Jill Bivona, D.C.

(205) 384-5358

CONFIDENTIAL PATIENT INTAKE FORM

NAME:_____AGE:_____DOB:_____SS#_____

HOME ADDRESS:_____CITY:_____ST:_____ZIP_____

EMPLOYER:_____OCCUPATION:_____E-MAIL_____

HOME TEL:_____PAGER/CELL:_____WORK TEL:_____FAX:_____

PREFERRED METHOD OF CONTACT: ☐HOME TEL ☐CELL TEL ☐WORK TEL ☐EMAIL

EMERGENCY CONTACT:_____ RELATIONSHIP_____ TEL:_____

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐SIGNIFICANT OTHER ☐DIVORCED ☐WIDOWED # CHILDREN_____

RACE: ☐AMERICAN INDIAN OR ALASKA NATIVE ☐ASIAN ☐BLACK OR AFRICAN AMERICAN
☐NATIVE OR OTHER PACIFIC ISLANDER ☐WHITE ☐PATIENT DECLINED TO PROVIDE

ETHNICITY: ☐HISPANIC OR LATINO ☐NOT HISPANIC OR LATINO ☐PATIENT DECLINED TO PROVIDE

PRIMARY CARE PHYSICIAN:_____ PHYSICIAN PHONE: _____

REFERRED BY: DR._____ PATIENT: _____ OTHER_____

YOU ARE *CURRENTLY* EXPERIENCING: ☐BACK PAIN ☐NECK PAIN ☐HEADACHE ☐OTHER_____

DESCRIBE☐:_____

THIS HAPPENED *WHEN?* _____ *WHERE?* ☐HOME ☐WORK ☐CAR WRECK ☐OTHER_____

THIS HAPPENED *HOW?* _____

HAVE YOU HAD THIS OR SIMILAR HAPPEN BEFORE? _____

WHAT MAKES THE PROBLEM BETTER?_____

WHAT MAKE THE PROBLEM WORSE? ☐SITTING ☐STANDING ☐LYING ☐MOVEMENT ☐REST
☐USE ☐WALKING ☐RUNNING ☐WORKING ☐ACTIVITY
☐BENDING ☐LIFTING ☐TWISTING ☐OTHER_____

DESCRIBE THE PAIN OR SENSATION: ☐ACHY ☐BURNING ☐DULL ☐NUMB ☐SHARP
☐SHOOTING ☐SORE ☐STABBING ☐STIFF ☐TINGLING

DOES THE PAIN RADIATE TO ANOTHER AREA OF THE BODY? ☐NO ☐YES - *WHERE*? _____

HOW FREQUENT IS THE PROBLEM? ☐CONSTANT ☐FREQUENT ☐INTERMITTENT ☐OCCASIONAL ☐ON/OFF
☐EVENING ONLY ☐MORNING ONLY ☐WORSE IN THE: ☐AM or ☐PM

WHAT % OF THE DAY DO YOU EXPERIENCE THIS PROBLEM? ☐0-25% ☐26-50% ☐51-75% ☐76-100%

OTHER DR.S SEEN FOR THIS CONDITION: ☐ NO ☐YES:_____WHEN? _____

PAST CHIROPRACTIC CARE: ☐NO ☐YES DRS NAME: _____WHEN? _____

PATIENT SIGNATURE: _____ DATE_____
GUARDIAN SIGNATURE: _____ DATE_____

BIVONA
CHIROPRACTIC CLINIC

JASPERL, AL 35501
205-384-5358
bivonachiropractic@gmail.com
www.bivonachiropractic.com

REVIEW OF SYSTEMS AND HISTORY

Check or circle the appropriate response, please leave blank if it does not apply.

