



Dr. Melissa Kelling
Dr. Lisa Geurink
902 5th Street, P. O. Box 715
Durant IA 52747
Phone: 563-785-6511 Fax: 563-785-5011
www.durantchiropractic.com

CONFIDENTIAL PATIENT CASE HISTORY

Welcome to our office. Please complete this information as thoroughly as possible. We don't just treat symptoms, we treat causes, and this information will help us get a better understanding of your overall health. If at any point you have any questions, our staff will be happy to assist you.

Thank you!

PERSONAL INFORMATION

Name: _____ Preferred Name: _____ Date: _____

Date of Birth: ___/___/___ Age: _____ Sex: Male Female Marital Status: S / M / D / W

Ethnicity: Hispanic Non-Hispanic Choose not to specify Race: White Other _____

Address: _____ City: _____ State: _____ Zip Code: _____

Social Security Number: _____ - _____ - _____ Home Phone: (_____) _____

Cell Phone: (_____) _____ E-mail: _____

Occupation: _____ Employer: _____

Employer Address: _____

Work Phone: (_____) _____

Spouse's Name: _____ Date of Birth: ___/___/___ Age: _____

Spouse's Employer: _____ Employer Address: _____

Spouse's Social Security Number (only needed if on spouse's insurance): _____ - _____ - _____

Do you have children? Yes No Ages: _____

Emergency Contact: _____ Phone: (_____) _____ Relationship: _____

How did you hear about us? Friend Family Member Google Search
 Website Drive-by Facebook
 Other Social Media Other: _____

Who may we thank for referring you? _____

CURRENT PRIMARY HEALTH CONCERN

What is your main symptom? _____

When did this condition begin/become exacerbated (date)? _____

Have you had this or similar conditions in the past? _____

What do you think caused this condition? _____

What positions make your pain worse (sitting, standing, walking, bending, etc.)? _____

What positions make your pain better (ice, heat, resting, sitting, stretching, etc.)? _____

Over time, is this condition: Improving Unchanged Getting Worse

What Activities of Daily Living is this condition interfering with?

- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Chores/Farm work | <input type="checkbox"/> Cleaning house | <input type="checkbox"/> Climbing stairs | <input type="checkbox"/> Dishes |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Exercising | <input type="checkbox"/> Getting Dressed | <input type="checkbox"/> Getting in/out of vehicle | <input type="checkbox"/> Grocery shopping |
| <input type="checkbox"/> Lifting children | <input type="checkbox"/> Sitting | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Standing | <input type="checkbox"/> Tying shoes |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Working | <input type="checkbox"/> Yardwork | <input type="checkbox"/> None | |

CURRENT PRIMARY HEALTH CONCERN Patient Name: _____

Have you sought advice or treatment from other doctors or therapists for **THIS** condition? Yes No

If yes, list all doctors or therapists consulted for **this** condition (include approximate date of visit and diagnosis):

Name Date of Visit Diagnosis

Describe any treatment you have had for **THIS** condition (include medication dosage & frequency): _____

Family Medical Doctor: _____ Office Name/Location: _____

Date of Last Physical: _____

May we communicate our findings on your current health condition to the above provider(s)? Yes No

Days lost from work due to this condition: _____

Please list the specific complaints you are experiencing at this time and mark the location on the diagram. Beside each complaint, rate its severity on a scale of 1-10, with 1 being the least discomfort and 10 being the most discomfort.

Primary Complaint:

1. _____ 1 2 3 4 5 6 7 8 9 10

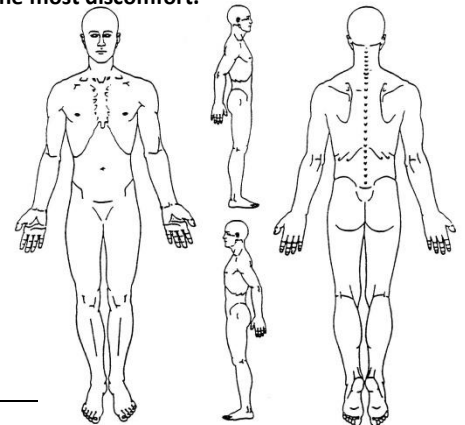
Additional Complaints:

