Weatherford Chiropractic Health Center

Patient Information and History – ACUPUNCTURE (New Patient)

PATIENT INFORMATION

Date: _____

Name_____
Last First Middle

Address: _____

_____

Sex: __M __F Age: _____ Birth Date: _____

Social Security #---------- _____
If patient is a minor, parent's Social Security # ----------_____

Occupation: _____Employer: _____

☐Single ☐Married ☐Separated ☐Divorced

Spouse's Name: _____

How were you referred to our office? _____

CONTACT INFORMATION

Cell #_____Carrier: _____
(This is for text reminders)

Home: _____Work: _____

Email: _____

In case of an emergency, contact:

Name: _____

Relationship: _____Number: _____

ACCIDENT INFORMATION (IF APPLICABLE)
Is this due to an accident? __Y __N
If yes (please circle one): Auto Work Home Other
To whom did you report the accident to? (Please circle one)
Auto Insurance Worker Comp Employer

***Please note this office does not file Worker's Comp.**

HEALTH HISTORY

Have you ever received acupuncture before? __Y __N
By Whom? _____When?_____
List other Doctors you have seen for this condition:
Who: _____
Address: _____When: _____

Who: _____
Address: _____When: _____

What treatment have you received for this condition?
__Medication __Physical Therapy __Chiropractic Services
__Surgery __Other:_____

Who is your family Physician? _____
Address: _____
Phone: _____
May we send him/her an update on your treatment in our office?
Yes No

Date of last:
Physical Exam: _____Spinal X-ray: _____ Chest X-ray: ___
MRI/ CT/ Bone Scan: _____OB/GYN Exam: _____
Blood Test: _____Urine Test: _____

List all medications and Supplements:

This office complies with applicable Federal civil rights laws & does not discriminate on the basis of race, color, national origin, age, disability, or sex.

PATIENT CONDITION (ALL QUESTIONS SHOULD BE ANSWERED)

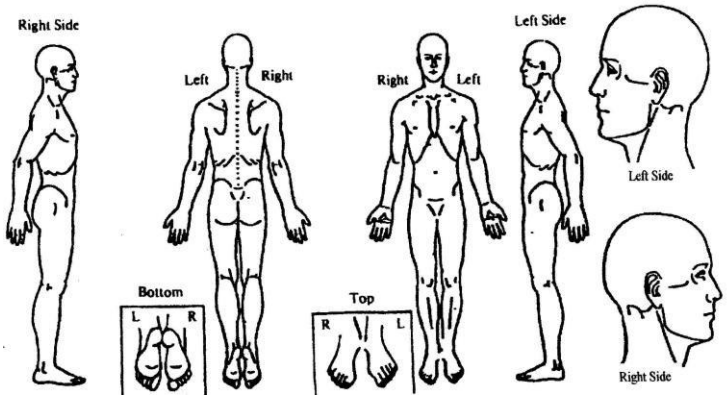
Main Reason For this visit: _____
When did the symptoms first appear: _____*Was onset: __Gradual __Sudden Is it getting worse? __Y __N
Cause of symptoms: _____
How often do you experience Symptoms?
__Constant (100%) __Frequent (75%) __Intermittent (50%)
__Occasional (25%) __Rare (10% or less)

Type of Pain: __Sharp __Dull __Throb __Numb __Ache
__Shooting __Burning __Tingle __Cramp __Stiff __Other

Do the symptoms radiate (travel)? _____
Where does it radiate to? _____
What gives relief? _____
What makes it worse? _____

Does it interfere with: __Work __Daily Activities __Sleep

Rate the pain from 0 (no pain) to 10 (worst pain felt): _____



PLEASE MARK ALL AREAS OF PAIN (INCLUDING ANY RADIATIONS) ON THE FIGURE ABOVE

Name: _____ **Date:** _____

Please indicate here if you are: Pregnant Taking Blood thinners Have a Bleeding Disorder
(Circle all that apply) Neuropathy Autoimmune Disorder Diabetic

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Please circle the symptoms or conditions you experience frequently:

Sp/ St	Ht/ P	Lu/ LI	Ki/ UB	Liv/ GB
Excessive appetite	Insomnia	Cough	Low back pain	Eye problems
Loose stool/ diarrhea	Palpitations	Shortness of breath	Knee problems	Jaundice
Digestive problems	Cold hands & feet	Decrease sense of smell	Hearing impairment	Difficulty digesting oily foods
Vomiting	Nightmares	Nasal problems	Ear ringing	Gall stones
Belching/ burping	Mentally restless	Skin problems	Kidney stones	Light-colored stool
Heartburn/ reflux	Laughing for no reason	Claustrophobia	Decreased sex drive	Soft or brittle nails
Stomach bloating	Chest pain	Colitis/ diverticulitis	Hair loss	Easily angered
Obsession in work	Poor memory	Constipation	Urinary problems	Difficult relationships
Blood in stool	Sadness	Allergies	Dental problems	Difficulty making decisions
Lack of appetite	Depression	Asthma	Fatigue	Dizziness
Hemorrhoids	Anxiety	Get sick easily	Edema	Headache
Easily bruise	I usually feel chilled	I usually feel warm		

Please check/indicate if the following pertain to you:

NOTE: This Symbol ♀: before a question, indicates that it is for Women only

KD Yin Deficiency

□ Do you have lower back weakness, soreness or pain?
□ Do you have ringing in your ears?
□ Is your hair prematurely gray?
□ Do you have dark circles under your eyes?
□ Do you have night sweats?
□ Are you prone to hot flashes?
□ Would you describe yourself as "afraid" frequently?
□ Do you have dizziness?
□ Do you have knee problems?
□ ♀: Do you have vaginal dryness?
□ ♀: Is your mid-cycle cervical mucus scanty or missing?

KD Yang Deficiency

□ Is your back sore or weak?
□ Are your feet cold, especially at night?
□ Are you typically colder than those around you?
□ Is your libidolow?
□ Are you often fearful?
□ Do you have early morning loose/urgent stools?
□ Do you wake up at night or early in the morning because you have to urinate?
□ Do you urinate frequently, and is the urine diluted and/or profuse?
□ ♀: Do you feel cold cramps during your period that respond to a heating pad?
□ ♀: Do you have low back pain pre-menstrually?
□ ♀: Do you have profuse vaginal discharge?

SP (Qi, Blood, and/or Yang Deficiency)

□ Are you often fatigued?

□ Do you have poor appetite?

□ Is your energy low after a meal?

□ Do you feel bloated after eating?

□ Do you crave sweets?

□ Do you have loose stools, abdominal pain, or digestive problems?

□ Are your hands and feet cold?

□ Are you prone to feeling sluggish?

□ Are you prone to heaviness or grogginess in the head?

□ Do you feel dizzy or light-headed, or have visual changes when you stand up fast?

□ Do you have varicose veins?

□ Are you prone to worry?

□ Do you sweat a lot without exerting yourself?

□ Are you often sick, or do you have allergies?

□ Have you ever been diagnosed with hypothyroid or anemia?

□ Do you have hemorrhoids or polyps?

□ Have you been diagnosed with low blood pressure?

□ ♀: Is your menstruation thin, watery, profuse, or pinkish in color?

□ ♀: Are you more tired around ovulation or menstruation?

□ ♀: Do you ever spot a few days or more before your period comes?

□ ♀: Have you ever been diagnosed with uterine prolapse?

□ ♀: Are your menstrual cramps accompanied by a bearing down sensation in your uterus?

Blood Deficiency

□ Do you have dry, flaky skin?

□ Are you prone to getting chapped lips?

□ Are your fingernails or toenails brittle?

□ Is your hair brittle or dry?

□ Do you have diminished nighttime vision?

□ Are your lips, the inner side of your lower eyelids, or tongue pale in color?

□ ♀: Do you get dizzy or light-headed around your period?

□ ♀: Are you losing hair on your head?

□ ♀: Are your menses scant or late?

Blood Stasis

□ Do you experience periodic numbness of your hands and feet, especially at night?

□ Do you have varicose/spider veins?

□ Do you have red cherry spots (hemangioma) on your skin?

□ Do you have chronic hemorrhoids?

□ Do you have dark spots in your eyes?

□ ♀: Does your menstrual blood contain clots?