Past Medical and/or Family History

P = patient M = mother,
F = father S = Sibling

☐ Heart Disease	P M F S
☐ Asthma	P M F S
☐ Cancer	P M F S
☐ Arthritis	P M F S
☐ Headaches	P M F S
☐ Diabetes	P M F S
☐ MVP	P M F S
☐ Emphysema	P M F S
☐ Anemia	P M F S
☐ Fibromyalgia	P M F S
☐ Hernia	P M F S
☐ High BP	P M F S
☐ Low BP	P M F S
☐ Alzheimers	P M F S
☐ Alcoholism	P M F S
☐ Colitis	P M F S
☐ Epilepsy	P M F S
☐ Goiter	P M F S
☐ Gout	P M F S
☐ High Cholesterol	P M F S
☐ Kidney Disease	P M F S
☐ Leukemia	P M F S
☐ Lupus	P M F S
☐ Mental Condition	P M F S
☐ Obesity	P M F S
☐ Rheumatoid Arth.	P M F S
☐ Ulcers	P M F S
☐ Injuries	P M F S
☐ Trauma auto/etc.	P M F S
☐ Other_____	
_____	P M F S

Surgical History

☐ Appendectomy	☐ Hemorrhoid
☐ Gall Bladder	☐ Tonsillectomy
☐ Thyroidectomy	☐ Kidney Stone
☐ Bladder	☐ Endoscopy
☐ Angioplasty	☐ Heart Bypass
☐ Back Surgery	☐ Neck Surgery
☐ Arthroscopic_____	
☐ Joint Replacement_____	
☐ Mastectomy	☐ Breast Implants
☐ Tubaligation	☐ C-Section
☐ Endometriosis	☐ Hysterectomy
☐ Other_____	
☐ Other_____	

Social History

Caffeine: ☐ No ☐ Light ☐ Heavy
Tobacco: ☐ No ☐ Yes
Packs Per day_____
Alcohol: ☐ No ☐ Yes
_____per day/week

Work History

☐ No work ☐ Part time
☐ Full Time ☐ School
☐ Retired ☐ Disability

Exercise

☐ Frequently
☐ Occasionally
☐ Rarely/Never

Review Of Systems

Please circle if you have had any problems in any of the following:
(P=Past, 1=Mild, 2=Moderate, 3=Severe)

General Health

P 1 2 3 Fatigue/Tiredness
P 1 2 3 Fever/Night Sweats
P 1 2 3 Trouble Sleeping
P 1 2 3 Skin Irritation/Rash
P 1 2 3 Bleeding Disorder
P 1 2 3 Depression
P 1 2 3 Anxiety/Tension/Stress

EENT

P 1 2 3 Vision/Eye
P 1 2 3 Hearing/Ear
P 1 2 3 Throat/Swallowing
P 1 2 3 Nasal/Sinus
P 1 2 3 Headaches/Face Pain

Cardiopulmonary

P 1 2 3 Breathing
P 1 2 3 Swelling/Edema
P 1 2 3 Chest Pain

GI

P 1 2 3 Stomach/Abdominal
P 1 2 3 Diarrhea/Constipation
P 1 2 3 Vomiting

GU

P 1 2 3 Urinary Frequency/Urgency
P 1 2 3 Urinary/Burning/Discoloration
P 1 2 3 Sexual/Reproductive

Skeletal

P 1 2 3 Morning Stiffness
P 1 2 3 Night Pain
P 1 2 3 Neck Pain
P 1 2 3 Back Pain
P 1 2 3 Joint Pain_____
☐ Fracture_____

NeuroMuscular

P 1 2 3 Muscle Pain
P 1 2 3 Weakness
P 1 2 3 Numbness/Tingling
P 1 2 3 Tremors/Shakes
P 1 2 3 Loss of Consciousness
P 1 2 3 Passing out

