Molstad Chiropractic Clinic

Please **PRINT or TYPE** the following information

Name (with middle initial) _____ Nickname: (example: Bob for Robert)_____

Address:_____ Apt. #_____ City, State, Zip:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Age: _____ Date of Birth:_____ Sex: ☐ **male** ☐ **female**

Occupation:_____ Employer:_____

Work Phone:(_____)_____ ext._____ Marital Status: ☐**single** ☐**married** ☐**separated** ☐**divorced** ☐**widowed**

Spouse's name:_____ Spouse's employer:_____

Spouse's date of birth:_____

Please list how you heard of us:_____ Email address: _____

If the patient is a minor (17 years old or younger), please complete the following section:

Mother's name:_____ contact number: (_____)_____

Father's name:_____ contact number: (_____)_____

Medicare patients: A spinal adjustment is covered up to **80%** once your deductible has been satisfied. The remaining amount may be covered by your supplement insurance or is your responsibility.

The following services & products are NOT covered:
X-rays, ultrasound, traction, interferential & laser therapies, Foot Leveler inserts, pillows, Cryoderm, Biofreeze, & supplements.

Title 19 (Medicaid) patients: ***This clinic does not accept Medicaid***. If you would like to continue with a consultation & possible treatment, we will help you set up a payment plan.

Patient Health Information Consent Form

We want you to know how your Patient Health Information **(PHI)** is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information **(PHI)** for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health care records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. *I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care.* ***I understand that I am responsible for all costs of chiropractic care regardless of insurance coverage.***

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Signature of Patient *or* Legal Guardian **Dated**