□ Have you been diagnosed with any vascular abnormality or blood clotting disorder?

□ ♀: Have you been diagnosed with endometriosis or uterine fibroids?

□ ♀: Your menstrual flow ever brown or black in color?

□ ♀: Do you feel mid-cycle pain around your ovaries?

□ ♀: Do you have painful, unmovable breast lumps?

□ ♀: Do you have piercing or stabbing menstrual cramps?

LR Qi Stagnation

□ Are you prone to emotional depression?

□ Are you prone to anger and/or rage?

□ Are your pupils usually dilated and large?

□ Do you have difficulty falling asleep at night?

□ Do you experience heartburn or wake up with a bitter taste in your mouth?

□ ♀: Do you become irritable pre-menstrually?

□ ♀: Does it feel as if your ovulation lasts longer than it should?

□ ♀: Are your breasts sensitive/sore at ovulation?

□ ♀: Do you become bloated pre-menstrually?

□ ♀: Are your menses painful?

□ ♀: Do you feel bloated or irritable around ovulation?

□ ♀: Do you experience nipple pain or discharge from your nipples?

□ ♀: Do you have a lot of pre-menstrual breast distention or pain?

□ ♀: Do you feel your menstrual cramps in the external genital area?

□ ♀: Is your menstrual blood thick and dark, or purplish in color?

HT (Any Disorder)

□ Do you have nightmares?

□ Do you seem low in spirit or lacking vitality?

□ Are you prone to agitation or extreme restlessness?

□ Do you fidget?

□ Do you sweat excessively, especially on your chest?

□ Do you wake up early in the morning and have trouble getting back to sleep?

□ Do you have heart palpitations, especially when anxious?

Excess Heat

□ Are your mouth and throat usually dry?

□ Are you often thirsty for cold drinks?

□ Do you often feel warmer than those around you?

□ Do you wake up sweating or have hot flashes?

□ ♀: Do you have a short menstrual cycle?

□ ♀: Do you have vaginal irritation?

□ ♀: Do you breakout with red acne, especially pre-menstrually?

Dampness

□ Do you feel tired and sluggish after a meal?

□ Do you have cystic or pustular acne?

□ Do you have urgent, bright, or foul-smelling stools?

□ Are you overweight?

□ Do you have a wet, slimy tongue?

□ Does your body feel like a barometer? Can you sense when it will rain?

□ ♀: Does your menstrual blood contain stringy tissue or mucus?

□ ♀: Are you prone to yeast infections &vaginal itching?

□ ♀: Do you have fibrocystic breasts?

♀For Women Only:

Have you gone through menopause or have you had a hysterectomy? Yes No

Age of first period: _____Date of last period: _____Number of children (live births): _____

Number of days between periods (your cycle): _____Number of days of flow: _____

Are you or is there possibility you are pregnant? Yes No

♀ Check All that Apply:

Color of flow: □ pale/light red □ red □ bright red □ dark red □ dark red/brown □ dark red/purple

# of pads /tampons you use per day: ____1st day ____2nd day ____3rd day ____4th day

Pain and Cramping: Yes No

Are they? -mild (mil) -moderate (mod) -severe (sev) - (please indicate the severity in the spaces below)

_____1st day _____2nd day _____3rd day _____4th day _____Before flow _____After flow

Amount of flow:

□ even throughout
□ clots □ Yes / □ No When? __1st day __2nd day __3rd day __4th day __Before flow __After flow
□ spotting □ Yes / □ No When? __1st day __2nd day __3rd day __4th day __Before flow __After flow
□ light □ Yes / □ No When? __1st day __2nd day __3rd day __4th day __Before flow __After flow
□ heavy □ Yes / □ No When? __1st day __2nd day __3rd day __4th day __Before flow __After flow

Other symptoms related to menses: (please circle all that apply)

Discharge PMS Headache Nausea Constipation Diarrhea

Swollen Breasts Mood Swings Increased Appetite Decreased Appetite Insomnia

Have you ever been diagnosed with? (please circle all that apply)

Fibroids Fibrocystic breasts Endometriosis Ovarian Cyst PID

Polycystic Ovary Syndrome STD _____

Fertility Information: # of IVF procedures_____ # of IUI procedures_____

Has a physician diagnosed a difficulty with fertility due to?

