**Advanced Integrative Health Center**
**Medical Consent and Waiver of Liability Form**

## Non-Discrimination Policy

At Advanced Integrative Health Center, we are committed to providing high-quality medical care to all individuals. We do not discriminate against any person based on race, color, national origin, ethnicity, ancestry, religion, creed, sex, gender identity, sexual orientation, age, disability, genetic information, military status, or any other characteristic protected by federal, state, or local law.

All patients are treated with respect, dignity, and equality in all aspects of care, including but not limited to treatment decisions, facility access, and patient-provider interactions.

**1. Consent to Medical Procedures** I, the undersigned, consent to receive medical evaluation and treatment, including diagnostic procedures, physical examinations, and other necessary medical interventions provided by the Advanced Integrative Health Center (AIHC). I understand that all procedures will be explained to me before they are performed, and I have the right to ask questions and decline any treatment I am not comfortable with.

**2. Consent to Chiropractic Procedures** I, the undersigned, consent to receive chiropractic care, including spinal adjustments, manipulations, and other therapeutic techniques. I understand that while chiropractic care is generally safe, there are potential risks, including but not limited to muscle soreness, joint stiffness, or, in rare cases, neurological complications. My physician has explained the benefits and potential risks associated with these procedures, and I have had an opportunity to ask questions.

**3. Consent to Acupuncture & Dry Needling Procedures** I, the undersigned, consent to receive acupuncture treatments, including the insertion of fine needles, cupping, moxibustion, and other related therapies. I understand that while acupuncture is considered safe, potential risks include minor bleeding, bruising, dizziness, or infection at the needle site. These risks have been explained to me, and I have had an opportunity to ask questions.

**4. Consent to Physical Therapy Procedures** I, the undersigned, consent to participate in physical therapy treatments, including exercises, manual therapy, therapeutic modalities, and other rehabilitative interventions. I understand the potential risks involved, such as temporary discomfort, muscle soreness, or exacerbation of pre-existing conditions. These risks have been explained to me, and I have had an opportunity to ask questions.

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**5. Acknowledgement of Risks** I understand and acknowledge that:

- All medical, chiropractic, acupuncture, and physical therapy procedures carry inherent risks.
- The staff at AIHC will take all reasonable precautions to minimize these risks.
- There are no guarantees regarding the outcome of any treatment.

**6. Waiver of Liability** I hereby release and discharge AIHC, its staff, and affiliates from any and all claims, demands, damages, or liabilities of any kind arising from or related to the treatments provided, except in cases of gross negligence or willful misconduct. I understand that this waiver does not waive any rights or protections afforded to me under state or federal law.

**7. Confidentiality and Privacy** I understand that all medical records and information shared during my care will be kept confidential in accordance with HIPAA regulations. I consent to the sharing of my medical information with other healthcare providers as necessary for the coordination of my care.

**8. C**onsent for Photographing or Other Recording for Security and/or Health Care Operations** I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

**9. Electronic Communication Authorization** I, the undersigned, authorize AIHC physicians or employees, or one of their affiliate entities to send/receive confidential healthcare information as the term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile, text, email, voicemail, etc. to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed below. I may revoke this authorization by giving AIHC physicians or employees five (5) days written notice. This revocation may be by facsimile transmission, however, a written copy of the revocation must be mailed to AIHC as well.

**10. Voluntary Agreement** I certify that I have read and fully understand the content of this consent and waiver of liability form. I confirm that all my questions have been answered to my satisfaction, and I voluntarily agree to the terms outlined above.

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**Signature:**

Patient Name (Printed): _____

Patient Signature: _____

Date: _____ Date of Birth:_____

**For Minor Patients:**
Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____

Date: _____ Date of Birth:_____