INFORMED CONSENT OF CHIROPRACTIC TREATMENT

Informed Consent for Chiropractic Treatment of your Pain

The nature of chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she/he determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medication, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. Please inform your chiropractor of all medications you are taking, including blood thinners, and surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.

Other options for the treatment of pain include: do nothing – live with it, over- the-counter medications, physical therapy, medical care, injections, or surgery. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.

Please discuss any questions or problems with the doctor before signing this statement of policy.

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My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.

I have read, and understand the foregoing.

_____ _____

SIGNATURE Date

PROTECTED PATIENT INFORMATION BY THE FEDERAL HIPAA ACT

Dr. Yoshio Homma B.E.S.T. Chiropractic Clinic 430 East Second Street, Los Angeles CA 90012 (213) 617-2228

Dear Patient:

In Accordance with the federal government requirements of the 1996 Health Insurance Portability and Accountability Act (HIPAA), effective 14th.April 2003, I am proving you Privacy Policies. We are updating your file to comply with this federal HIPAA act. As part of this process, we need to have your signature on file, indicating that you know **we are doing our best to fully protect the privacy of your health information.**

I understand that by voluntarily signing and dating this Privacy Statement, I:

a) Am verifying that I have read this statement for my health care,

b) Am authorizing Dr. Homma and his staff to have access to Personal Health Information provided by me, or received about me from other authorized sources (such as other doctors or labs),

c) Am understanding that they will keep my information private and safe,

d) Am giving permission to the clinic to use case study in educating other similar patients or accumulating data for research purpose without disclosing my name or address, and telephone numbers,

e) Neither Dr. Homma not his staff will release and private health information without my prior written authorization, except as noted in Law enforcement officials or a court-appointed attorney presenting a subpoena and in response to a subpoena issued in a civil matter.

f) And authorize the release of any my medical or other information necessary to process my insurance claims to my insurance company.

Print Patient Name _____ **Your Signature:** _____ **Date** _____