
Dr. Jeanette I. Chomic, D.C.
837 West Shaw St., P.O. 688, Howard City, MI 49329
P: (231) 937-9370 ~ F: (231) 648-6263

**Notice of Privacy Practices**

I acknowledge that Tri County Family Chiropractors’ “Notice of Privacy Practices” has been provided to me.

I understand I have a right to review Tri County Family Chiropractors’ Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Tri County Family Chiropractors. The Notice of Privacy Practices for Tri County Family Chiropractors is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Tri County Family Chiropractors’ duties with respect to my protected health information.

Tri County Family Chiropractors reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, ask for one at the time of my next appointment or accessing Tri County Family Chiropractors’ website (if applicable).

I have the right to revoke this consent, in writing, except to the extent that Tri County Family Chiropractors. has taken action in reliance on this consent.

**PATIENT ACKNOWLEDGEMENT**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

 Signature of Patient or Personal Representative Date

 Name of Patient or Personal Representative Description of Personal Representative’s Authority

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## DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGEMENT

On , presented this Acknowledgment of Receipt of Notice of Privacy Practices Form to (the “Patient”). The Patient refused to provide a signature when requested.

Revised Nov 2024


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**Informed Consent for Chiropractic Care**

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or pain.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic (no symptoms).

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand or instrument. To make an adjustment the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness, and stroke.

All questions regarding the doctor’s objective to my care in this office have been answered to my complete satisfaction.
The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

I authorize the staff to perform any necessary services needed during diagnosis and treatment.

Print Name Signature Date

**Consent to Evaluate and Adjust a Minor Child**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Signature: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Treat and Adjust a Minor Child Without Parent**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_ hereby give my permission for my child to be seen at Tri County Family Chiropractors for an appointment without a parent or guardian present.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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