CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND/OR HEALTHCARE OPERATIONS.

Through the use of this consent form, Dr. Scott Jurica, referred to as the "office" or this "office" is notifying you and you agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or healthcare operations.
2. If you do not consent to the above use and/or disclosure, Federal Rules do not require or oblige this office/practice to treat you in the absence of your consent.
3. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosures necessary to carry out treatment, payment and/or healthcare operations, is available for you to read in our office and you are herby encouraged to do so prior to signing this consent form.
4. The following appointment reminders maybe be used by this office: a) a postcard mailed to you at the address provided by you; b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone: c) auto email reminders from the online service that is on our site for booking appoinments.
5. This office reserves the right to change its privacy practice that are described in the above referenced notice, in accordance with applicable law, and make available to all patients any and all revised and current notices.
6. You have a right to request that this office restrict how protected health information is used and or disclosed to carry out treatment, payment and for healthcare operations.
7. This office is not required to agree to any restrictions on your health information that you have requested.
8. If this office agrees to a requested restriction, then the restriction will be binding on this office/practice.
9. This consent is valid for seven years. You have the right to revoke this consent, in writing, at any time for all future transactions with the understanding that any revocation will not apply to the extent that this office/practice has already taken action in reliance of previously signed Consent.
10. Should you revoke this consent at any time, the office retains its right to refuse treatment based upon the revocation and the future lack of such consent.
11. You must sign and date all consents and authorizations requested to which you agree.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Patient/Individual Responsible (Please Print) _____

Signature of Patient/Individual Responsible_____

Date Signed _____

24 Hour Cancellation Policy

I agree to giving a minimum 24 hour notice of cancellation, otherwise I will be charged in full for the appointment. If something such as a family emergency has caused a cancellation less than 24 hours, Dr. Jurica will discuss on a case by case basis.

Name of Patient/Individual Responsible (Please Print) _____

Signature of Patient/Individual Responsible_____

Date Signed _____

Informed Consent to Treat

By signing you, you agree to our consent form. Please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of the eight (8) chemical components of the VSC (Vertebral Subluxation Complex). If chiropractic treatment is performed I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed.

CHIROPRACTIC CARE: All healthcare professionals are regulated by laws and boards. These healthcare professionals are required to give you, the patient, advanced notice of any care risks, because healthcare is not an exact science. It is not reasonable to expect any doctor to foresee all risks and or complications. Informed consent information regarding any risks such as paraplegia, quadriplegia, brain damage, stroke, disc injury, breaks, fractures, dislocations, drug reactions, death or loss of function of any organ or limb, or disfiguring scars associated with physical care, drugs, surgery and or treatment is an undesirable result, but it does not necessarily indicate an error in clinical judgment. No guarantee of cure or results has been made to you, the patient in the clinic. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgery. The practice of chiropractic can include exams and diagnostic testing. In some cases, this includes the utilization of specialized instrumentation, lab tests, radiological exams,

nutritional advice, rehabilitation, physical therapy, etc... There is a special procedure unique to chiropractic: the chiropractic adjustment, chiropractic manipulative therapy, CMT. Adjustments are made by chiropractors to correct and or reduce or stabilize vertebral or extremity aberrant motion. The goal of chiropractic health care is to reduce or stabilize the nerve interference caused by the aberrant motion of the joint and surrounding soft tissue structures. Adjustments are usually performed by hand but may be performed by hand guided instruments. An adjustment is the application of a specific force applied to a segmental contact point, usually on a vertebra, to reduce or stabilize the joint and its surrounding environ. You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur Seldom enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care. The risks may include musculoskeletal sprain strain, disc injuries, dislocations, fractures, neurological deficits, Horner's syndrome, vertebral artery syndrome, stroke, etc... The chances of this occurring have been estimated by experts to be approximately only 1 per 400,000 treatments to 1 per 1,000,000 treatments.

Please discuss any questions or problems with the Doctor BEFORE signing this consent for treatment statement of policy.

I have read and understand the foregoing. I agree to the above information and I have no expectations of any absolute results.

Name of Patient/Individual Responsible (Please Print) _____

Signature of Patient/Individual Responsible_____

Date Signed _____