New Patient Information

PATIENT: ______________________________________ DOB: ________________

(first) (middle) (last)

Guardian if patient is a Minor: ____

Home Address: ____

(Street) (City) (State) (Zip)

Home Phone: _________________ Cell Phone: _____________Work Phone:___________

Employer: _________________________ Occupation: _____________Student(y/n):_____

Spouse Name: ________________________________ DOB: _____________________

Spouse employer: ____

Emergency Contact: ____________________________ Phone: ____________________

How did you hear about us: ____

Who is responsible for this account? ____

I understand and agree that health and accident insurance policies are an arrangement between me and an insurance company. Furthermore, I understand that this Chiropractic Office will only provide me with payment receipts that are necessary for me to file with my insurance company myself. If office notes or narratives are needed, I agree to inform the office staff at the onset of first treatment. Therefore, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Payments that are overdue at 90 days will be sent to a collection agency.

Signature: ____________________________________ Date: ______________

(parent or guardian if patient is minor)

INFORMED CONSENT TO RECEIVE CHIROPRACTIC ADJUSTMENTS and PHYSICAL MODALITIES

I, ______________________________, give full informed consent to receive Chiropractic adjustments and treatment to Dr. Sara L. DeHart and/or Dr. Jennifer L. Polen.

I further give full informed consent to receive any physical modalities that they deem necessary to assist in the treatment of my condition. These will be administered by the doctors or their staff.

[Minors]

I, ______________________________, give full informed consent for chiropractic adjustments and treatment for ______________________________ (minor) to Dr. Sara L. DeHart and/or Dr. Jennifer L. Polen.

I further give full informed consent for said minor to receive any physical modalities that they deem necessary to assist in the treatment of their condition. These will be administered by the doctors or their staff.

Signed: ______________________

Date: ______________

DeHart Chiropractic

Notice of Privacy Practices

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.
As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include clearance for dental treatment.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be beneficial to you.

Any other uses and disclosures will be made only with your written authorization. You make revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do not agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to a paper copy of this notice from us upon request.

Signed________________________ **Date**____________