Jenna L. Seto D.C.
11610 Iberia Place, Ste. 102 – San Diego, CA 92128
(858) 848-5671

Informed Consent for Chiropractic Care

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic.

I understand that the chiropractor will use her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to such injuries as fractures, bruising, stroke, or disc injuries. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit. I wish to rely on the doctor to exercise judgment that is in my best interest during the course of care. To further reduce these risks, it is the patient's responsibility to make it known whether they are suffering from: pathological conditions (latent or otherwise), illnesses, injuries, or deformities which otherwise might not come to the attention of your doctor.

Notice of Privacy Practices and HIPPA Compliance

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your information may be used and disclosed and how you can get access to this information.

We may share your health information to: treat you, collect payment from insurance, store information on our secure and HIPPA compliant web-based practice management program *Office Ally*, perform posture analysis using an encrypted web based application *Posture Screen*, inform you about other services, discuss your case with a chiropractic colleague, discuss your case with your family members if present, and do research.

We may use your information for: visit reminder calls, monthly e-newsletters, birthday postcards, referral "Thank You" cards, health and safety reports, reporting to law officials, reporting victims of abuse, court hearings and fillings, report to workers compensation.

You have the right to request a copy of your health record, ask us to limit the information we share, request a list of whom we share your information with, and request confidential communications. Advise our management if you believe your privacy rights have been violated.

Financial Responsibility

I know that I am responsible for, and agree to pay, all fees incurred as they are rendered at this office. I understand that any insurance benefits that I may have are a contracted arrangement between me and the insurance company. This office will be responsible for preparing notes, billing receipts, and informational reports as needed to aid in insurance payment/reimbursement.

Treatment of a minor

I, _____ being the parent or guardian of _____, a minor, the age of _____ do hereby consent, authorize, and request Dr. Seto to administer such treatment deemed advisable, necessary, or requested on the above minor.

Please discuss any questions before signing this statement of understanding and consent for care.

Patient or Guardian signature: _____ Date:_____

Relationship to patient if signing on their behalf: _____

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