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:_____

Primary Medical Doctor:_____ Doctors Address:_____

Doctor's Phone #:_____ City:_____ State:_____ Zip:_____

Primary reason for coming to our office:_____

_____

Is this condition the result of a Workers Compensation Accident? ☐Yes ☐No

When was your accident? _____ Was your accident reported: ☐Yes ☐No

Name and title of person you reported your accident:_____

Briefly describe what happened: _____

_____

Employer Name:_____ Employer Phone Number:_____

Employer Address: _____ City:_____ State:_____ Zip:_____

Supervisors Name:_____ Supervisors Phone Number:_____

Name if your Insurance Co:_____Claim#:_____

Adjustors Name:_____ Phone Number:_____

Who is your attorney? _____ ☐ I don't have an attorney

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

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 total responsibility for collecting an insurance claim or negotiating the disputed settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between patient and any insurance carrier, attorney, or third party signing this agreement. Financial responsibility will also include charges and services not covered by insurance for which payment is denied through any utilization review or recertification procedures.

_____ **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**

Authorization for Payment of Insurance Benefits to Provider

I hereby irrevocably authorize payment of medical benefits to be made payable and mailed directly to Advanced Chiropractic of Delaware, Todd A. Richardson, D.C., for professional services rendered. No other third party, including my attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges medical coverage and will send payment directly to this office.

_____ **Initials**

For Claims:

I fully understand that I am directly and fully responsible to Advanced Chiropractic, Todd A. Richardson D.C. for any and all Insurance Deductibles and outstanding medical bills for chiropractic services rendered to me for the enclosed matter mentioned. In the event another attorney or law firm is substituted in the prosecution of my claim, the new attorney must honor this agreement

I further understand that such payment obligation is not contingent on the successful settlement, judgment or verdict by which I may eventually recover monies and it continues to be my separate obligation to pay in full if no monies are recovered in connection with my accident case.

_____ **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:**_____

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

ADVANCED CHIROPRACTIC
natural health

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.

ADVANCED CHIROPRACTIC
natural health

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
ph:302-449-0149 fax: 302-449-2041

PAYMENT OF MEDICAL SERVICES COSTS

This agreement is entered into for and in consideration of services rendered by Todd A. Richardson D.C. of Advanced Chiropractic and in consideration of agreement to provide chiropractic services in connection with the accident of_____. I, _____, hereby authorize and direct my attorney, _____ to pay directly to Advanced Chiropractic any outstanding balance due and owing for such medical services rendered to me for my accident and to withhold such sums from any settlement, judgment or verdict recovered in my favor as may be necessary to adequately pay said medical bills.

I direct my attorney to contact Advanced Chiropractic at the time of settlement of my claim to notify them of the recovery and to obtain a statement of my accounts.
***In addition, I agree that no distribution of monies will be made to me until such time as my undisputed medical bills and all chiropractic costs have been PAID IN FULL.**

In the event another attorney or law firm is substituted in the prosecution of my claim, the new attorney must honor this agreement.

I fully understand that I am directly and fully responsible to Advanced Chiropractic for any and all Insurance Deductibles and outstanding medical bills for chiropractic services rendered to me for the above matter mentioned.

***I further understand that such payment obligation is not contingent on the successful settlement, judgment or verdict by which I may eventually recover monies and it continues to be my separate obligation to pay in full if no monies are recovered in connection with my accident case.**

_____ _____
Client's Signature **Date**

_____
Client's Name (Printed)

The undersigned being of record for the above named client in connection with the said accident case does hereby agree to observe all the above terms and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and pay in full the outstanding balance due to arising from the above mentioned accident.

_____ _____
Firm's Name **Attorney's Name**

_____ _____
Firm's Address **City** **State** **Zip**

_____ _____
Telephone # **Fax#** **Date**

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

ADVANCED CHIROPRACTIC
natural health

WORKERS COMPENSATION ACCIDENT INFORMATION FORM

- IF YOU NEED MORE SPACE, WRITE ON THE BACK OF THIS PAGE

NAME_____AGE _____ Date of Birth _____ Sex [ ] M [ ] F

Marital Status_____ Home Ph_____Work Ph_____Cell Ph_____

Address_____City_____State_____Zip_____

E-mail Address_____

Accident Date_____ Time of Accident_____ Name of person accident was reported_____

EMPLOYER NAME_____ Employer Ph_____Employer Fax _____

Type of Injury: [ ] Lifting [ ] Fall [ ] Other

PLEASE GIVE A DETAILED DESCRIPTION OF HOW THIS ACCIDENTINJURY HAPPENED.

