PERSONAL INJURY PATIENT CHECK LIST

We have prepared this easy to use check off list for your convenience. The first part is information you need to bring into the office in order for us to determine the best way to assist you with your case and to minimize your out of pocket expense. Many times your medical costs will be 100% covered by you or the other party's insurance. Please put N/A next to any of the items on the list that you don't have access to.

The second part of the list is action steps for you to take in order to report and document your case properly.

If you have any questions or concerns don't hesitate to call our office 408.985.1111 for clarification.

Please bring these items to your next visit if you do not have them today:

__ Police Report
__ Your auto insurance policy.
__ Your health insurance card.
__ Other party's auto insurance information.

Please take the following action steps before your next visit if you have not already done so:

__ Call your auto insurance to report your accident.
__ Inform your auto insurance that you have suffered a bodily injury.
__ Ask for a claim number for your bodily injury claim.
__ Ask if you have Med Pay on your auto insurance policy and if yes, how much. IF YOU HAVE MED-PAY IT IS YOUR RESPONSIBILITY TO FIND OUT THE AMOUNT IN ADVANCE $_____

Discover Chiropractic

…an extraordinary chiropractic experience Today's Date: _____

Automobile Accident/Personal Injury Questionnaire

Please answer all questions completely anything that does not apply put N/A

Name: _____Birth Date: _____ Age: _____Sex: ☐M☐F
Address: _____ City: _____ State: _Zip: _____
Home Phone: _____ Business Phone: _____ Cell #: _____
E-Mail Address: _____Social Security Number: _____
Employer: _____Occupation: _____ ☐ Married☐ Single ☐ Widowed☐ Divorced
Name of Spouse: _____Spouse's Employer: _____
Names and Ages of your children: _____
_____
Name and Phone # of Emergency Contact: _____ Relationship: _____
Who referred you to our office? _____
Who is responsible for your bill: ☐ Self☐ Med-Pay ☐Third Party ☐ Attorney Lien
What is your primary complaint? (Please be SPECIFIC): _____

What is your Vehicle Insurance Company_____Policy #:_____
Name of your Vehicle Insurance adjustor _____Phone#:_____

Claim#:_____ Do you have MED-PAY on your policy? _____
Driver of other vehicle (if any) Third Party Insurance Information

Name_____ Insurance Company_____ Policy #:_____

Third Party Insurance:_____Policy#:_____ Claim# _____

Name of insurance adjustor
_____Phone#:_____
Any other passengers?(Please list here)
_____

Patient signature: _____
Today's Date: ___/___/___

Please mark all areas that apply and the percentage of the day that you experience the symptom. If something does not apply at this time please mark as N/A.

Head

☐ Migraine☐ Light headed ☐ Memory loss ☐ Fainting
☐ Blurred vision ☐ Ear Ringing ☐ Sensitivity to light
☐ Balance loss ☐ Hearing loss ☐Double vision

No Pain ☐☐☐☐☐☐☐☐☐☐ Extreme Pain
% of day ☐ 0-25 ☐ 26-50 ☐ 51-75 ☐ 76-10

Neck

	Right	Left	Both
Pain:	☐	☐	☐
Stiffness:	☐	☐	☐
Muscle spasm	☐	☐	☐

No Pain ☐☐☐☐☐☐☐☐☐☐ Extreme Pain
% of day ☐ 0-25 ☐ 26-50 ☐ 51-75 ☐ 76-100

SHOULDERS

			Right	Left
Both				
Pain in joint:	☐	☐	☐	
Pain across shoulder:	☐	☐	☐	
Limitation of movement:	☐	☐	☐	
Tension:	☐	☐	☐	

No Pain ☐☐☐☐☐☐☐☐☐☐ Extreme Pain
% of day ☐ 0-25 ☐ 26-50 ☐ 51-75 ☐ 76-100

MIDBACK

	Right	Left	Both
Pain:	☐	☐	☐
Muscle spasm	☐	☐	☐

No Pain ☐☐☐☐☐☐☐☐☐☐ Extreme Pain
% of day ☐ 0-25 ☐ 26-50 ☐ 51-75 ☐ 76-100

CHEST

	Right	Left	Both
Pain around ribs:	☐	☐	☐
Deep chest pain:	☐	☐	☐

No Pain ☐☐☐☐☐☐☐☐☐☐Extreme Pain
% of day ☐ 0-25 ☐ 26-50 ☐ 51-75 ☐ 76-100

LOW BACK

	Right	Left	Both
Upper low back pain:	☐	☐	☐
Lower low back pain:	☐	☐	☐
Sacroiliac pain:	☐	☐	☐
Muscle spasm:	☐	☐	☐

N No Pain ☐☐☐☐☐☐☐☐☐☐ Extreme Pain
% of day ☐ 0-25 ☐ 26-50 ☐ 51-75 ☐ 76-100

ARM

	Right	Left	Both	
Pain in upper arm:	☐	☐	☐	
Pain in elbow:	☐	☐	☐	
Pain in forearm:	☐	☐	☐	
Pins& needles (arm):	☐	☐	☐	
Pins& needles (forearm):		☐	☐	☐
Numbness in arm:	☐	☐	☐	
Numbness in forearm:	☐	☐	☐	

