GLASGOW CHIROPRACTIC / GLASGOW SPINE AND WELLNESS
Confidential Patient Health Record

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

NAME:_______________________________ Home Phone_(________)____________________
ADDRESS/PO BOX:________________________________ Work Phone _(________)____________________
CITY:____________________STATE:_______ZIP:_________ Cell Phone (________)______________________
E-Mail____

Please initial:
________I would like to receive text messages about our practice. These automated text messages can include special promotions, information about new services or team members, as well as allow me to request an appointment. I understand that I will always have the ability to opt-out if I decide that I no longer want to receive texts from this practice.

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?____

I am seeking:

□ Chiropractic □ Acupuncture □ Massage □ Rehabilitation

□ Body Contouring □ Scar Removal □ Laser Skin Renewal □Laser Hair Removal

□ Stretchmark Removal □ Laser Skin Revitalization □ Interventional Pain Management

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
____
____

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. (In Blue Binder on Reception Room Desk) It is a very lengthy document. If you would like a copy to take home, please ask the Front Desk Coordinator.

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.

X____

Patient Signature/Legal Representative/Guardian

____ **DATE:**_____________________________

Printed Name/Legal Representative & Relationship

WITNESS:____**DATE:**_____________________________