Patient and Insurance Information

Name email Date

Address Apt #

Town State ZIP

Home Phone Work Phone Cell

Driver's License # Birth Date SS#

Marital Status M S D Sep Spouse Name # of Children

Referred By: Age Range of Children

Employer Occupation

Address

Town State ZIP

Health Insurance Info

Carrier Ins Co phone

Address

Policy # Group #

Patient Relationship to the insured Self Spouse Child Other

If you are covered under another person's insurance.... Please complete

Name of Insured

Address of insured

Phone of insured Sex Birth date

Insured's Employer

Address

Employer Phone Plan Name

Auto Accident Insurance

Policy Number

Carrier

Address

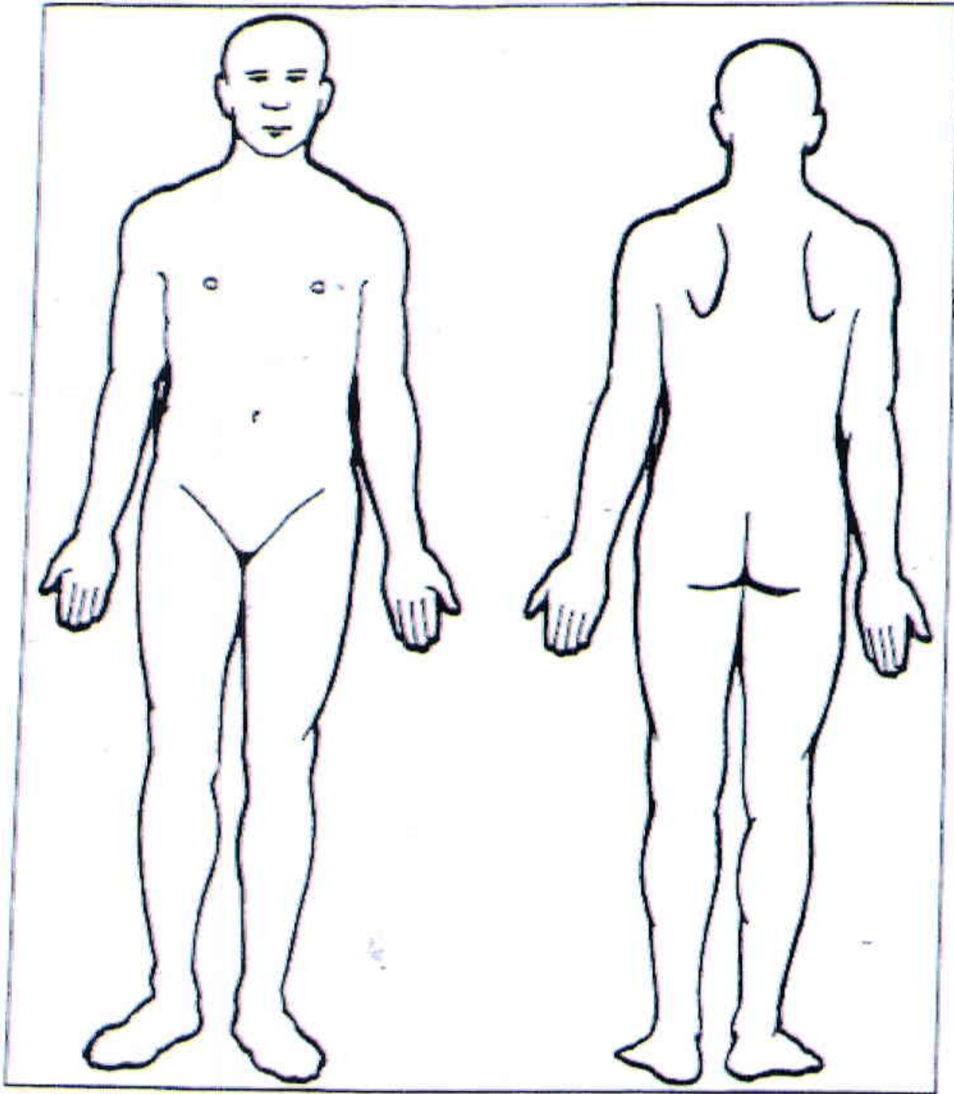
City State ZIP Phone

Person To Contact... Claim #

Date of Accident Patient Relationship to the insured Self Spouse Child Other

Patient Name: ______________________________ Date: ____________________

Whole Body Symptom Description



KEY:	Ache	Numbness	Pins & Needles	Burning	Stabbing
	^ ^ ^ ^	= = = =	0 0 0 0	x x x x	////

Please indicate on the line below the number between 0 and 100 that best describes your pain.

A zero (0) would mean "No Pain" and a one-hundred (100) would mean the "Worst Pain Possible"

Please write only one number: ________

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical modalities and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and informed that, as in the practice of medicine, the practice of chiropractic posses some risks to treatment, including, but not limited to, fracture, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. Therefore, I wish to rely on the Doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, and is in my best interest.

I have read, or have read to me, the above consent I have also had and opportunity to ask questions about its content, and by signing below 1 agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

All charges incurred at Hillsboro Chiropractic Clinic are my total Responsibility regardless of payment by my insurance policy or not.

If this account is placed with an attorney for collection, I am aware of having additional attorney fees added. If the attorney should have to pursue litigation, I also understand I will be responsible for additional court cost or attorney fees.

Print Patient's Name: ____

Patient's Signature: ____

Patient's Representative's Signature: ______________________________

Date Signed: _____/_____/_____

FINANCIAL POLICY – CASH

Payment is expected at the time of service unless payment arrangements have been made in advance. We will be happy to set you on a payment plan that will fit your budget.

The level of service in regards to exams, x-rays, manipulation (determined by region of the body), therapy, rehabilitation, supports and supplements will be determined by Dr. Johnson. Each patient is treated on an individual basis and will receive a different level of service and treatment plan. As part of your recovery, you will not only need to keep your appointments, but you will need to do home exercises and treatment as designated by Dr. Johnson.

Payment arrangements can be made to meet your financial needs.

I have read the above financial policy. I am aware of my obligation in regards to the service I receive.

Patient Signature: ______________________________ Date: __________

Staff Signature: ________________________________ Date: __________

HIPAA Notice of Privacy Practices

Hillsboro Chiropractic Clinic

211 East Franklin Street
Post Office Box 706
Hillsboro, Texas 76645

(254) 580-0701

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. **You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:__________________________ Signature______________________ Date______