

# PATIENT CONFIDENTIALITY PERSONAL DATA

No. \_\_\_\_\_ Date \_\_\_\_\_  
Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security No.: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Name of Spouse: \_\_\_\_\_ SS No.: \_\_\_\_\_ No. of Children: \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
How did you learn of this clinic? \_\_\_\_\_  
Nearest relative not living with you? \_\_\_\_\_ Phone: \_\_\_\_\_  
Who is responsible for payment?  Self  Spouse  Other  
PATIENT'S INSURANCE SPOUSE'S INSURANCE  
Name of Company: \_\_\_\_\_ Name of Company: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
ID & Group No.: \_\_\_\_\_ ID & Group No.: \_\_\_\_\_  
Phone No.: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
Purpose of this appointment and list your complaints: \_\_\_\_\_

Date of illness: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM Location: \_\_\_\_\_  
How did accident occur?  Auto  On the job  Other, \_\_\_\_\_  
Please describe the circumstances and what makes the condition(s) better or worse: \_\_\_\_\_

Other Doctor seen for this condition: \_\_\_\_\_  
Have you been treated by a Doctor for any health condition in the last year?  Yes  No  
If yes, please describe: \_\_\_\_\_

## INSURANCE INFORMATION

*I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.*

Signature Physician: \_\_\_\_\_ Signature Patient: \_\_\_\_\_

## CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

*I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in any case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.*

Patient's Signature: \_\_\_\_\_  
Parent's or Guardian's Signature: \_\_\_\_\_



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

\_\_\_\_\_ 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 that 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 that 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 Individual (Printed):** \_\_\_\_\_

**Signature of Individual:** \_\_\_\_\_

**Signature of Legal Representative:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Date signed:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**OFFICE PROCEDURES**

**APPOINTMENT REMINDERS:** Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment. \_\_\_\_\_

**AUTHORIZATION FOR PAYMENT:** Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to your Insurance Company, Lawyers, Third Party Insurance Company or the credit bureau. This disclosure will be made if we need their assistance to receive reimbursement for your services or, we need their assistance because the party responsible for reimbursing your service has improperly processed your claim. By signing this form you are giving us authorization to send them this information. You are also giving them authorization to re-disclose your information to the party responsible for the payment of your services, the association's legal counsel, and state or federal agencies that may be asked to intercede on your behalf. \_\_\_\_\_

**THANK YOU CARDS:** If you referral a friend, family member or colleague in to our office, we would like to send you a thank you card. By signing this form you are giving us authorization to send you a card in the mail. \_\_\_\_\_

**REFERRAL BOARD:** If you referral a friend, family member or colleague in to our office, we would like to put your name on our referral board thanking you for sending he/she in to our office. By signing this form you are giving us authorization to display your name on our board. \_\_\_\_\_

**FINANCIAL ARRANGEMENTS:** We have an open front desk and all of our financial arrangements are discussed at the front counter. If you feel that you need a more private place to discuss your financial arrangement we can always move to the back office. Please notify the office staff or doctor if arrangements need to be made. \_\_\_\_\_

**YOUR RIGHT TO LIMIT USES OR DISCLOSURES**

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us knowing in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binging on us.

I authorize you to use or disclose my health information in the manner descried above. I am also acknowledging that I received a copy of this authorization.

\_\_\_\_\_  
PATIENT NAME PRINTED

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE