kōr CHIRO STUDIO

WELCOME TO KOR CHIRO STUDIO

Please fill out the following info for our records...we promise it's pretty painless and shouldn't give you a hand cramp. All info is strictly confidential. If you'd like us to check into any insurance coverage you may have for chiropractic care, simply provide us with your insurance card and we'll take care of the rest.

First/Last Name

Address

City State Zip

Primary Phone Cell Phone

Email

(We send out helpful, healthy tips, recipes and special offers.)

Date of Birth / / Social Security #

Marital Status Number of Children

Have you been under Chiropractic care before?

How did you hear about us?

Emergency Contact – Name/Phone

Occupation

Employer

Work Phone

NOTICE OF INFORMATION PRACTICES AND PRIVACY STATEMENT FOR KOR CHIRO STUDIO

HOW WE COLLECT INFORMATION ABOUT YOU: Kor Chiro Studio and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

WHAT WE DO NOT DO WITH YOUR INFORMATION: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

HOW WE DO USE YOUR INFORMATION: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between Kor Chiro Studio and health care providers, insurance companies and other providers necessary to: verify your medical information is accurate; determine the type of health care services you need.

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

INFORMATION WE DO NOT COLLECT: We do not use cookies on our website to collect date from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page (www.korchirostudio.com) that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic data through our site.

LIMITED RIGHT TO USE NON-IDENTIFYING PERSONAL INFORMATION FROM BIOGRAPHIES, LETTERS, NOTES, AND OTHER SOURCES: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of Kor Chiro Studio. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

By signing below, I acknowledge and have read the above privacy statement regarding how my personal information will be used by Kor Chiro Studio.

Name (please print) _____

Signature _____ Date_____

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CHIRO STUDIO

INFORMED CONSENT FOR CHIROPRACTIC CARE

Doctors of Chiropractic who use manual therapy techniques are required by law to advise patients that there may be some risks associated with such treatment. In particular you should note:

A) While rare, some patients may experience short term aggravation of symptoms. However this effective approach to health has been serving people for over 100 years. It is licensed in every state, and in many countries also.

B) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. In 2001 the Canadian Medical Association Journal found there is only a 1 in 5.85 million risk that a cervical manipulation from an MD, PT, or DC would be followed by a stroke. Author David Cassidy, a professor of epidemiology at the University of Toronto, said patients had already damaged the artery before seeking help from either a medical doctor or a chiropractor, and then the stroke occurred after the visit.

C) Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has demonstrated to be effective treatment for many conditions. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many traditional medical treatments.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Name (please print) _____

Signature _____ Date_____