Consents / Signatures:

Date: _____

CONSENT TO TREAT:

I knowingly and willingly authorize the professionals at LifeArts Integrated Health Center, PC and LifeArts Medical, LLC to review my past medical history, current medical history, and any pertinent data relevant to my health care. Furthermore, I acknowledge that no guarantees have been made to me concerning the results of the care and treatment, and that there are risks and benefits to any form of health care. Additionally, I acknowledge that several disciplines of health care are available at this facility, and consent to all forms of therapy as advised by the provider. *(Please check the boxes for those treatments you consent to either now or possibly in the future).*

Furthermore, I understand that all medical care provided at LifeArts Medical, LLC is performed by an Advanced Practice Registered Nurse. Chiropractic care is provided by a licensed Chiropractor at LifeArts Integrated Health Center, PC. Having this knowledge, I knowingly authorize LifeArts Integrated Health Center, PC and LifeArts Medical, LLC to proceed with my care.

Approved disciplines of treatment: ***Signature:*** _____

- ☐ Chiropractic Care
- ☐ Medical Care
- ☐ Acupuncture
- ☐ Bioidentical Hormone Replacement Therapy
- ☐ Platelet Rich Plasma Injection

If at any time you wish to change your decision, you may let us know and we will ask you to resign a consent.

PRIVACY NOTICE:

The privacy notice (HIPAA) describes how medical information about you may be used and disclosed and how you can get access to that information. We are committed to maintaining the privacy of your protected health information (PHI). This includes information about your health and the treatment that you receive. A health record is created that details the care and services you receive in this office to provide you with high quality health care. This notice is to inform you how your PHI may be used and disclosed to third parties. This is also to inform you of your rights regarding your PHI.

I understand that there are independent providers within the same location as LifeArts Integrated Health Center, PC and LifeArts Medical, LLC. To provide quality care, these providers may collaborate about your health information and treatments. At no time will they identify you by name or other identifier to protect your privacy. *If you consent to the providers collaborating about your case in detail, please indicate by checking the box next to the provider's name.* Boxes left blank will indicate that you want your identity kept private during collaborative discussions.

By signing below, I acknowledge that I have received and reviewed this notice and all questions have been answered to my satisfaction in language that I can understand.

Signature: _____

I authorize LifeArts Integrated Health Center, PC and LifeArts Medical, LLC to release my PHI to the below listed individuals:

- ☐ Dr. Courtney Bradley, DC
- ☐ Erin Smith, FNP-C
- ☐ Other: _____ (example spouse's name, children's name, etc.)
- ☐ Other: _____ (example spouse's name, children's name, etc.)
- ☐ Other: _____ (example spouse's name, children's name, etc.)