_____

_____

What part(s) of your body were hurt? _____

_____

Have you ***EVER*** hurt these parts of your body before? [ ] YES [ ] NO

If YES, How and When:_____

_____

Where do you now feel pain? _____

What symptoms/problems began when you were hurt?_____

_____

What symptoms/problems do you feel right now?_____

Have you ***EVER*** had these symptoms/problems Before the accident? [ ] YES [ ] NO

If YES, when and from what?_____

_____

Where were you when you were hurt?_____

Were you hurt during normal working hours? [ ] YES [ ] NO

Since the injury, have you developed other symptoms?[ ] YES [ ] NO

If YES, please describe them_____

_____

How soon after the injury did other symptoms develop? [ ] MINUTES [ ] HOURS [ ] DAYS

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

ADVANCED CHIROPRACTIC
natural health

LIFTING INJURY:

What was your posture at the time of injury?_____

How much did the object you were lifting weigh? approximately _____LBS.

What was the position and height of the object lifted? _____

****

FALLING INJURY:

From what height did you fall? _____ What did you land on?_____

Which part of your body got the impact from the fall?_____

What else got hurt?_____ Was a work related injury reported? [ ] YES [ ] NO

****

Did you lose consciousness? [ ] YES [ ] NO Were you given emergency care at the scene? [ ] YES [ ] NO

Immediately after the accident, where did you go or where were you taken?_____

What were you doing just before you were injured? _____

What activities are required for you to do your job? [ ] BENDING [ ] LIFTING [ ] CRAWLING [ ] CLIMBING
[ ] DRIVING [ ] PULLING [ ] PUSHING [ ] REACHING [ ] KNEELING [ ] RUNNING [ ] WALKING [ ] SITTING
[ ] SQUATTING [ ] STANDING [ ] GRASPING [ ] TYPING [ ] OTHER -
If OTHER, please describe in detail:_____

_____

List all the Doctors that you have been examined or treated by since this accident.
INCLUDE DOCTOR'S NAME, ADDRESS, TREATMENT YOU WERE GIVEN, REASON FOR TREATMENT, AND WHAT EFFECT DID THE TREATMENT HAD ON YOU? USE BACK OF THIS PAGE IF YOU NEED MORE SPACE.

_____

_____

Did you miss work due to this accident? [ ] YES [ ] NO What was the first day that you missed? _____

Have you returned to work? [ ] YES [ ] NO If YES, on what date_____
Between these dates did you do any work for this employer or any other? [ ] YES [ ] NO If YES, on what date_____
Was anyone else injured with you? [ ] YES [ ] NO
If YES, who and what relationship does that person(s) have to you? _____
Has that person(s) been treated due to this accident? [ ] YES [ ] NO
Did you report this to your insurance? [ ] YES [ ] NO
Is there anything that you can Not do as a result of this accident? [ ] YES [ ] NO
If YES, please give a description. Be specific about what you can NOT do._____

_____

To the best of my knowledge, all information above is accurate and true. I authorize my insurance carrier(s), trustees, executors, accountant, custodian &/or attorney to make payment directly to <Provider Clinic>for services rendered to me/my family by <Provider Clinic>. I agree to pay any balance left unpaid. I authorize<Provider Clinic> to send bills/claims &/or reports for services rendered directly to my insurance carrier &/or attorney and to release to my insurance carrier &/or attorney any information needed to process my claim. I acknowledge that I am completely and fully responsible for paying all fees that I or my family incur with <Provider Clinic>. If I have financial difficulties/hardships, I shall pay <Provider Clinic> according to the terms of any agreement that I make with <Provider Clinic>. This authorization serves as a Doctor's Lien, directing my attorney to withhold from any settlement, judgment, or verdict which may be paid to my attorney or me whatever sum is needed to protect <Provider Clinic>, and to pay <Provider Clinic> directly from those proceeds. If <Provider Clinic> has to resort to collection proceedings against me, I agree to pay all collection costs including the fees of collection agents, attorneys, and court costs, in addition to paying all fees due <Provider Clinic> for services rendered by <Provider Clinic> to &/or for me or my family. I authorize <Provider Clinic> and staff to call me on the telephone to discuss appointments, treatment information, and/or any other details related to my/my family's therapy and treatment. <Provider Clinic> and staff may leave messages about appointments on my answering machine. If I am unavailable or incapacitated, I authorize <Provider Clinic> and/or staff to discuss my case with my spouse, parents, adult children, and/or other health care providers. <Provider Clinic> is authorized to release any and all information requested to any other health care provider involved in my care and treatment.

Todays Date:_____ **Your Signature**_____

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