Females

Pregnant: ☐Yes ☐No ☐I Don=t Know
☐ Last Menstrual Cycle_____

Males

☐ Prostate problems

Present Medication

☐None ☐List_____
_____
_____
_____
_____

Allergies

☐ Penicillin	☐ Codeine
☐ Aspirin	☐ Sulfa

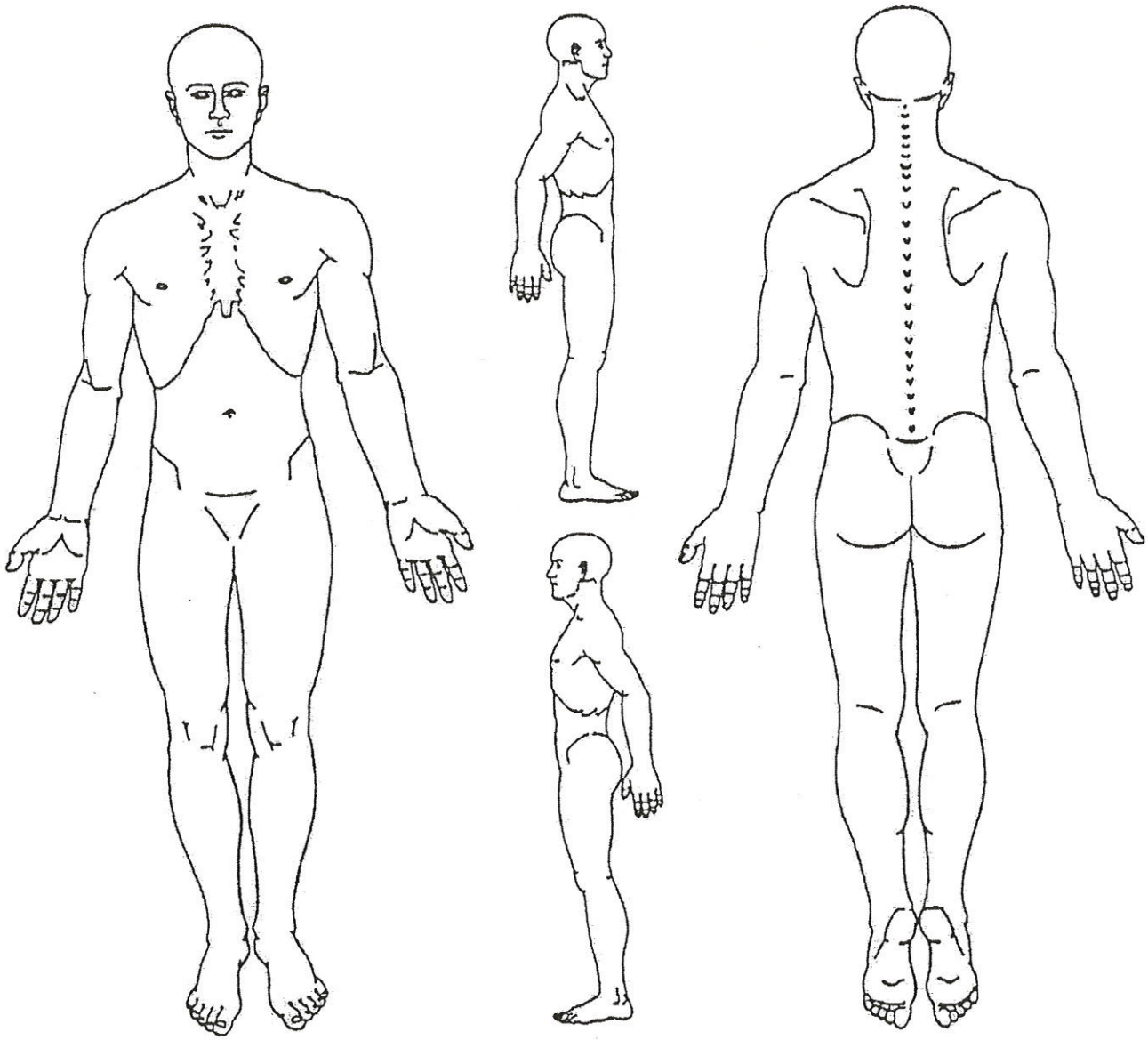
☐ Other_____
☐ Other_____

Patient Signature_____ Date_____
Reviewer_____ Date_____

Jill Bivona, D.C. 301 22nd Ave. East Jasper, AL 35501 (205) 384-5358

On the diagrams below please mark where you are experiencing your symptoms.

