DERRICK FAMILY CHIROPRACTIC

3535 Martin Way E Olympia, WA 98506 360 491-9135

Notice of Privacy Practice Summary

This summary discloses how health information about you may be used. A full notice is available upon request.

Derrick Family Chiropractic uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check laws), for administrative purposes and to evaluate the quality of care that you receive.

Derrick Family Chiropractic will not disclose your information to others unless you tell us to do so, ore unless the law authorizes or requires us to do so.

Derrick Family Chiropractic may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Derrick Family Chiropractic may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. You have a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an account of your health records.

You may confer to the privacy officer and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Derrick Family Chiropractic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any question or complaints, please contact Jay Sweet, DC at the above location.

_____	_____	_____
Patient Signature	Patient Printed Name	Date

Terms of Acceptance

Chiropractic care has one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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

Subluxation: A misalignment of one or more of the joints which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's ability to express its maximum health potential.

Chiropractic is the practice of healthcare that deals with the diagnosis or analysis and treatment of the (vertebral) subluxation complex, and its effects, articular dysfunction and musculoskeletal disorders, all for the restoration and maintenance of health. If during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Our practice objective is to eliminate interference of the body's ability to heal itself. Our main method is specific adjustments to correct vertebral subluxation. The patient should understand that there is some inherent risk in the nature of manual treatment. These may include, but are not limited to, temporary increased soreness, and other issues related to the restoration of joints to their optimal position and function.

I, _____ have read and fully understand the above statements.
(print name)

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

I therefore accept chiropractic care on this basis.

_____	_____	_____
Patient Signature	Patient Printed Name	Date

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