Pali Cooper, D.C., C.C.S.P.
Certified Chiropractic Sports Practitioner
Active Release Techniques
300 Tamal Plaza, Suite 100
Corte Madera, CA 94925
(415) 924-3381 Fax (415) 924-3380

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by Pali Cooper, D.C., and/or other licensed doctors of chiropractic who now or in the future may work at this office.

I have had/will have an opportunity to discuss with Dr. Cooper the nature and purpose of chiropractic 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 risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known to her, 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 procedures. I intent this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name ____________________________________

Patient Signature ________________________________

Date ____

If you are a minor, or if you are being represented by another party

__________________________ ____

Personal Representative (Please Print) Personal Rep. Signature Date

Description of Authority to act on behalf of the patient:____________________________________

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You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Pali Cooper, D.C.

If you would like further information about our privacy policies and practices, please contact Pali Cooper, D.C.

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of April 14, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created.

My signature acknowledges that I have received a copy of this notice.

_____________________________ ________________________ ___________

Name (Please Print) Signature Date

If you are a minor, or if you are being represented by another party

_____________________________ ____

Personal Representative (Please Print) Personal Rep. Signature Date
Description of Authority to act on behalf of the patient:____

I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME OF TREATMENT.
A 24-HOUR NOTICE OF CANCELLATION IS REQUIRED TO AVOID A CHARGE FOR A MISSED APPOINTMENT.