Stroupe Chiropractic LLC
Rambling Road Family Wellness And Chiropractic
James H. Stroupe, D.C.
Valerie A. Stroupe, D.C.

Acknowledgement - Receipt of Notice of Privacy Practices

I acknowledge that Rambling Road Family Wellness and Chiropractic's / Stroupe Chiropractic LLC's (hereinafter referred to as Stroupe Chiropractic) "Notice of Privacy Practices" has been presented to me. I understand I have a right to review Stroupe Chiropractic's Notice of Privacy Practices prior to signing this document and that this notice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations Stroupe Chiropractic. The Notice of Privacy Practices is also provided on request at the main administration desk of this practice. This notice describes my rights and the office's duties with respect to my protected health information. Stroupe Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by calling the office and requesting a revised copy be sent via mail or at the time of my next appointment. _____

Consent to Care

I hereby request and consent to the performance of chiropractic manipulation or adjustments and other chiropractic procedures, including various modes of physical therapy or physical medicine procedures, and diagnostic x-rays, on me by Dr. James Stroupe, Dr. Valerie Stroupe other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor the nature and purpose of chiropractic manipulations or adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all possible risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition.

Signature of Patient:_____ Date:_____

Signature of Representative_____

Relationship to Patient _____

Dr. Signature:_____ Date_____