ADVANCED CHIROPRACTIC
natural health

CONFIDENTIAL PATIENT HEALTH RECORD

Welcome to our office! Please thoroughly complete all questions. Thank You

Name:_____ Date: _____

Address:_____ Birth Date:_____ Age:_____

City:_____ Social Security #:_____

State:_____ Zip:_____ Check One: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Home Phone:_____ Emergency Contact Name:_____

Mobile Phone:_____ Emergency Contact Phone#:_____

Business Phone:_____ Email Address:_____

Your Occupation:_____ Primary Medical Doctor:_____

Your Employer:_____ Doctor's Phone #:_____

Business Address:_____ City:_____ State:_____ Zip:_____

Primary reason for coming to our office:_____

_____

I do not have any medical insurance at this time.

I do understand that if I am to obtain any type of medical insurance it is my responsibility to report this change to Advanced Chiropractic, Todd A. Richardson, D.C. and provide them with a copy of my insurance card as well as any additional information they may need in order to verify coverage.

I understand that Advanced Chiropractic, Todd A. Richardson, D.C. will not submit any back dated insurance claims once I have provided them with my insurance information.

Any dates of service prior to my insurance information being presented to Advanced Chiropractic, Todd A. Richardson, D.C. are solely my responsibility and any reimbursement due from my insurance company will be pursued by the insured.

The above information is true and accurate to the best of my knowledge.

_____

Patient or Guardian Signature

Dr. Todd A. Richardson 708 Ash Boulevard Middletown, DE 19709
ph:302-449-0149 fax: 302-449-2041

AUTHORIZATION FORM

Patient Name: _____ **Date:** _____

Release of Information

I hereby authorize Advanced Chiropractic of Delaware, Todd A. Richardson, D.C.,to release any medical information and financial data to my insurance carrier/s, other medical facilities and attorney/s.

_____ **Initials**

Responsibility of Bills

The undersigned here accepts full financial responsibility for charges and services rendered to the patient. Advanced Chiropractic of Delaware, Todd A. Richardson, D.C. cannot accept
responsibility for collecting any outstanding balance or negotiating the disputed settlement. The undersigned here acknowledges that all monies are due at the time of service. Advanced Chiropractic of Delaware, Todd A. Richardson, D.C. will not bill for services rendered.

_____ **Initials**

Consent for Treatment of a Minor Child

Consent is hereby given by the undersigned for chiropractic treatment and diagnostic studies as rendered by the doctors and performed by the technical staff of Advanced Chiropractic of Delaware, Todd A. Richardson, D.C. The undersigned states that he/she is the patient's legal guardian.

_____ **Initials**

CONSENT TO X-RAY

I understand that if I am pregnant and have x-rays taken, which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that the 10 days following the onset of menstrual period are generally considered to be safe for X-Ray exams. With the full understanding of the above, I do hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time, and I wish to have an X-Ray examination performed now.

_____ **Initials**

Missed Appointments

I understand that if I do not call to cancel my appointment with a 24hr notice that I may be responsible for a $35. missed appointment fee that is not covered by my insurance company.

_____ **Initials**

Patient Signature: _____ **Date:** _____

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Medical Record Release

Patient's Name_____ Date of Birth____/____/_____

I hereby authorize _____to release all medical records or those concerning the dates of treatment on ____/____/_____ to Advanced Chiropractic of Delaware, Todd A. Richardson, D.C. 708 Ash Boulevard Middletown, DE 19709. These are being requested for the purpose of Medical Care.

Documentation Requested should include:

_____Discharge summary
_____History and Physical
_____Operative record
_____Physical Progress Notes
_____Diagnostic Tests
_____Other

_____

_____

_____

I understand that this request for release of information stands effective for 120 days. This request may be revoked at any time but is not retroactive for request that have been complied within good faith. This authorization can be revoked by written request to an authorized representative of Advanced Chiropractic of Delaware, Todd A. Richardson, D.C.

_____ Date_____/_____/_____
Patient Signature

_____ Date_____/____/_____
Signature of Representative/Relationship

Disclosure of specific information authorized for release is limited to the above mentioned recipient only.
Federal regulations, 42 CFR Part 2, prohibit the re-disclosure of the enclosed information unless the content expressly permits further disclosure or the re-disclosure is otherwise permitted under regulations.

Dr. Todd A. Richardson 708 Ash Boulevard Middletown, DE 19709
ph:302-449-0149 fax: 302-449-2041

HIPPA Notice of Privacy Practices

Advanced Chiropractic
Todd A Richardson, D.C.

708 Ash Boulevard Middletown, DE 19709 Phone: 302-449-0149 Fax: 302-449-2041

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will, be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: health Oversight: Abuse or Neglect: Food and Drug Administration requirements: legal Proceedings: law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary or the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, or your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

You may file a complaint with us by notifying our privacy contact of your complaint.

We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____Signature_____Date_____

Dr. Todd A. Richardson 708 Ash Boulevard Middletown, DE 19709
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