2. _____ 1 2 3 4 5 6 7 8 9 10

3. _____ 1 2 3 4 5 6 7 8 9 10

4. _____ 1 2 3 4 5 6 7 8 9 10

5. _____ 1 2 3 4 5 6 7 8 9 10



Have you sought care for a **DIFFERENT** health condition in the past year? Yes No

In the past 2 years? Yes No

If yes, for what condition? _____

Was treatment administered? Yes No Describe: _____

Do you take medications: Yes No List medication, dosage, frequency & reason: _____

Any prior hospitalizations or surgeries: Yes No Describe with dates: _____

Have you been in an auto accident or had any other personal injuries? Yes No Describe: _____

CHIROPRACTIC HISTORY

Previous Chiropractic Care? Yes No If yes, Doctor's Name: _____

Date of last chiropractic visit: ____/____/____ Date of last spinal x-rays: ____/____/____

Reason for care: _____ How long were you under care? _____



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Were you satisfied with the previous chiropractic care you received? Yes No

Are other family members under chiropractic care? Yes No Who? _____

Are you open to looking at new ideas in health and wellness? Yes No

SOCIAL HISTORY

Staff Only: BP: _____ / _____ BPM: _____ Left Arm Right Arm

Height: _____ ft. _____ in. Current Weight: _____ lbs. Have you recently lost/gained more than 10 lbs? Yes No

Are you: Left-handed Right-handed Ambidextrous

Shoe Size: _____ Wide Narrow Moderate

Mental Work: Heavy Moderate Light Hours per day: _____
 Physical Work: Heavy Moderate Light Hours per day: _____
 Exercise: Heavy Moderate Light Hours per week: _____ Type: _____
 Tobacco: Never Currently Previously Packs/dips per day _____ How long?: _____
 Are you interested in quitting? Yes No
 Alcohol: None Beer/week: _____ Liquor/week: _____ Wine/week: _____
 Caffeine: None Cups/day: _____
 Aspirin: Yes No How many per day?: _____

FAMILY HISTORY – List any diseases which run in your family

<u>Relative</u>	<u>Age if Living</u>	<u>Age at Death</u>	<u>Cause of Death</u>	<u>Illnesses/Diseases</u>
Father:	_____	_____	_____	_____
Mother:	_____	_____	_____	_____
Brother(s):	_____	_____	_____	_____
Sister(s):	_____	_____	_____	_____
Grandfather (Mat.):	_____	_____	_____	_____
Grandmother (Mat.):	_____	_____	_____	_____
Grandfather (Pat.):	_____	_____	_____	_____
Grandmother (Pat.):	_____	_____	_____	_____

Spouse's Health Status: Poor Fair Good Excellent
 Children's Health Status: Poor Fair Good Excellent
Your Overall Health Status: Poor Fair Good Excellent

INSURANCE INFORMATION – If you have provided Staff with a copy of your insurance card(s), skip this section.

Who is responsible for this account?: _____
 Relationship to Patient: _____ Date of Birth: _____
 Insurance Co: _____ Patient ID #: _____ Group #: _____
 Is Patient covered by additional or secondary insurance? Yes No
 Subscriber's Name: _____
 Relationship to Patient: _____ Date of Birth: _____
 Insurance Co: _____ Patient ID #: _____ Group #: _____

REVIEW OF SYSTEMS (NOW = within the past 1 year; PAST = over 1 year ago)

