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mydrnicci@gmail.com

Consent to Services

Dr. Nicole Sletten, D.C. and/or Dr. Bret Buffalohead, D.C.

1. I,___________________, authorize the performance upon my person the following procedure(s) :
   ____Manipulation
   ____Examination
   ____Urinalysis
   ____X-Rays
   ____Physical Medicine
   ____CBC
   ____SMAC
   ____Other _____________________________________

2. _______In addition I understand that other examination and treatment procedure(s) may be necessary throughout the course of my admission and I understand that I will be so informed of the intent to perform and risks and benefits of the proposed procedures.

3. _______I understand these procedures will be authorized by a licensed Chiropractic Doctor any performed by any interns under the supervision of those attending Doctors of Chiropractic.

4. _______The nature and purpose of these procedures, possible alternatives, and the risks involved, the possible consequences and the possibility of complications have been sufficiently explained to me by the Doctors of Chiropractic and/or their designees.

5. ______I understand that there are charges for these procedures and that they will be explained to me by Wellness Heights Doctors of Chiropractic and /or designees upon my request.

Consent "Protected Health Information"

I,____________________, consent to **Wellness Heights'** (The Practice) use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for The Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operations activities. I understand that The Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.
For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by The Practice, that relates to my past, present, or future physical or mental health condition; the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.
I understand that I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment, or healthcare operations of The Practice, but **Wellness Heights** is not required to agree to these restrictions. However, if The Practice agrees to a restriction that I request, the restriction is binding on The Practice.
I understand I have the right to review The Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and The Practice's duties regarding the types of uses and disclosures of my Protected Health Information.
I have the right to revoke this consent, in writing, at any time, except to the extent that the Doctor of Chiropractic or The Practice has acted in reliance on this consent.

Signature of Patient or Personal Representative ______________________ Date ____________________