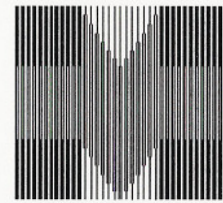


Consent to Chiropractic Care



Menner Chiropractic

165 S. Rand Road
Lake Zurich, IL 60047
Phone: 847-540-6060
Fax: 847-540-6063

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____ by licensed doctors of chiropractic who may be employed by or engaged in practice in the Menner Chiropractic LLC Clinic.

I have had an opportunity to discuss with **Menner Chiropractic, LLC** or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of possible complications which have been alleged. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had an opportunity to ask questions about its contents, and by signing below, acknowledge my understanding of its contents.

Date: Saturday, January 20, 2007

Patient Name

Patient Signature

Relationship or authority if not signed by
patient or if patient is a minor

Signature of authority or guardian

**PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION TO CARRY OUT
TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**



Manner Chiropractic

165 S. Rand Road
Lake Zurich, IL 60047
Phone: 847-540-6060

_____, hereby states that by signing this Consent, I
acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for the treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for the treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.
7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Patient

Signature of Patient

Signature of Legal Representative
(e.g. Attorney-in-fact, Guardian, Parent)

Relationship

Date Signed: ____/____/____

Witness: _____

- Yes No I give the right for my immediate family to discuss my PHI upon request in writing. I understand that they may only obtain a copy of my file upon written authorization given by me which this form does not give such an authorization.
- Yes No I give the right for the **names listed below** to discuss my PHI upon request in writing. I understand that they may only obtain a copy of my file upon written authorization given by me which this form does not give such an authorization.

Person allowed to discuss my PHI

Patient Signature