Patient Name: _____

<u>GENERAL</u>	Now	Past	<u>BREASTS</u>	Now	Past	<u>NEUROLOGICAL</u>	Now	Past	<u>PAST MEDICAL HISTORY</u>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Check only the ones you have had in the past
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever <input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Mumps <input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Hand Trembling	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever <input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Allergies <input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Angina <input type="checkbox"/>
<u>SKIN</u>			Bloated	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Facial	<input type="checkbox"/>	<input type="checkbox"/>	Cancer <input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	<u>RESPIRATORY</u>			Weak Grip	<input type="checkbox"/>	<input type="checkbox"/>	Tumor <input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease <input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Difficult Speech	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia <input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>	Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble <input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins <input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis <input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<u>ENDOCRINE</u>			Hypertension <input type="checkbox"/>
<u>HEAD & EYES</u>			Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Stroke <input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant exposure	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers <input type="checkbox"/>
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<u>CARDIOVASCULAR</u>			Extremely Thin	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice <input type="checkbox"/>
Last Eye Exam Date:	_____		Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Skin Trouble <input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones <input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Liver Trouble <input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Extremity	<input type="checkbox"/>	<input type="checkbox"/>	Breast Changes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis <input type="checkbox"/>
<u>EARS</u>			Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<u>IMMUNIZATION/VACCINATION</u>			Parasites <input type="checkbox"/>
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Press	<input type="checkbox"/>	<input type="checkbox"/>	DPT	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy <input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis <input type="checkbox"/>
ringing	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Small Pox	<input type="checkbox"/>	<input type="checkbox"/>	Polio <input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness <input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	<u>GASTROINTESTINAL</u>			Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism <input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Depression <input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Break <input type="checkbox"/>
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>	Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Influenza	<input type="checkbox"/>	<input type="checkbox"/>	Migraine <input type="checkbox"/>
<u>NOSE</u>			Belching	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	Covid-19 <input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	MMR	<input type="checkbox"/>	<input type="checkbox"/>	Gout <input type="checkbox"/>
						Covid-19	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids <input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<u>PSYCHIATRIC</u>			Prostate Problems <input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Irreg. Bowel	<input type="checkbox"/>	<input type="checkbox"/>	Hyperventilation	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Problems <input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Insecurity	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea <input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis <input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes <input type="checkbox"/>
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Irritable	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Trouble <input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones <input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection <input type="checkbox"/>
<u>MOUTH</u>			Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Dysentery <input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	
Sores	<input type="checkbox"/>	<input type="checkbox"/>	<u>GENITOURINARY</u>			Drug Dependent	<input type="checkbox"/>	<input type="checkbox"/>	<u>ALLERGIES</u>
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal Thoughts	<input type="checkbox"/>	<input type="checkbox"/>	List known allergies below; indicate <u>NONE</u> if there are no known allergies
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Extreme Worry	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Straining	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Pain with Urination	<input type="checkbox"/>	<input type="checkbox"/>	<u>MUSCULOSKELETAL</u>			_____
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Stones	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>THROAT</u>			Burning	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	Small Stream	<input type="checkbox"/>	<input type="checkbox"/>	Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>				
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>				
Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>				
<u>NECK</u>			Spotting	<input type="checkbox"/>	<input type="checkbox"/>				
Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramp	<input type="checkbox"/>	<input type="checkbox"/>				
Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Painful Periods	<input type="checkbox"/>	<input type="checkbox"/>				
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>				
Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>				
Masses	<input type="checkbox"/>	<input type="checkbox"/>	Irreg. Periods	<input type="checkbox"/>	<input type="checkbox"/>				

If FEMALE,
Are you Pregnant?
 Yes
 No
If Yes, what is your approx. due date? _____
How many weeks are you? _____
Is this your first pregnancy? Yes No



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ASSIGNMENT AND RELEASE

I certify that if I, and/or my dependent(s) have insurance coverage, I will assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that interest is charged on overdue accounts at the annual rate of 18%. I authorize the doctor or this office to contact me via mail, email, phone, and text message in regards to treatment as well as promotional activities. This clinic may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have also received a copy of this office’s Financial Policy and Appointment Policy and agree to its terms.

_____ Initial

AGREEMENTS and AUTHORIZATION

Consent to Health Care Services/Release of Health Care Information

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient’s behalf), hereby request and consent to Patient health care services from this office. The Patient health care services will be provided by and overseen by licensed, treating physicians. Health care services will also be provided by non-physician health care professional and assistants employed or otherwise retained by this office. Medical, nursing, and other health care personnel who are in training may also participate in the Patient’s care as part of their education.

