

New Patient Information

Patient: _____ DOB: _____ Gender: M ___ F ___
(first) (m) (last)

Guardian if patient is a minor: _____ Relationship: _____

Home Address: _____
(street) (city) (state) (zip code)

Cell Phone: _____ Email: _____

Occupation: _____ Employer: _____ Student: Yes ___ No ___

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 are an arrangement between an insurance carrier and myself. Furthermore, I understand that DeHart Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance carrier and that any amount authorized go be paid directly this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

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 to 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.

Signature: _____

Date: _____

(parent or guardian if patient is minor)

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 may 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 _____