Precision Chiropractic &Wellness
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WELCOME

We at Precision Chiropractic and Wellness welcome you and want to provide you with the best possible wellness care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that chiropractic care is appropriate we will not accept you as a patient but will refer you to another health care provider, if necessary.

Name: _____

Street Address: _____ City/State/Zip: _____

Phone-- Home: _____ Mobile: _____ Work: _____

E-mail address: _____ SS #: _____

Occupation: _____ Employer: _____

Work Status ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed ☐ Off-Work ☐ Other

Date of Birth _____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status ☐ Single (never married) ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Spouse's Name: _____ Telephone: _____

Spouse's Employer: _____ Work Telephone: _____

Emergency Contact: _____ Telephone: _____

Family Medical Doctor: _____ Telephone: _____

Address: _____

How did you hear about Precision Chiropractic? _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

The patient understands and agrees to allow this chiropractic office to use his/her Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA notice that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

_____ _____
Signature Date

_____ _____
Signature of Legal Guardian Date

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8. **Employee DOT Physical and Drug Test Failures will be automatically and immediately be reported to your employer.**

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

X_____ Date: _____ X_____

SIGNATURE PRINT