_____ Initial

Payment Guarantee

In consideration of the services provided by this office, Provider to Patient, you agree to: 1) guarantee payment of all charges incurred by Patient in connection with such services (“Patient Charges”); 2) irrevocably assign and transfer to this office, all right, title and interest to medical reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and 3) authorize payment of such benefits directly to this office. You also agree to be fully responsible for the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits.

_____ Initial

Notice of Non-Coverage

If you have insurance, insurance companies will only pay what is covered in each individual’s insurance policy. Your insurance does not pay for all of your healthcare costs, specifically as it relates to treatment in a chiropractic office. Your insurance policy will only cover services that it deems are “Medically Necessary” according to their specific guidelines. When you receive a service or item that your insurance policy does not cover, then you are personally responsible for the non-covered services at the time they were rendered (unless prior arrangements have been made). Specifically, your insurance policy will not allow payment for the following non-covered services and you will have to pay out-of-pocket the normal fee as listed below because they are routinely deemed not-medically necessary according to insurance guidelines: maintenance/wellness chiropractic care, nutritional supplements, therapeutic modalities used for maintenance, massage and any services beyond your benefit plan visit limitations or services that are excluded from the benefit plan.

_____ Initial

Patient Right to Restrict Disclosure of Protected Health Information (PHI)

For any service in which you pay for 100% out-of-pocket, you have a right to restrict the disclosure of that healthcare information for that particular service to any health insurance entity. This is according to your HIPAA privacy rights established under the American Recovery and Reinvestment Act (ARRA) of 2009. For services that are non-covered under your insurance plan and that you pay for in-full out-of-pocket, you understand and request that this office does not bill for any of these non-covered services or items on your behalf and that you wish to restrict the disclosure of PHI of these services from your insurance company.

_____ Initial

Responsibility for Personal Property

You accept sole responsibility for all Patient property, except for property expressly accepted by this office for safekeeping under its sole care and custody.

SIGNATURE of Patient, Parent or Guardian: _____

PRINTED Name of Patient, Parent or Guardian: _____

Date: _____

Relationship to Patient: _____



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AUTHORIZATION and HIPAA PRIVACY NOTICE

Consent to Release Information

Here at this office, we do not sell or release your information to third parties. There will be cases along the course of your care where information will need to be released in certain circumstances. You authorize this office to release to employer groups, government agencies (Medicare, Medicaid, Champus, State or Federal government, etc.), insurance companies or other third-party payers and their agents, and its collection representatives and attorneys, the following "Patient Information": medical history, diagnosis and procedures performed, course of treatment, plan of care, prognosis, supplies and/or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization/payment for Patient's health care services, or billing and collection of amounts due to this office for services rendered. In the case of Patient Information released for purposes of payment of Patient Charges, this authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual health care professional, including treating physician(s), to provide this office or its designee with Patient Information for quality assurance and, or risk management purposes. Finally, in the event that the Patient's employer, or an insurance company representing such employer, requests Patient Information relating to healthcare services provided for worker's compensation injuries. It is understood and agreed that this office is required, under state law, to release copies of such information to such employer or insurance company without the authorization of Patient of Patient's representative. Again, here at this office, we strive to provide you with the best care possible and in order to do that this consent is necessary.

_____ Initial

HIPAA Privacy Notice Patient Acknowledgement

Patient Acknowledgment and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

I hereby state that by signing this Consent, I acknowledge and agree as follows:

- 1) The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request and that a copy of it is always available at the Front Desk.
- 2) The Practice's Privacy Notice has been provided to me prior to my signing this Consent and a copy of it has been shown to me at the Front Desk. 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.
- 3) The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.
- 4) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
- 5) The Practice's "Notice of Privacy Practices" is also provided in the reception area display table and on the Practice's website. I may also request a copy from this office at any time via US Mail.

This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

_____ Initial

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.

SIGNATURE of Patient, Parent or Guardian: _____

PRINTED Name of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____