No Pain ☐☐☐☐☐☐☐☐☐☐ Extreme Pain
% of day ☐ 0-25 ☐ 26-50 ☐ 51-75 ☐ 76-100

FEET

	Right	Left	Both	
Ankle pain:	☐	☐	☐	
Swollen Ankle:	☐	☐	☐	
Foot pain:	☐	☐	☐	
Numbness of feet:	☐	☐	☐	
Swollen feet:	☐	☐	☐	
Cramps:		☐	☐	☐

No Pain ☐☐☐☐☐☐☐☐☐☐ Extreme Pain
% of day ☐ 0-25 ☐ 26-50 ☐ 51-75 ☐ 76-100

HAND

	Right	Left	Both
Pain in wrist:	☐	☐	☐
Pain in hand:	☐	☐	☐
Pins& needles (hand):	☐	☐	☐
Numbness (hand):	☐	☐	☐

No Pain ☐☐☐☐☐☐☐☐☐☐ Extreme Pain
% of day ☐ 0-25 ☐ 26-50 ☐ 51-75 ☐ 76-100

HIPS & LEGS

	Right	Left	Both	
Pain in buttocks:	☐	☐	☐	
Pain down leg	☐	☐	☐	
Numbness down leg		☐	☐	☐
Pins& needles	☐	☐	☐	
Knee pain	☐	☐	☐	

No Pain ☐☐☐☐☐☐☐☐☐☐ Extreme Pain
% of day ☐ 0-25 ☐ 26-50 ☐ 51-75 ☐ 76-100

Patient Name:_____ Date:_____

Over the past week:

- On average, how would you rate your pain?
  completely able to function 1 2 3 4 5 6 7 8 9 10 totally unable to function

- How much have you been able to control (reduce/help) your back pain on your own?
  completely control it 1 2 3 4 5 6 7 8 9 1 0 no control whatsoever

- How anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?
  not at all anxious 1 2 3 4 5 6 7 8 9 10 extremely anxious

- How depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?
  not at all depressed 1 2 3 4 5 6 7 8 9 10 extremely depressed

- How have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?
  have made it no worse 1 2 3 4 5 6 7 8 9 10 have made it much worse

Over the past week, how much has your pain interfered with your ability to:

- Interact with your family? (i.e. at -home responsibilities such as yard work, chores at home or driving the kids to school)
  completely able to function 1 2 3 4 5 6 7 8 9 10 totally unable to function

- Perform your normal recreational activities? (i.e. hobbies, sports or other leisure activities)
  completely able to function 1 2 3 4 5 6 7 8 9 10 totally unable to function

- Participate in your normal social activities? (i.e. parties, theater, concerts, dining –out and attending other social functions)
  completely able to function 1 2 3 4 5 6 7 8 9 10 totally unable to function

- Perform your normal activities of employment? (i.e. volunteer work and homemaking tasks)
  completely able to function 1 2 3 4 5 6 7 8 9 10 totally unable to function

- Perform your normal activities of daily living? (i.e. taking a shower, driving or getting dressed)
  completely able to function 1 2 3 4 5 6 7 8 9 10 totally unable to function

- Perform your normal daily activities? (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?
  no interference 1 2 3 4 5 6 7 8 9 10 unable to carry out activity

- Participate in normal life support activities? (i.e. eating and sleeping)
  completely able to function 1 2 3 4 5 6 7 8 9 10 totally unable to function

ACTIVITIES:	**EFFECT:**			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

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Accident Report

Date of accident ____/_____/_____ Time of accident: _____

Visibility at the time of the accident: ❑Poor ❑ Fair ❑ Good

Where did the accident occur?_____

Road conditions at the time of accident :❑Icy ❑ Rainy ❑ Wet ❑ Clear ❑ Other_____

Position in the Car? ❑ Driver ❑ Front passenger ❑Rear passenger❑ Right ❑ Left

Other passengers? ❑Yes ❑ No How many? _____

Vehicle year Make _____ Model _____ Year _____

Type of accident: ❑ Head-on collision ❑ Rear-end ❑ Broad-side ❑ Front impact ❑ Rear-ended car in front

What was your vehicle's estimated property damage? _____

How fast was your vehicle traveling (estimate) _____ How fast was the other vehicle traveling (estimate) _____

Were you pre-warned that the accident was about to happen? ❑ Yes ❑ No

Did you brace yourself for impact? ❑Yes ❑ No

Were seatbelts and shoulder harnesses worn? ❑Yes ❑ No

Where were your hands upon impact? ❑Both on steering wheel ❑ One hand on steering wheel

If there were airbags, did any inflate and from which direction? ❑Side ❑ Front

Did you receive any injury or bruises from the seatbelt? ❑Yes ❑ No

Does your car have headrests? ❑Yes ❑ No

Head position at the time of impact: ❑ Left ❑ Right ❑ Looking straight ahead

As a result of the accident were you: ❑Rendered unconscious ❑ Circumstances vague ❑ Dazed ❑ Shaken up but could function

