511 N D STREET PHONE: (402) 721-6372
FREMONT, NE FAX: (402) 721-6932
68025-5051 WWW.DUNCANCHIRO.COM

CONSENT OF TREATMENT / PRIVACY NOTICE

I have been informed of the nature and purpose of **chiropractic care**, the possible consequences of the care, and the risks of the care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment. Having this knowledge, I knowingly authorize Duncan Chiropractic Health Center, LLC with **chiropractic care** and treatment.

Signature: ________________________________

I have been informed of the nature and purpose of **acupuncture therapy**, the possible consequences of the therapy, and the risks of the therapy, including the risk that it may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment. Having this knowledge, I knowingly authorize Duncan Chiropractic Health Center, LLC with **acupuncture therapy**.

Signature: ________________________________

CONSENT TO TREAT A MINOR CHILD

I, ______________________, hereby give Duncan Chiropractic Health Center, LLC permission to treat ______________________.
Name of parent/guardian *Name of minor child*

I acknowledge that I am the legal parent/guardian for this minor child.

Signature: ________________________________

PRIVACY NOTICE

The privacy notice describes how medical information about you may be used and disclosed and how you can get access to that information. We are committed to maintaining the privacy of your protected health information (PHI). This includes information about your health and the treatment that you receive. A health record is created that details the care and services you receive in this office in order to provide you with high quality health care. This notice is to inform you how your PHI may be used and disclosed to third parties. This is also to inform you of your rights regarding your PHI.

By signing below, I acknowledge that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in language that I can understand.

Signature: ________________________________

All consents reviewed/witness by Dr Kate Duncan ________________________________