HILL COUNTRY HOLISTIC HEALTH, LLC

Dr. Adam Youngblood DC, PAK, QNCP & Dr. Emily Youngblood, DC DACNB, PAK, QNCP
Website: www.blancochiro.com
Phone:(830)-383-0213
Email: youngbloodchiro@gmail.com

HIPAA disclosure

The Health Insurance Portability and Accountability Act of 1996 established legal guidelines for medical practitioners to protect your medical information. Public Law 104-191, required the U.S. Department of Health & Human Services (HHS) to adopt national standards for electronic health care transactions and code sets, unique health identifiers, and security. Full details are available at the HHS.GOV website.

I _____ have access to the HHS.GOV website to review the government mandated Patient Privacy Policy honored by Drs. Youngblood DBA Hill Country Holistic Health LLC.

By initialing here____and signing below, I give my permission to use and disclose my health information. I understand that I may revoke this consent to the use and disclosure of Protected Health information with a formal written request.

Waiver on X-rays

If current x-rays are not made available to Drs. Youngblood DC for analysis so a complete study *o*f my present complaint can be diagnosed, I will be given a doctor's order for x-rays to be taken elsewhere and returned for full analysis, as such I do not feel that my present situation is serious enough to warrant the use of x-rays. Thereby authorizing Drs. Youngblood to treat my present complaints to the best of their ability without a complete x-ray study and analysis, while I assume full responsibility for unknown internal issues not discover*ed/* diagnosed in advance of treatment.

Authorization for Chiropractic Exam and Treatment

I hereby authorize Drs. Youngblood DC, DBA Hill Country Holistic Health, LLC to administer Chiropractic exam and treatment, and to perform any therapy, manipulation or procedures that are considered beneficial based on the clinical findings presented during the course of exam and treatment. I certify that NO guarantee or assurance has been made as to the results that may be obtained. I acknowledge the advantages of treatment compared to the risks which include any rare, but possible complications from treatment. I further certify that I will be honest and disclose any known injuries, previous diagnosis, conditions, medication use, herbal or chemical factors that would be applicable to my treatment procedures.

Patient Signature: _____ Date:_____

Doctor Signature: _____ Date:_____