**CONFIDENTIAL PATIENT INFORMATION**

**The following information is needed in order to better serve you. Please complete all questions. PLEASE PRINT CLEARLY**

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years on Job:\_\_\_\_\_\_\_\_

Office Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drivers Lic # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have health insurance?” Yes No Please circle one payment type: Cash Check Credit Card

Plan/Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have Medicare? Yes No Do you have Medicaid? Yes No

Name of Spouse or Parent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years on Job:\_\_\_\_\_\_\_\_\_\_\_

Spouse Employer Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_

Spouse Office Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse Drivers Lic #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your spouse have health insurance? Yes No

Plan/Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the Major Complaints that bring you to our office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your condition due to an accident? Yes No If so, Date of Accident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Accident: Auto Work/On Job At Home Other

Have you ever been in an Auto Accident? Past Year Past 5 Years Over 5 Years Ago Never

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered and non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Unless otherwise arranged through our Fee Schedule, full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance prior to seeing the doctor. On all insurance assignments, the deductible must be met in the beginning unless prior arrangements have been made.

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT RECORD OF DISCLOSURE/PRIVACY CONSENT**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Female Male

I wish to be contacted in the following manner: (check all that apply)

* Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ It is okay to leave a message with detailed information
	+ Leave a message with a call back number only
* Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ It is okay to leave a message with detailed information
	+ Leave a message with a call back number only
* Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ It is okay to leave a message with detailed information
	+ Leave a message with a call back number only
* Written Communication:
	+ It is okay to mail my home address
	+ It is okay to mail my work address
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ It is okay to leave a message with detailed information
	+ Leave a message with a call back number only

I have received or reviewed a copy of Realief Chiropractic’s Notice of Privacy policies, containing a more complete description of the uses and disclosures of my health information. I understand the situations in which this practice may need to utilize or release my medical records. I also understand that this organization has the right to change its Notice of Privacy policies from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Policies. I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand that this office is not required to agree to my requested restrictions but if agreed office is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that office has taken action relying on this consent.

**SIGNATURE ON FILE**

All patients must read, check and sign:

I certify that the information given for payment under Title XVII of the Social Security Act.

* I authorize the use of this form in all my insurance submissions.
* I authorize the release of information to all my insurance information.
* I authorize my doctor to act as my agent in helping me obtain information from my insurance companies.
* I authorize payment directly to my doctor or his assigns.
* I permit a copy of this authorization to be used in place of the original.

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY POLICIES**

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this notice describes how information about you may be used and disclosed and how you can get access to this information.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activates, public health, research, and law enforcement actives. Information will also be used to (1) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, (2) Obtain payment from third party payers. (3) Conduct normal healthcare operations such as quality assessments and physical certifications. You may request restrictions on disclosures. Our practice has the right to accept or deny your request.

**You may inspect and receive copies of your records within 30 days of a written request. There may be a reasonable cost-based fee for photocopying, postage, and preparation**.

You may request changes to your records, in writing. Our practice has the right to accept or deny your request.

In the future, we may contact you to provide appointments reminders or information about treatment alternatives, or other health-related benefits and services that may be of interest to you. Your Patient Record of Disclosure will be used to obtain contact. You have the right to request confidential communications by alternative means by resubmitting a Patient Record of Disclosure form.

**Notice of care being provided in a “open-door” environment**

It is the desire of this office to provide care in an “open-door” environment. An “open-door” approach involves doctors moving from one open area to another to perform patient care. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. As a result patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and NOT the environment used for taking patient histories, performing examinations, or presenting reports or findings. These procedures are completed in a private, confidential setting.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

The effective date of this Notice of Privacy Practices is May 15, 2012

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT CONSENT FORM**

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritations of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between on instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examination(s) that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Printed) Relationship to Patient

Patient or Legal Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR WOMEN ONLY: Pregnancy Release**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associated have my permission to perform and x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Printed) Relationship to Patient

Patient or Legal Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_