□ Female Factor □ Male Factor □ Unexplained

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

_____ _____

Print Patient's Name Date

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____day of _____, 20___

By_____

Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____

Signature of Parent / Guardian (circle one)

INFORMED CONSENT TO RECEIVE TREATMENT AND CARE: ACUPUNCTURE/CUPPING

Weatherford Chiropractic Health Center, PA, practices chiropractic, Acupuncture, Herbal Medicine, and other Physical Medicine procedures, which is a Complementary and Alternative Medicine (CAM.) Each patient is treated as an individual and there is no "one size fits all" course of diagnosis or treatment.

The CAM practices utilized may include, but are not limited to, one or more of the following: acupuncture, dietary supplements, herbal remedies, exercise, lifestyle counseling ,chiropractic, massage, cupping, trigger point release/scrapping, moxibustion, stretching, physical manipulation, electrical muscle stimulation, needle retention, micropuncture (bleeding therapy), and diagnostic palpation on various areas of the body.

I understand that the diagnosis given to me conforms to the principals of Traditional Chinese Medicine (TCM), and in no way purports to replace allopathic medical evaluation, diagnosis, or treatment. I understand that the doctors at Weatherford Chiropractic Health Center,PA are not Oriental Medicine doctors, but are trained in TCM basic diagnosis in relation to acupuncture.

I have provided a full history and description of the complaints and health status which is complete and accurate. I understand that the need for communication with all of my health care providers regarding my health status is ongoing and necessary.

I understand that no guarantee has been made concerning the use and effects of CAM. I understand that in some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is sustained.

I understand that I may stop treatment at anytime.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

Acupuncture: I understand that it is a technique using small, sterile, stainless steel needles inserted at specific points in the body, causing a positive response in order to correct various ailments. Only disposable needles are used. The location and the application of the needles and the depth of the needle insertion are determined by the nature of the problem. I understand that the application of these needles may be accompanied by a brief painful sensation, and that there is a slight possibility of minor swelling, bleeding, discoloration of the skin, hematoma, a bruise at the site of needling, or fainting. Momentary euphoria or light headedness may occur after treatment. The attending acupuncturist can easily handle any immediately reported problems that arise from the acupuncture treatment, and the possibility of minor problems need not be a cause of concern. Some very rare risks of acupuncture include pneumothorax and infection. Burns and or scarring are a potential risk of indirect moxibustion. Rarely, bodywork may cause a temporary increase of symptoms or new symptoms may present. Needle Sickness is a potential temporary side effect where a vertigo or even loss of consciousness can occur.

Moxibustion: I understand that this is the application of indirect heat supplied by burning the herb Folium Artemesiae Vulgaris over a single acupuncture point or a group of points. this generally produces a pleasurable sensation of relaxation. The area being treated may remain red and warm for several hours after treatment. In rare incidences, a minor burn may occur at the site of moxibustion. The attending doctor can easily address this.

Cupping: I understand it uses round vacuum cups over a large muscular area, such as the back to enhance blood circulation to the designated area. This method may produce a deep redness, discoloration and on rare occasions, a minor blister which may persist for up to a week. These marks may resolve on their own and are not indications of complications or injuries.

PT INITIALS_____

Deep Tissue/Scrapping: I understand that I may also be given soft tissue/Trigger Point therapy as part of my treatment to modify or prevent pain perception and to normalize the body's physiologic functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, mild bleeding, sore muscles or aches, and the possible aggravation of the symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Herbs and Nutritional Supplements: I understand that supplements may be recommended to me to treat bodily dysfunction, to modify or prevent pain perception, and to normalize the body's physiological functions. Herbs are used to facilitate the body's own restorative process. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them.

I understand that recommended herbs are traditionally considered safe in the practice of CAM, although some may be toxic in large doses. I understand that some dietary supplements are inappropriate during pregnancy, may interact with medications or other supplements, may have side effects of their own, or may contain potentially harmful ingredients not listed on the label. I also understand that most supplements have not been tested in pregnant women, nursing mothers, or children. Potential risks include but are not limited to: allergic reactions, nausea, gas, stomachache, vomiting, headache, diarrhea, rash, hives, and tingling of the tongue. Some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives and tingling of the skin. I will immediately notify my physician if any unanticipated or unpleasant effects associated with the consumption of herbal teas, tinctures, topical creams, or patent (pill form) medicine.