X = PAIN DISCOMFORT
O = NUMBNESS / TINGLING



Patient Signature:_____ Date:_____

Jill Bivona, D.C.

LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (Revised Oswestry)

(205) 384-5358

Please read instructions: *This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life.* ***Please check the ONE ITEM in each section*** *which most closely applies.*

PAIN SEVERITY SCALE: Rate the severity of your pain by checking **one** box on the following scale:

Section 1 - Pain intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 - Personal care (washing, dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 - Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking
- ☐ I have no pain walking.
- ☐ I have some pain walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

Section 5 - Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than one hour.
- ☐ Pain prevents me from sitting for more than 30 minutes.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ I avoid sitting because it increases pain right away.

Section 6 - Standing
- ☐ I can stand as long as I want without extra pain.
- ☐ I have some pain when standing but it does not increase with time.
- ☐ I can't stand for longer than one hour without increasing pain.
- ☐ I can't stand for longer than 30 min. without increasing pain.
- ☐ I can't stand for longer than 10 min. without increasing pain.
- ☐ I avoid standing because it increases the pain right away.

Section 7 – Social Life
- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interest (dancing, etc.)
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

Section 8 - Traveling
- ☐ I have no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.

Section 9 - Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed. (less than 1 hour sleepless)
- ☐ My sleep is mildly disturbed. (1-2 hours sleepless)
- ☐ My sleep is moderately disturbed. (2-3 hours sleepless)
- ☐ My sleep is greatly disturbed. (3-5 hours sleepless)
- ☐ My sleep is completely disturbed. (5-7 hours sleepless)

Section 10 – Changing Degree of Pain
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

0	1	2	3	4	5	6	7	8	9	10

No Pain **Excruciating Pain**

Signature: _____ Date: _____

Jill Bivona, D.C.

NECK PAIN AND DISABILITY QUESTIONNAIRE (Vernon-Mior)

(205) 384-5358

Please read instructions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check the ONE ITEM in each section which most closely applies to you.

Section 1 - Pain intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 - Personal care (washing, dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 - Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Reading
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight neck pain
- ☐ I can read as much as I want with moderate neck pain
- ☐ I can't read as much as I want because of moderate neck pain
- ☐ I can hardly read at all because of severe neck pain
- ☐ I cannot read at all

Section 5 - Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently
- ☐ I have moderate headaches which come frequently
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Section 6 - Concentration
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating
- ☐ I have a lot of difficulty in concentrating
- ☐ I have great difficulty in concentrating
- ☐ I cannot concentrate at all.

Section 7 - Work
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Section 8 - Driving
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

Section 9 - Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless)
- ☐ My sleep is mildly disturbed (1-2 hours sleepless)
- ☐ My sleep is moderately disturbed.(2-3 hours sleepless)
- ☐ My sleep is greatly disturbed.(3-5 hours sleepless)
- ☐ My sleep is completely disturbed.(5-7 hours sleepless)

Section 10 - Recreation
- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of neck pain.
- ☐ I can't do any recreation activities at all.

PAIN SEVERITY SCALE: Rate the severity of your pain by checking one box on the following scale:

0	1	2	3	4	5	6	7	8	9	10

No Pain — Excruciating Pain

Signature: _____ Date: _____

Bivona Chiropractic
301 22nd Avenue East
Jasper, AL 35501

Patient Name: _____

Date of Birth: _____ SS#: _____

By signing this form, I authorize you to use and disclose the protected health information described below:

_____ Any and all information

_____ Lab and test results

_____ Financial history

_____ Release information to no one except insurance company

_____ Appointment date and time

_____ Pick up prescription/forms

_____ Other _____

You may release my protected health information to the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Messages

Please call ( ) my home ( ) my work ( ) my cell number: _____

If you are unable to reach me:
( ) you may leave a full message
( ) leave a message asking me to return your call
( ) other: _____

This release of information shall remain in force until I revoke the authorization. I understand that I have the right to revoke this authorization, in writing, at any timer. I also understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA privacy regulations.

