TOTAL HEALTH
CHIROPRACTIC

Confidential Patient Information

Today's Date _____

Name _____ Age _____ Date of Birth _____

Home address _____ City _____ State _____ Zip _____

Home phone # _____ Email _____

Occupation _____ Employer _____

Emergency Contact: _____ Phone # _____ Relationship: _____

Person responsible for this account _____ Relationship to patient _____

Phone # _____ Address (if different from above) _____

How did you hear about us? _____

Insurance Information

Type of policy: (√) Health Insurance _____ Auto _____ Worker's Comp _____

Name of insured _____ Relationship to patient _____

Insurance company name _____ Phone # _____

MEMBER ID# _____ GROUP or CLAIM # _____

Policy Holders Name _____ Date of Birth _____

Office Policy Regarding Fees and Payments

1. Private Pay – Full payment is expected at time of each visit. We accept cash, check or MC/Visa. If payment is not received at the time of your visit, you will not be eligible for a TOS fee. Labs, supplies and supplements are excluded from this fee. No insurance will be billed if this option is selected.

2. Insurance - For patients who have private health plans covering our services: We require your co-payment at the time of service, per your insurance policy. We will verify your benefits, however, verification is **NOT** a guarantee of payment and you are fully responsible for any fee your insurance does not cover.

3. Personal Injury –As a courtesy, we will bill and collect from your car insurance company, however if your insurance company does not pay your balance in full, you are responsible for any unpaid portion and you can recover any monies paid at the time of settlement.

4. Worker's Compensation – if you have been injured on the job, you are required by law to report to your employer first and open a claim. The first provider you see following your injury will be considered your 'primary provider' for this case. If we are not your primary provider on the case, it will require a referral from that provider. If a denial occurs, you will be fully responsible for the balance of your account.

I understand that all billing and balances are ultimately my responsibility and that I will pay these amounts in a timely fashion. There will be a charge for returned checks. We require advanced notice if you are unable to keep your scheduled appointment. Our voicemail is available 24 hours a day, 7 days a week. You will be charged the full cost of a visit for any missed appointment without 24-hour notice. Patients who arrive late may be asked to reschedule.

Client/Patient signature_____ ***Date***_____

Notice of Privacy Practices

This form describes the confidentiality of your health records, how the information is used, your rights, and how you may obtain this information.

Our Legal Duties
State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide by these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place. The content of material disclosed to us at Craig Total Health Chiropractic is covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information
Information about you may be used by the personnel affiliated with Craig Total Health Chiropractic for diagnosis, treatment, continuity of care, and billing. We may disclose it to practitioners at Craig Total Health Chiropractic or employees and business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation. Both verbal information and written records about a patient cannot be shared with another party without the written consent of the patient, legal guardian or personal representative. It is our policy not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Exceptions to Confidentiality:
Signed Consent: You sign a consent to release information;
Duty to Warn: If a client/patient discloses intentions or a plan to harm another person or persons;
Abuse: If a client/patient states or suggests that he or she is abusing or has recently abused a child or vulnerable adult.
Judicial or Administrative Proceedings: Health care professionals are required to release records of clients under a court order.
Third-Party Billing: For billing purposes, including insurance providers, managed care, and other third-party payers for payment of services. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of treatment, and summaries.
Defending claims brought by a patient against a practitioner.
Contacting Patient: In the event we must telephone you for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing if your contact information changes and if you have any special requests about how we leave messages
Collection Company: In pursuit of payment for services rendered and when payment has not been remedied.
Consultation with other Professionals: Information about clients/patients may be disclosed in consultation with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed.

You have the right to:
- Request in writing that I not use or disclose your health information as described above. We may not be able to fulfill your request.
- Know of any uses or disclosures I make with your health information beyond the above normal uses.
- Transfer copies of your health information to another practitioner.
- See and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, there may be a reasonable fee for copies.
- Request an amendment or change to your health information. Give me your request in writing. If you want to include a statement in your file, please give it to me in writing. I may or may not make the changes you request, but I will be happy to include your statement in your file. If I agree to an amendment or change, I will not remove or alter earlier documents, but will add new information.

Complaints:
If you have any complaints or questions regarding these procedures, please contact your Craig Total Health Chiropractic practitioner. You may also file a complaint with the Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

I have read the notice of privacy practices. I have read and understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

(Signature)	(Date Signed)
(Print Name)	(Patient Name – if signing as a parent or legal guardian)