I understand that Weatherford Chiropractic Health Center doctors cannot be expected to anticipate and explain all risks and complications. I understand and agree that my doctor will exercise judgment during the course of treatment which they feel at the time, based on the facts known then, is in the best interest of me as the patient.

Contraindications for acupuncture treatment and certain herbs include a history of a bleeding disorder or current anticoagulant therapy, and implanted pacemaker or prosthetic heart valve, use of certain medications. Though acupuncture is safe during pregnancy, I agree to tell my doctor as soon as possible if I become pregnant, as certain cautions and contraindications are vital.

Potential benefits of treatment include but are not limited to: restoration of health and the body's maximum functional capacity without the use of drugs or surgery; relief of pain and symptoms of disease; assistance in injury and disease recovery; and prevention of disease or its progression.

PT INITIALS_____

Patient Authorization and Consent for Treatment

I herby state that I have read and understand this form, that I have been given an opportunity to ask questions, and that all questions have been answered in a satisfactory manner. and I understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such a time that I make known that I choose to terminate it. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Print Name of Patient: _____

Signature of Patient: _____

Date: _____

CONSENT TO TREAT A MINOR CHILD

I authorize, Weatherford Chiropractic Health Center, PA, to treat_____**(name)**

who is my_____**(relationship)**

Adult's Signature: _____**Date:** _____

Office Use ONLY

- ❒ **I have discussed the above information with the patient and given the patient an opportunity to ask questions.**
- ❒ **Patient appeared cognitive and appeared to understand risks and SE**

Provider's Signature: _____

Date: _____

FINANCIAL POLICY – PAYMENTS TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us. Our Facility & staff are not responsible for what a payer and/or representative may tell us, including mis-quoted benefits, coverage and liability**.**

1. **Our Facility will not file insurance claims for you on acupuncture treatments. Secondary claim submission and /or additional reports or documents sent for your benefit may result in an additional filing medical report charge, which you are responsible to pay.**
2. **Co-pays, deductibles and all non-covered service charges are due the day the service is rendered and are the patient's sole responsibility.**
3. **Patients are responsible for charges on all service(s) and/or product(s) which 1) are non-covered (regardless of in our out of network status) or 2) may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet the cost of service.**
4. **All account balances, including automobile claims must be paid within** 90 days **of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, and judgment. If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.**
5. **A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, or massage therapy.**
6. **The Facility offers the use of Care Credit to patients preferring to use a credit type payment plan. Any agreement made is between Care Credit and the Patient. Patient is responsible for any and all charges for services rendered.**
7. ***Interest is computed by a periodic rate of 18% per annum & is added to all balances owed 60 + days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for collection for which the undersigned agrees to be 100% responsible for all interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fees.***
8. **Missed appointments that are not canceled at least 24 hours prior to appointment time will be subjected to a Missed Appointment Fee at the Office's discretion. The Fee will be the patient's sole responsibility.**
9. **Patient consents to use of cell phone as a contact when necessary for any and all purposes including, but not limited to communication about care or accounts, collection calls, appointment reminders, etc.**
10. **If your Insurance does not pay within** 60 days **of the service date, the patient becomes responsible for the FULL amount owed on that service date, REGARDLESS of whether insurance is supposed to pay, will pay or does pay in the future and regardless of benefits quoted, in or out of network status of the provider, or any billing errors made or perceived to have been made by WCHC. Any credit that results from future payments by insurance company will be applied to patient account, and a refund check will be issued at patient request.**
11. **If the patient at any point during the treatment plan** discontinues care**, voluntarily or involuntarily, their balance IN FULL of rendered care becomes immediately due REGARDLESS of whether insurance is supposed to pay, will pay or does pay in the future and regardless of benefits quoted, in or out of network status of the provider, or any billing errors made or perceived to have been made by WCHC.**
12. **Checks drawing on insufficient funds, closed account, stop payments or other reasons of non-payment will be assessed a $30 fee. If the fee and original check amount are not paid to the office in a reasonable amount of time after notification, the matter will be turned over to the County or district attorney.**