_____ Date: _____
Signature of Patient or Personal Representative

_____
Relationship to Patient

Bivona Chiropractic Clinic (205) 384-5358

FINANCIAL AGREEMENT

In consideration for services rendered or to be rendered by Jillian Bivona, D.C., I agree and fully understand the following:

1. Payment is expected at time of visit unless other arrangements have previously been made with the office staff.

2. I authorize the release of any information acquired in the course of my examination and/or treatment necessary for the process of this claim/assignment.

3. I direct payment of medical benefits otherwise payable to me to Jillian Bivona, D.C.

4. I will pay any and all charges known not to be covered by insurance at the time services are rendered.

5. I will deliver to Jillian Bivona, D.C. any checks received from an insurance company relative to services rendered within 3 days of receipt of said checks. I also agree that Jillian Bivona, D.C. be given Power of Attorney to endorse/sign my name on any checks from third party payers for payment of services rendered at this clinic.

6. I understand that it is the clinic's policy to designate the best plan of care for each of its patients. This plan of care is not based on what an insurance company may or may not pay. I hereby understand and agree that examinations, diagnostic tests, Chiropractic treatments, therapy, rehabilitation, braces, and other supplies filed to my insurance company may or may not be covered by my insurance carrier. Therefore, I agree to pay for all services rendered regardless if they are deemed medically unnecessary or a non-covered service by my insurance carrier. I understand that the clinic staff makes no representation as to coverage of my insurance and I do not rely on any insurance information conveyed to me by the clinic staff.

7. If my plan required a referral prior to evaluation, treatment or for ongoing care, I understand it is my responsibility to obtain the referral and/or authorization in these circumstances. Any claims denied due to non-authorization or non-certification will be my responsibility.

8. I understand and agree that Bivona Chiropractic Clinic may charge a fee for copying records and/or radiographs, and for missed appointments without a 24 hours notice. I understand that I am entitled to my records after the appropriate fees (including record search, copy fees ($1.00 for the first 25 pages $.50 for each additional page, plus mailing fees) have been paid.

9. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. However, I understand that this clinic will prepare any necessary will be credited to my account on receipt.

11. Our office requires 24 hour notification if you are unable to keep your scheduled appointment. If less than 24 hour notice is given a $55.00 fee will be charged to your account. This fee must be paid in full before another appointment can be scheduled. If you are 15 minutes late to your appointment you may be asked to reschedule.

10. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Failure to make payment when requested is the basis for legal action and I agree to pay all costs of collections including attorney's fee if required. I further understand that 30-45 per annul interest will be charged on all accounts over thirty days and a billing fee of $10.00/mailed statement will be added to your past due balance. I will waive the right of exemption under the constitution of laws of Alabama or any other state as to personal property.

Patient: _____ Date: _____

Witness: _____ Date: _____

Bivona Chiropractic Clinic
301 22nd Avenue East
Jasper, AL 35501
(205) 384-5358

HIPAA Acknowledgement of Receipt of Notice of Privacy Practices

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq. and regulations there under, as amended from time to time (collectively referred to as "HIPAA"). This authorization affects your rights in the privacy of your personal healthcare information.

By signing this authorization, you acknowledge and agree that this Chiropractic ("Practice") or its Business Associates may use or disclose your Protective Health Information (PHI) for the purpose of providing treatment, for purposes of relating to the payment of services rendered, and for the Practice's healthcare operations purposes.

Further, by signing this authorization, you acknowledge that you have been provided a copy of and have read and understand this Chiropractor's Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While this office has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available and can be received by sending a written request with return address to the center where you were seen.

By signing below, you are acknowledging that you have received, reviewed, understand and agree to the Notice of Privacy Practices of this Chiropractic office, which describes the Practice's policies and procedures regarding the use and disclosure of any of your Personal Health Information created, received, or maintained by the Practice.

