DATE ____________ NEW PATIENT _____ REACTIVE _____

ABOUT YOU

Name ____

Preferred Name ____________________ Birthdate _______________

Sex at Birth M ____ F ____ Gender ___________________

SSN ____

Address ____

City ____________________________ State _____ Zip __________

Ph __________________________ Cell ______________________

Email ____

How would you like to be contacted for appt. reminders?

____ Text ____ Email ____ Phone

Employer ____

Work ph ____

Student: Y N (circle one) Marital Status ____________________

Spouse Name ____

Spouse Ph ____

Spouse Employer ____

Additional Family Member(s) ______________________________

____

Emergency Contact Name ______________________________

Ph ____

Relationship ____

How were you referred to us ______________________________

Have you had Chiropractic care before? Y N (circle one)

If yes, Doctor/Clinic ____________________________________

ETHNICITY ____ Hispanic ____ Non-Hispanic

RACE ____ Alaska Native ____ Asian ____ Native Hawaiian

____ White/Caucasian ____ Native American ____ Black/African American

____ Other Pacific Islander ____ Other: ______________________

Consents & Authorizations:

Notice of Privacy Practices: I acknowledge that I received the Notice of Privacy Practices and have completed the "Acknowledgment of Receipt of the Notice of the Privacy Practices".

Authorization for use & Disclosures of Protected Health Information (PHI) and Wisconsin & Minnesota Consent -

I understand that by signing below I authorize the Use and Disclosure of Protected Health Information (PHI) described herein and in the Notice of Privacy Practices that has been provided to me. I also acknowledge that Long Chiropractic Center has reserved the right to make changes to the privacy practices as necessary. If Long Chiropractic Center makes any changes, a revised Notice of Privacy Practices will be provided to me. I understand those changes will apply to any of my PHI that Long Chiropractic maintains.

Disclosure authorizations that may apply:

I consent to disclosure of my patient health care records for disaster relief purposes permitted by law.

I consent to use and disclosure of my patient health care records to the following person(s), including those involved in my care or payment for that care or is considered an emergency contact (Specify person(s) below):

______________________________ ______________________

(Person Name) (Relationship)

____

(Address)

______________________________ ______________________

(Person Name) (Relationship)

____

(Address)

Unless indicated by me otherwise, Long Chiropractic Center may use professional judgment and experience with common practice to make reasonable inferences of my best interest in allowing a person acting on my behalf to pick up supplies, X-rays or other similar forms of PHI as applicable.

Copy of Consent - I understand I am entitled to a copy of this Consent and Policy Brochure and I will inform clinic staff if I choose to have a copy. The original will be retained in my patient file.

Effect of Declining Consent - I understand that this consent is a condition of my treatment with Long Chiropractic Center and if I decline to sign this consent, treatment my be declined.

Right to Revoke - I understand that consent is in effect until I choose to revoke it and I have the right to revoke it at any time by giving written notice. I acknowledge that such revocation will not affect any action Long Chiropractic took in reliance on this consent before receiving the revocation. I also understand that upon revocation, Long Chiropractic my decline to continue treatment.

Release of Information: I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in my case.

Assignment of Direct Payment: I authorize any and all benefit payments to be made on my behalf directly to Long Chiropractic Center.

Notice of Privacy Practice: I acknowledge that I have been provided the opportunity to take a copy of the Notice of Privacy Practices from Long Chiropractic Center and understand your health records are confidential here.

Financial Policies: I understand and agree to adhere to the Financial Policies as outlined above and described herein.

Office Policies: I understand and agree to adhere to the Office Policies as outlined above and described herein.

Diagnostic Procedures, X-rays & Examinations: I hereby request and consent to receiving Diagnostic Procedures, including X-rays, and Chiropractic Examinations from the Doctors of Chiropractic and/or licensed support staff employed by, associated with, or serving as back-up support for, Long Chiropractic Center.

This consent is for these procedures to be performed on me, or for the patient named herein (for whom I am legally responsible)

Patient Signature:

By affixing my signature below, I acknowledge that I have fully read and understand the items listed above. I hereby consent, authorize and acknowledge the policies, consents and items as listed above and described herein and as outlined within the Notice of Privacy Practices provided by Long Chiropractic Center.

____

Patient Name (Print)

____________________________________ ______________

Patient Signature Date

____

Legal Guardian/Representative Name (Print)

____________________________________ ______________

Legal Guardian/Representative Signature Date