Dr Jen Badding-Benton
Aberdeen Family Chiropractic Center
110 N Philadelphia Blvd
Aberdeen, MD 21001
410-273-5900
www.aberdeenfamilychiropractic.com

chiropractic

Bringing Out The Best In You!

Terms of Acceptance

Pediatric Patients

Patient _____

When we accept you as a patient into our practice, **it is important** that you understand **the objectives of our care.**

Chiropractors provide a **unique service** that other healthcare providers do not offer: the location and correction of subluxations (structural and nervous system stress) in your body.

A **subluxation** is a misalignment or distortion of your spinal column or related structures that can affect your brain, nervous system and overall body function. **Subluxations can cause dis-ease** or loss of proper body function.

Chiropractors spend years studying how to locate and correct this destructive condition, first by analyzing your structural system (especially your spine) using various methods. Secondly, we **correct or adjust your subluxations** by using specialized techniques (adjustments). When your structural system, spine and nervous system are free from the deep stress of subluxations **you function more efficiently** and your natural healing ability, **your inner healer**, will better communicate through your body.

We do not medically diagnose or treat any disease, symptom or condition. No matter what condition(s) you may have been diagnosed with and no matter what symptom(s) your body is expressing, **you always need a body free from subluxations**.

If, during the course of our chiropractic examination, we encounter unusual findings, **we will let you know**. You may then decide whether you wish to investigate further and discuss your healthcare options with other healthcare professionals. **We will cooperate with you and with them in your goals**.

To summarize: the purpose of chiropractic care is not to treat diseases or conditions, nor to suppress symptoms, nor to perform surgery, but rather to make your body function better by **removing structural nerve stress (subluxations)**. Therefore we do not prescribe surgery or medications. If you wish to decrease or stop medications you should discuss that with your MD.

Our objective is to **eliminate a major interference to the expression of your physical/emotional health and healing**—subluxations—so that your natural healing ability and **your inner healer may function without this severe form of stress**.

I, _____, have read and fully understand the above statements.
(Parent / Guardian Signature)

Date _____

ABERDEEN FAMILY CHIROPRACTIC CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient name: _____ **ID Number:** _____

Persons/organizations providing the information:

Aberdeen Family Chiropractic Center

Persons/organizations receiving the information:

_____

_____

_____

Specific description of information (including date(s):

_____

_____

_____

_____

Section B: Must be completed only if a health plan or a health care provider has requested the authorization:

1. The health plan or health care provider must complete the following:
   a. What is the purpose of the use or disclosure?
   _____

   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No _____

2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials: _____

   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials: _____

Section C: Must be completed for all authorizations:

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ____/____/_____ (DD/MM/YY) Initials: _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on my actions they took before they received the revocation. Initials: _____

_____

Signature of patient or patient's representative **Date**

(Form must be completed before signing.)

Printed name of patient's representative:

_____

Relationship to patient:

_____

- **YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ***

You may use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.

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ABERDEEN FAMILY CHIROPRACTIC CENTER

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

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ABERDEEN FAMILY CHIROPRACTIC CENTER

Authorized Representative to Bring Minors for Treatment

In the event that I am not able to be present for an appointment, I give my permission for the following minor child/children to receive treatment at **Aberdeen Family Chiropractic Center** on their own.

Child's Name _____ Child's Name _____

Child's Name _____ Child's Name _____

Child's Name _____ Child's Name _____

_____ _____

Signature of Parent/Guardian Date

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ABERDEEN FAMILY CHIROPRACTIC CENTER

Medical Release Authorization

I _____, hereby authorize Aberdeen Family Chiropractic Center to release information regarding my ☐ appointments,☐ financial records,☐ medical records to:

_____.

_____ _____

Date **Patient Signature**

_____ _____

Date of Birth **Address**

_____

City, State, Zip

_____ _____

Date **Witness Signature**

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