Acknowledged and agreed to by:

_____ _____

Name of Patient (printed) Signature of Patient

Date signed by patient: _____

_____ _____

Name of Witness (printed) Signature of Witness

Date signed by witness: _____

Bivona Chiropractic Clinc
Informed Consent

I hereby authorize Bivona Chiropractic ("the Practice") and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I understand that Alabama law entitles me to receive information concerning my condition and proposed treatment, and to refuse any treatment to the extent permitted by law. With that knowledge and with my consent, I wish to rely on Dr. Bivona to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care has been explained and described to my satisfaction.

Based on current findings, Dr. Bivona and staff will discuss my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment, and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the costs of reasonable alternatives to the proposed treatment.

Practice doctors have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those that relate to physical aberrations unknown or reasonably undetectable by the doctor.

This document is intended as a general, broad-based consent applicable to any and all contemplated procedures. However, without in any way limiting the general applicability of this Consent, in the event the Practice has recommended that I undergo cervical (neck) adjustment or manipulation based on my diagnosis and condition, the Practice has also informed me specifically regarding cervical (neck) adjustment and manipulation as follows: There is a rare association of this type of adjustment or manipulation with stroke due to compromise of the vertebrobasilar (VBA) artery (a neck artery at the base of the brain). In 2008, the risk was reported to be 1 case per 400,000 to 1,000,000 cervical spine adjustments in a study of VBA stroke patients admitted to Ontario hospitals from 1993 - 2002. 1 The study found no evidence of excess risk of VBA stroke associated with chiropractic care compared to primary care.

I have discussed all of the above risks and benefits with the Practice, and, if applicable, have made an informed decision that the potential benefits outweigh the risks in my case.

[1] Cassidy JD, Boyle E. Cote P, *et al.* Risk of vertebrobasilar stroke and chiropractic care; results of a population-based case-control and case-crossover study, *Spine* Feb 15, 2008;33(4 Suppl): S176-183. Republished in *J Manipulative Physio.* Ther, 2009 Feb;32(2 Suppl): S201-8.

I understand and accept that;

1. I have the right to withdraw from or discontinue any treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and propose course of care and treatments by the Practice.

_____ _____

Name of Patient (printed) Signature of Patient

Date patient signed: _____

_____ Date signed by doctor: _____

Jillian E. Bivona, DC

Note: Inclusion of the above consent elements, except in unusual circumstances, will concurrently meet those standards published by the American Chiropractic Association and the International Chiropractic Association.

Bivona Chiropractic Clinic

HIPAA Authorization for Use/Disclosure of Information
Consent to Receive Text Messages

Bivona Chiropractic respects the privacy and security of our patients. Ensuring that medical information is kept confidential is among our highest priority. To ensure that Bivona Chiropractic Clinic is acting in accordance with your wishes, using your personal information with your authorization, and communicating with you in a manner with which you authorize, please complete and sign this form. We will keep a copy of your written permission on file.

I specifically authorize text messaging communication with Bivona Chiropractic Clinic. The phone number I wish to have text communication sent to is _____. I understand that text communication may be unsecured. I understand that a risk of unsecured text messages has the potential to be viewed by a third party. Depending on my service provider, I understand that text messaging rates may apply.

I understand that I am not required to sign this authorization and that Bivona Chiropractic Clinic does not base treatment, payment, benefit eligibility, or enrollment activities on the signing of the form.I understand this is an optional service provided for convenience to our patients.

I understand that I may opt out of text communication at any time by texting STOP to any text message sent from Bivona Chiropractic Clinic. I understand that if I revoke or withdraw this permission that I will no longer receive text messages from Bivona Chiropractic Clinic. A copy of this authorization can be provided upon request.

_____	_____	_____
Patient Name (printed)	Patient Signature	Date
_____	_____	_____
Witness Name (printed)	Witness Signature	Date