Adopt Chiropractic Photo Release

I grant Adopt Chiropractic and its employees the right to take photographs of me with connection to the promotion of chiropractic via websites, social media, and any other avenues. I agree that Adopt Chiropractic may use such photographs of me and for any lawful purpose, including such purposes as publicity, illustration, advertising and web content.

I am at least 18 years of age and have read and understand the above:

Signature: _____

Printed name: _____

If under 18 years of age the legal guardian or parent has read and understands the above:

Signature: _____

Printed name: _____

With my consent, Dr. Craig Raschke may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO). Please refer to Notice of Privacy for a more complete description of such uses and disclosure.
I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Raschke reserves the right to revise its Notice of Privacy Rights at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Raschke.
With my consent, Dr. Raschke may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my chiropractic care.
With my consent, Dr. Raschke may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
By signing this form, I am consenting to Dr. Raschke's use and disclosure of my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, Dr. Raschke may decline to provide treatment to me.

Signature of Patient or Legal Guardian:

_____

Print Name of Patient or Legal Guardian:

_____

X-RAY CONSENT

During your examination, the doctor may feel that x-rays will be needed. In order to perform x-rays on any patient, our office requires the patients consent for such tests. I understand that my doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests and x-ray.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

FEMALES ONLY:

I understand that x-rays may be needed at some point and that by signature on this form, I do herby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time. If determined at a later date that I am pregnant, I do not hold the doctor, this establishment or anyone associated with this establishment accountable in any way.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____