GLASGOW CHIROPRACTIC / GLASGOW SPINE AND WELLNESS
Confidential Patient Health Record

(Please print in **BLACK** ink only)

Name_____ Home Phone_(_____)_____
Address_____ Work Phone _(_____)_____
_____ Cell Phone (_____)_____
_____ E-Mail_____
Gender: Male/Female
Birth Date_____/_____/_____ Occupation_____
SSN_____ Employer_____
Marital Status_____ # Children_____ Spouse's Name_____
Emergency Contact_____ Contact's Phone_(_____)_____
How were you referred to our office?_____

Treatment(s) you are seeking: □ Chiropractic □ Acupuncture □ Massage □ Pain Management
□ DRX □ Rehabilitation □ Nutritional Counseling □ Stress Management

People go to chiropractors for a variety of reasons, and there are different levels of care.
Please check the type of care desired so that we may provide you the most appropriate care:

Stage 1 ___ Pain Relief: Just get rid of the pain. Relief is short term.

Stage 2 ___ Rehabilitation: Get rid of the pain, but then fix the problem so it won't come back.

Stage 3 ___ Optimal Health: Get rid of the pain, fix the problem, and then put me on a preventive maintenance plan so that I stay as healthy as possible.

Primary Physician Name_____ Phone_(_____)_____

Is your visit due to an accident? Y N Date of Injury:_____/_____/_____
Type of Injury:_____

Present Complaints:_____
_____

Other doctors seen for this problem:_____

Significant Health History
_____
_____
_____
_____
_____

Medications/Supplements: _____

CONSENT TO TREAT: My signature stands proof that I give Glasgow Chiropractic/Glasgow Spine and Wellness my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice. (If you would like a obtain a copy of this notice, please feel free to ask the front desk)

Patient Print Name_____

X Patient/Guardian Signature_____ Date_____/_____/_____

GLASGOW CHIROPRACTIC / GLASGOW SPINE AND WELLNESS

Who is responsible for your bill? You and: □Personal Insurance □Medicare □Workers Comp □Auto

HMO/PPO Limitation of Liability

Your insurance plan may have limitation for services covered in our office. According to your specific plan, the following services may not be covered:

♦Examinations ♦Re-exams ♦Diagnostic Tests ♦Acupuncture ♦Rehabilitation ♦Massage
♦Vitamins, Supplements, or Supports ♦Modalities (such as EMS, Ultrasound, Hot/Cold packs)

Please initial by the following:

_____Should any of these determinations be made by your plan, you agree that you have been informed before the services were rendered and you agree to be responsible for payment of the specific services listed above.

SIGNATURE ON FILE

Please initial by the following:

_____ Payment is expected at the time of service in the form of a deductible, co-payment or co-insurance payment. **It is illegal to waive these fees.**

_____ Your insurance policy is a contract between you and the insurance company, and you are responsible for any unpaid or denied claim and for any collection fees, court costs, and attorney's fees if your account is turned over for collection.

_____ If your insurance company sends you checks, it is your responsibility to deliver them to our office.

_____ I understand that I am responsible for my bill

_____ I authorize use of this form on all my insurance submissions

_____ I authorize release of information to all my insurance companies

_____ I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies

_____ I authorize direct payment to my doctor

_____ I permit a copy of this authorization to be used in place of the original

___ "I hereby authorize you to furnish information to my insurance company concerning my care. I further hereby assign all insurance payments for services rendered to me or my dependents."

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name: _____ **Date of Birth:** _____

Please initial by the following:

_____ I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **Glasgow Chiropractic L.L.C., / Glasgow Spine and Wellness**.

_____ I understand that the Notice describes the uses and disclosures of my protected health information by **Glasgow Chiropractic L.L.C., / Glasgow Spine and Wellness** and informs me of my rights with respect to my protected health information.

ADVANCE DIRECTIVE:

_____ YES, I HAVE AN ADVANCE DIRECTIVE, LIVING WILL OR HEALTH CARE POWER OF ATTORNEY

_____ NO, I DO NOT HAVE AN ADVANCE DIRECTIVE, LIVING WILL OR HEALTH CARE POWER OF ATTORNY.

_____ I WOULD LIKE TO HAVE INFORMATION ON ADVANCE DIRECTIVES.

_____ I have been given the opportunity to ask questions regarding any of the above information provided to me.

X_____
Patient Signature/Legal Representative/Guardian

_____ **DATE:**_____
Printed Name/Legal Representative & Relationship

WITNESS:_____ **DATE:**_____