Keddy Family Chiropractic
Patient Information Form

Patient's Name:_____
Last First Middle

Address:_____ Apt. #:_____

City:_____ State:_____ Zip Code:_____

Home: ( )_____ Work: ( )_____ Other: ( )_____

Email Address:_____

Employer:_____ Occupation:_____

Employer's Address:_____

Marital Status:_____ Sex:___ Birth Date:___/___/___ Age:_____

Patients SS#:__ __ __ - __ __ - __ __ __ __ Drivers License #:_____

Spouse's Name:_____ Occupation:_____

Children's Names and Ages:_____

If Minor: Mother's Name:_____ Father's Name:_____

Family Doctor's Name:_____ Phone:( )_____

Referred By:_____

Financially Responsible Party: _ Patient _Insured Party _Other:_____

Responsible Party Address (if different than patient):

Address:_____ Apt. #:_____

City:_____ State:_____ Zip Code:_____

Home:( )_____ Work:( )_____ Other: ( )_____

Policy Holder's Name:_____ SS#:__ __ __ - __ __ - __ __ __ __

Relation to Policy Holder: __ Self __Spouse __Other:_____

Insurance Company:_____ Phone #:( )_____

Employer of Policy Holder:_____

ID #:_____ Group/Plan #:_____ Insured's Birth Date:___/___/___

_____ ____/____/____
Signature of Patient Date

_____ ____/____/____
Signature of Responsible Party Date

DISCLOSURE & CONSENT
CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: *You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or physically or legally incapacitated:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as: _____
relationship or authority of patient's representative

_____
date signed

To be completed by doctor or staff

_____
witness to patient's signature

_____
translated by

To be completed by doctor or staff

_____
date

_____
date

Keddy Family Chiropractic

PATIENT CONSENT FOR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I_____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and / or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice has explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my rights to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice may not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Legal Representative Relationship
(E.g., Attorney-In-Fact, Guardian, Parent if minor):

Date Signed___/___/___ Witness:_____