Other:_____

Since the accident have you had any: ❑ Disoriented /Confusion ❑ Dizzy ❑Light-headed ❑Blurred vision ❑ Ring/Buzzing in ears

Other:_____

Was a police report made? ❑Yes ❑ No

Were you able to get out of the car and walk unaided? ❑Yes ❑ No

After the accident, was the car drivable? ❑Yes ❑ No

Were you examined by paramedics? ❑Yes ❑ No

Were you taken to a hospital? ❑Yes ❑ No If Yes, what hospital? _____

Was Treatment Rendered? ❑Yes ❑ No If so, what treatment? _____

Were x-rays taken? ❑Yes ❑ No What parts of the body were x-rays taken of? _____

Were any fractures reported to you? ❑Yes ❑ No

Were you given any medications? ❑Yes ❑ No If Yes, what medications? _____

Did you have any immediate symptoms after the accident? ❑Yes ❑ No If Yes Describe_____

Anything else you would like to share?_____

Please Print Full Legal Name: _____ Date: _____

PATIENT FINANCIAL RESPONSIBILITY

OUR POLICY REGARDING PERSONAL INJURY INSURANCE

Dr. Osborne will be pleased to accept your personal injury insurance coverage as soon as your exact coverage is verified by the responsible party. We will file the claim forms and assist in every way we can. However, it must be understood that you are ultimately responsible for full payment of services rendered at Discover Chiropractic. We do not imply that insurance will cover all expenses.

Office policy regarding Personal Injury Protection or Med Pay:

_____ I was injured in a motor vehicle accident and this claim is being submitted through my automobile insurance company. In the event this claim is rejected by my insurance company, I understand that I am liable for full payment of services rendered.

____ I request that my automobile insurance company make the check(s) for billed services, payable to Discover Chiropractic. 408-985-1111; Fax (408) 985-2222

MY INSURANCE COMPANY INFORMATION

Name: _____ Claim #: _____ DOA: _____

Address: _____

Claims Adjuster: _____ Phone: _____ Fax: _____

If you understand and agree with the statements that are initialed above, sign and date the form here.

_____ _____ _____

Print Full Name Signature Date

Office policy regarding Third Party Liability and/or Legal Counsel:

____I was injured as a result of third party negligence and request that the doctor extend credit to me for services rendered until settlement of the third party claim.

____ I agree to complete the Financial Agreement as security for Dr. Osborne.

____ I will take full responsibility to ensure all outstanding debt for services rendered will be paid in full within ten days from receipt of the settlement check.

____ I will notify this office immediately if or when I retain the counsel of an attorney and I will instruct the attorney to furnish Dr. Osborne with a medical lien to protect Dr. Osborne's interest.

____ I completely understand that with or without an attorney I am responsible for all services rendered.
____ I have retained the services of an attorney to handle matters involving this injury. I shall instruct my attorney to furnish Dr. Osborne with a medical lien to protect Dr. Osborne's interest upon settlement.

MY ATTORNEY INFORMATION

Name: _____ Phone: _____

Address: _____ Fax: _____

If you understand and agree with the statements that are initialed above, sign and date the form here.

_____ _____ _____

Print Full Name Signature Date

Please Print Full Legal Name: _____ Date: _____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE PERSONAL INJURY, WORK COMP, ERISA, AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Provider Name: Dr. Thomas J. Osborne
Clinic: Discover Chiropractic
Address: 1305 C No. Bascom Ave. ~ San Jose, CA 95128

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, any and all medical benefits and/or any insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of all medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____ _____

Patient Signature Date

Please Print Full Legal Name: _____ Date: _____

MEDICAL LIEN

Patient: _____

Claim Nr: _____

Date of Injury: _____

I hereby authorize and direct _____, my attorney, to pay to Dr. Thomas J. Osborne, D.C., D.A.A.S.P. such sums as may be due and owing him/her for medical/chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further request that payment be made directly to said doctor which would otherwise be paid to myself, as the result of the treatment charges injured for the injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for services rendered me and that this agreement is made solely for said doctor's protection and in consideration of his/her awaiting payment. And I further understand that such payments are not contingent on any settlement, judgment or verdict which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if you do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but may declare the entire balance due and payable by me.

_____ _____

Date Patient's Signature

The undersigned attorney does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said doctor above and below named and make payment payable directly to said doctor.

_____ _____

Date Attorney's Signature

Please Print Full Legal Name: _____ Date: _____

Medical Information Release Form
(HIPAA Release Form)

Name: _____ **Date of Birth:** _____

Release of Information:
[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ]Automobile Insurance to be billed _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages:
Please call [ ] my home [ ] my work [ ] my mobile number: _____

If unable to reach me:
[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*) _____ between (*time*) _____

Signed: _____ Date: _____

Witness: _____ Date: _____

Please Print Full Legal Name: _____ Date: _____

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Discover Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY →*please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

Please Print Full Legal Name: _____ Date: _____

DISCOVER CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Susan Field at (408) 985-1111. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Please Print Full Legal Name: _____ Date: _____

*Patient initials:*_____**-retaining *page 1 of 2***

DISCOVER CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy ofDiscover Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name	DOB	HR#
Patient's Signature	Date	
Witness	Date	