: This place of business will not be held liable for any injury or condition that arises from application of massage or other progressive wellness treatments despite completion of this form.

Patient/Guardian: _____

Printed name

_____ _____

Signature Date

2-2527 Kaumuali'i Hwy.
PO Box 895
Kalaheo, HI 96741
PH: 808-332-5580 FX: 808-332-5581
wellness@kalaheochiropractic.com

PLEASE FLIP THIS PAGE OVER

HIPAA PATIENT AUTHORIZATION FORM

We are required they the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your Protected Health Information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Authorization and you are advised to do so. This authorization for release of information covers the period of healthcare from (insert today's date) _____, 2021 to December 31, 2021.

You, the patient, understand and agrees that:

For the purposes of this Consent form, "Office" shall refer to Kalaheo Wellness Center, LLC.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled "Notice of Privacy Practices". I understand that I may review this notice at any time prior to signing this form. I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy. I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this consent in, but only to the extent that the office has not taken action in reliance thereon and also provided that I do so in writing. I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing. The patient has the right to restrict the uses of his or her information, but KWC does not have to agree to all such restrictions.

The patient may revoke this authorization in writing at any time and all future disclosures that require the patient's prior written Authorization will then cease. See the notice of privacy practices for additional details.

KWC may not condition your treatment or payment on whether you sign this Authorization.

This Authorization was signed by:

Patient/Guardian: _____
Printed name

_____ _____
Signature Date

Witness: _____
Printed name

_____ _____
Signature Date