PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information
"Consent Form")

For the purposes of this Consent Form, "Office" shall refer to SJDC Ltd., DBA Johnson Chiropractic Wellness Center, 10700 Old County Road 15 Suite 240, Plymouth, MN 55441.

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, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior 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.

Patient Privacy
Due to the small, compact size of our office people can overhear conversations and some of your care may be provided in open areas. For this reason there are private consulting areas available upon request.

Initial _____

Professional Communication
I hereby grant the Office permission to share my medical health information with my other healthcare providers for the purpose of improving the coordination of my care.

Initial _____

Phone Message Privacy
I authorized the following phone numbers as places where Dr Stephen Johnson or members of his staff may leave messages that may include Personal Health Information (PHI).

(____)_____

(____)_____

Patient Name (please print): _____

Signature:_____ Date: ___/___/___

Johnson Chiropractic and Wellness Center
Stephen T. Johnson DC- 10700 Old County Road 15, Suite 240, Plymouth, MN 55441
Telephone: (763) 544-2001 E-Mail: drsteve@stephenjohnsondc.com

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Doctor Name: Stephen T. Johnson D.C.

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio-therapy, physical medicine, physical therapy procedures, etc.on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costo-vertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____
Printed name of Patient

x_____ _____
Signature of Patient Date

x_____ _____
Signature of Representative Date
(if patient is a minor or is handicapped)

x_____ _____
Witness to Patient's Signature Date

I have viewed the Activator Methods Chiropractic Orientation Video. Initial _____

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