



WHITE MOUNTAIN Chiropractic & Rehabilitation

1102 Route 119 Rindge, NH 03461
Tel: 603.899.5153 Fax: 603.899.5173

5 Dark Lane New Ipswich, NH 0307
Tel: 603.878.5387 Fax: 603.899.5173

140 Edmond Ave Portsmouth, NH 03801
Tel: 603.422.9220 Fax: 603.899.5173

INFORMED CONSENT FOR EXAMINATION, TREATMENT, & PRIVACY PRACTICES

I hereby request and consent to the performance of examination and treatment on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic Dr. Colby B. Lamson, Dr. Rachel L. Morgan and/or other licensed doctors of chiropractic who now or in the future work at White Mountain Chiropractic & Rehabilitation or any other office or clinic. Treatment includes chiropractic manipulation/adjustments and other chiropractic procedures, including various modes of physiotherapy, soft-tissue therapy, rehabilitative therapy and/or referral for diagnostic tests as necessary,

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

The Notice of Privacy Practices has been made available to me and I consent to the use or disclosure of my protected health information for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my care or to conduct health care operations of this office. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information and my rights and duties of this office with respect to my protected health information

Patient Name

Patient Signature

Date

If Patient is a Minor,

Parent/Guardian Name

Relationship to Patient

Date