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document and fully understand and have all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Name of Patient | Signature (if minor, parent must sign) | Date

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient; "Chiropractor" refers to Dr. Heather Wright, BS, DC, CCEP.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple providers who may be involved in the treatment directly and indirectly.'
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or health care operations. I also understand you are not required to agree to my requested restricts, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PERSONAL INFORMATION CAN BE GIVEN ONLY TO THOSE YOU LIST

1. Please list the **name** and **relation** and **phone number** of any person(s), if any, whom we may inform about your general medical condition, your diagnosis, prognosis **AND APPOINTMENTS**. (i.e. spouse, sibling, school nurse, or other.)

_____

_____

_____

2. Please list the **name** and **number,** if any to whom we may inform about your medical condition **ONLY IN AN EMERGENCY.**

_____

_____

3. If other than your home address, please print the primary address of where you would like all correspondence from our office sent. _____
4. If other than you home phone number, please print the telephone number of where you want to receive calls about your appointments, lab and x-ray results or other health care information. _____
5. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "**CONFIDENTAL"**
6. **Appointment reminders may be texted to you. Please indicate if you do not want us to text your appointment reminders. Please inform the front desk in writing when turning in paperwork.**

By my signature below I give Weatherford Chiropractic permission to contact me, and/or leave me messages using any of my contact information collected in my paperwork unless specifically excluded here: Do not contact me at:_____

_____

_____ _____ _____

Printed Name of Patient Signature of Patient Date

Weatherford Chiropractic Health Center's Acupuncture Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments.

Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

There will be a $40.00 charge for a cancelled and rescheduled acupuncture appointment without a 24 hour notice due to the fact that an acupuncture appointment takes up such a large portion of our schedule. We recognize that there are situations that cannot be foreseen i.e. illness, other doctor's appointments, life, etc. but we will still need to charge the $40.00 missed appointment fee. Please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

Print Name of Patient _____

Signature of Patient _____

Date _____

Weatherford Chiropractic Health Center
Patient Privacy Rights- Patient Information

Patient information will remain completely confidential and will never be sold. Patient information obtained in permanent records will be used solely for the business of Weatherford Chiropractic Health Care. Any disposal of records will be done in such a manner that the information contained within will be illegible and unobtainable to other parties. This will include any or all of the following: shredding, incineration, and silver recovery. Use of Patient information for marketing will not occur without your written permission, excluding any face-to-face disclosures or community service promotions.

While every attempt to protect your information will be made, overheard communications in the office may be unavoidable. Calling your name in the waiting room and sending mail to your house are all considered routine and normal disclosures.

Non-routine disclosures of patient information will not be released without a written valid authorization by the patient. This includes release of any information to family, friends, attorneys, insurances that are not the patient's health insurance company, and any other such release.

You have the following rights with your Protected Health Information (PHI) :

1) The right to have access to, review, and request changes of errors to your health records
2) The right to obtain a copy of these records at a reasonable cost incorporating the supplies and labor of copying and postage (if applicable.)
3) The right to protest procedures you feel are not protecting your PHI and submit a complaint to Dr. Wright, the privacy director.
4) In the case of an independent minor, the health care provider will use her discretion to approve or deny access of the minor's records to a parent.
5) For non-routine use or information disclosure, the patient will have to grant written permission. Routine releases of information that would not require express patient permission includes all activities to carry out treatment, payment, or health care operations.
6) The right to object to specific disclosure by Weatherford Chiropractic.
7) The right to receive notice of how your PHI will be used by Weatherford Chiropractic Health Center
8) The right to receive information by an alternative means. This office will use your home address and phone number and occasionally your work number, all provided by you on your intake form, to issue reminders and correspondence. Should you desire not to be contacted using that information, you may provide an alternative way for the office to contact you. In the case of an emergency, your emergency contact will be used.
9) The right to receive an accounting for all disclosures by this office
10) The right to file a formal complaint with the Secretary of the Department of Health & Human Services concerning any breach of these rights.