Marshall Chiropractic, LLC – Daniel E. Marshall, D.C.
12482 SW 131st Avenue; Tigard, Oregon 97223 (503) 598-7652

Patient Consent Form

Patient Name: _____ Date: _____

According to state and federal laws, consent is required for the following patient care items. **By initializing each item and signing below, I consent to the following items initialed.**

_____ **Open Room Environment:** The adjusting area is where education, learning, and healing take place. I understand and consent to participating in the open room environment. I also understand that if at any time I wish to speak to the doctor in private, I can schedule a consultation at no extra charge.

_____ **Marketing:** Marketing is considered to be " a communication about a product or service with the purpose being to encourage recipients to purchase or use the product or service". I understand Marshall Chiropractic, LLC, may at times have additional services they wish to inform me about, and I consent to being contacted. I understand Marshall Family Chiropractic, P.C. participates in charitable events to raise awareness, food donations, gifts, money, etc., and consent to being contacted for said events. I understand my information will be used for in-house services only and will not be released for outside marketing purposes.

_____**Testimonials:** I understand Marshall Chiropractic, LLC, will not use my personal testimony for any purpose without my prior consent. If Marshall Chiropractic, LLC, wishes to use information concerning my experience in treatment, I will be asked to sign a separate consent and release form.

_____**Miscellaneous use of name and picture:** I understand that Marshall Chiropractic, LLC, will at times ask to use my name and photo for internal purposes, such as patient appreciation boards, optimal health boards, and patient acknowledgment boards. I understand I will be notified in advance of such usage and have the right to decline.

_____**Pre-Enrollment Underwriting:** I understand that if I apply for new insurance coverage and the insurance company wants to review my personal health information, Marshall Chiropractic, LLC, will not release information without my written authorization. I understand that I am responsible for all fees incurred for treatment not covered by my insurance.

_____**Employment Determination:** I understand that if a pre-employment physical is conducted, Marshall Chiropractic, LLC, will not release information to the employer without my consent.

_____ **Appointment Reminders & Correspondences:** I understand that Marshall Chiropractic, LLC, will at times need to contact me for appointment reminders, missed appointment follow-up, special event announcements, birthday cards, referral thank-you cards, special occasion cards, notes, newsletters, and other correspondences. Such correspondences may be by phone, voice mail, mail and email. I consent to being contacted, and should I choose not to in the future, I am aware I can request not to be contacted.

***Email addresses are for Marshall Chiropractic, LLC< use only, they will not be distributed to other parties and any group emails such as newsletters and announcements will be received as Bcc (Blind carbon copy) to ensure privacy.**

My email address is:_____

Patient Signature:_____ Date:_____

Parent/Guardian Name:_____

Parent/Guardian Signature_____ Date:_____