Sarah M. Collins, DC, LLC

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 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 concerning privacy of your Patient Health Information we encourage you to read the HIPPA Notice that is available to you at the front desk before signing this consent.

I. 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 to be obtained one time for all subsequent care given to 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 consent 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 have 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 easily 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 form for the purpose of treatment, payment and health care operations, the chiropractor has the right to refuse to give care.

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

_____ _____ _____

Name Printed Signature Date

Sarah M. Collins, DC, LLC

Patient Name: _____ Marital Status: M S W D DOB: _____
Address: _____ Age: _____
City: _____ State: _____ Zip: _____ SSN: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Occupation: _____ **Primary Care Dr:** _____
Person Responsible for Bill: Referred here by: _____
Relationship to Patient: [ ]self, [ ]spouse, [ ]parent, [ ]other
Name: _____ Social Security Number: _____
Date of Birth: _____
Address: _____ Phone Number: _____
Address2: _____ Work Phone: _____

Please provide the front desk with your insurance card(s) for copying.

Have you had previous chiropractic care? ☐ **Yes** ☐ **No** Does this condition affect your work? ☐ **Yes** ☐ **No**

Main Complaint: _____

How do you feel today? _____

No pain 0 1 2 3 4 5 6 7 8 9 10 unbearable pain

Other Complaints: _____

How long have you had this condition? _____

Have you had similar conditions in the past? _____

What aggravates this condition? _____

Other doctors seen for this condition? _____

What medications are you taking? _____

What helps your symptoms? _____

Have you had any surgery, falls, or accidents? ☐ **Yes** ☐ **No** If yes, where? _____

Please describe _____

_____

Please circle any of the following that you suffer from:

Headaches	*Neck Pain*	*Arm/Shoulder Pain*	*Hip/Leg Pain*	*Chest Pain*	*Abdominal Pain*
Heart Trouble	*Palpitations*	*Poor Circulation*	*High BP*	*Low BP*	*Female Problems*
Kidney Trouble	*Bladder Problem*	*Sinus Trouble*	*Diabetes*	*Insomnia*	*Lung/Bronchial Disorder*
Digestive Disorder	*Constipation*	*Loose Stools*	*Anemia*	*Dizziness*	*Numbness*
Depression	*General Fatigue*	*Morning Fatigue*	*Poor Memory*	*Hot Flashes*	*Swollen Joints*

Is this condition due to: **A work related injury?** ☐ **Yes** ☐ **No** **An auto accident?** ☐ **Yes** ☐ **No** ***If yes to either, see front desk.**

I, _____, hereby voluntarily consent to treatment as it pertains to myself or _____, and the provision of care by the practitioners of this medical office. I have received and read a copy of this practices HIPAA policies. I certify that I have had the opportunity to discuss my care and the nature of the care being provided to me. I understand that the results are not guaranteed. Further, I have been informed and that I understand that, as in any practice of the healing arts, in the practice of Chiropractic care. there are some risks to treatment. Including, but not limited to; fractures, disc injuries, dislocations and sprains. I also understand that **Sarah M. Collins, DC, LLC** is not expected to be able to anticipate and explain all of the potential risks and complications. I will rely on **Sarah M. Collins, DC, LLC** to exercise appropriate judgment during the course of my care based upon the facts known at the time and in my best interest. My signature below certifies that I have read this statement.

Date _____ ***Signature*** _____ ***Relationship*** _____

I authorize the release of any medical information necessary to process insurance claims, and the release of information back to my physician. I also authorize payment of medical benefits to the above states practice or supplier for services rendered. I acknowledge that I am financially responsible for payment whether or not my insurance company covers services.

SIGNATURE: _____ Date: _____

SIGNATURE: _____ Date: _____

Pain chart