

# CONFIDENTIAL PATIENT CARD

FOR OFFICE USE ONLY

I.D. No. \_\_\_\_\_

PI    INS    W/C    MC    MK    Other \_\_\_\_\_

Name: \_\_\_\_\_ Sex: M / F    SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Street: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Bus. Phone: (    ) \_\_\_\_\_

## WHERE DO YOU HURT? CHECK SYMPTOMS YOU ARE HAVING

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Headache               | <input type="checkbox"/> Nervousness                  | <input type="checkbox"/> Diarrhea            |
| <input type="checkbox"/> Neck Pain              | <input type="checkbox"/> Numbness                     | <input type="checkbox"/> Constipation        |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Paralysis                    | <input type="checkbox"/> Hemorrhoids         |
| <input type="checkbox"/> Mid Back Pain          | <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> Weight Trouble      |
| <input type="checkbox"/> Low Back Pain          | <input type="checkbox"/> Forgetfulness                | <input type="checkbox"/> Abdominal Cramps    |
| <input type="checkbox"/> Arm Pain Rt or left    | <input type="checkbox"/> Confusion/Depression         | <input type="checkbox"/> Heartburn           |
| <input type="checkbox"/> Shoulder Pain          | <input type="checkbox"/> Fainting                     | <input type="checkbox"/> Bladder Trouble     |
| <input type="checkbox"/> Joint Pain/Stiffness   | <input type="checkbox"/> Convulsions                  | <input type="checkbox"/> Painful Urination   |
| <input type="checkbox"/> Walking Problems       | <input type="checkbox"/> Cold/Tingling Extremities    | <input type="checkbox"/> Chest Pain          |
| <input type="checkbox"/> Difficulty Chewing     | <input type="checkbox"/> Stress                       | <input type="checkbox"/> Short Breath        |
| <input type="checkbox"/> Clicking Jaw           | <input type="checkbox"/> Fatigue                      | <input type="checkbox"/> Ankle Swelling      |
| <input type="checkbox"/> General Stiffness      | <input type="checkbox"/> Loss of Sleep                | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Leg pain Rt. or left   | <input type="checkbox"/> Fever                        | <input type="checkbox"/> Vision Problems     |
| <input type="checkbox"/> Hip Pain Rt. or left   | <input type="checkbox"/> Vomiting                     | <input type="checkbox"/> Ear Ache or Ringing |
| <input type="checkbox"/> Frequent Nausea        | <b>FEMALES ONLY:</b> When was your last period? _____ |  |

Referred To This Office By: \_\_\_\_\_

Who Is Responsible For Your Bill, You and  Spouse  Workers' Comp.  Auto Insurance  Medicare  Medicaid

Personal Health Insurance (Name) \_\_\_\_\_  Health Care # \_\_\_\_\_

Have you tested HIV positive?     yes     no

PLEASE LIST INSURANCE PHONE #  
ON BACK OF CARD

I hereby authorize Conway Health Care to examine me, including X-rays if indicated by the exam, and to release my records to anyone I designate in writing. I further authorize treatments deemed necessary by the findings and I request all my chiropractic records be held in strict confidence and not be given to anyone without my written consent. I clearly understand that I am totally responsible for all charges should my Insurance Company deny payment.

By signing your name below you certify the accuracy of your medical and/or accident history and further certify that you present to Conway Health Care for evaluation and/or treatment of a health condition and for no other purpose.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorization to treat minor \_\_\_\_\_  
(Parent or Guardian)

## Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

This notice is effective as of \_\_\_\_\_ . This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my **health information in the manner** described above. I am also acknowledging that I have received a copy of this **authorization**.

\_\_\_\_\_  
Patient name printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Authorized provider representative

\_\_\_\_\_  
Personal representative Printed

\_\_\_\_\_  
Personal representative signature

\_\_\_\_\_  
Description of personal representative's authority to act for the patient.


## Consent for Use or Disclosure of Health Information

### Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.  your health condition.

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### Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

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### You may revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your

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