Preston Chiropractic and Rehabilitation, LLC.

Patient Information Form

Please Print

Patient Information

Electronic access to your health information is available upon request

Full Name _____ **Date** ___/___/___

Language _____ Race ☐ American Indian or Alaska Native ☐ Asian

Ethnicity ☐ Not Hispanic or Latino ☐ Black or African American ☐ White

☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander

Date of Birth ___/___/___ Sex: ☐ Male ☐ Female Social Security # _____

Home Address _____

Street City State Zip Code

Preferred Method of Contact ☐ Home Phone ☐ Mobile Phone ☐ Email ☐ Letter

Home Phone (___) _____ Work Phone (___) _____ Mobile Phone (___) _____

Home Email _____ Fax # (___) _____

☐ Student ☐ Employed ☐ Unemployed

Employer/School _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Does your current address match your insurance policy address? ☐ Yes ☐ No

If No: _____

Street City State Zip Code

Primary Care Physician _____ Office # (___) _____

How did you hear about us? _____

Were you referred by a patient? Yes No If yes, please list name _____

Providing this information constitutes your permission for Preston Chiropractic and Rehabilitation, LLC to contact you regarding related information via mail, e-mail, fax, and phone.

Consent for Treatment

Authorization expires 3 years from date signed

I request and consent to the performance of chiropractic, examination, adjustment/manipulation and any and all other chiropractic procedures permitted by our State law, including medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible) by any of the treating doctors of chiropractic on staff and/or any licensed chiropractor deemed appropriate by the office. I understand that results of treatment are not guaranteed. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are risks associated with treatment, although rare, including, but not limited to, fracture, disc injuries, strokes, dislocations, strains, and worsening symptoms. 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, and is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

I understand it is my responsibility to fill out my case history completely and to the best of my knowledge, and to inform the doctor of any information that is not listed on my case history. I also understand that it is my responsibility to inform the doctor of any changes that may occur once I have filled out that information. I authorize Preston Chiropractic and Rehabilitation, LLC to treat me.

I have read and understand the foregoing.

Signed: _____ **Date** ___/___/___

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Text Reminders

☐ By checking this box I hereby give permission to Preston Chiropractic and Rehabilitation to notify me via text message of my scheduled upcoming appointments. I can revoke permission at any time by notifying staff.

Text message charges from my cellphone Carrier may apply. Cell Phone ( ) _____

Emergency Contact

Name _____ Home Phone ( ) _____ Work Phone ( ) _____

Privacy

Receipt of Notice of Privacy Practices Written Acknowledgement
(Please Initial One)

_____ I was provided a Notice of Privacy Practices by Preston Chiropractic and Rehabilitation, LLC to read and keep as my own.

_____ I declined a copy that was offered to me, but I am aware of my rights.

(Please Initial)

_____ I authorize the release of my medical or incidental information necessary to provide continuity of my (the patient's) medical care and to process my (the patient's) medical insurance.

_____ I will allow this office to treat me in both private and open treatment rooms

_____ I will allow this office to record my medical information, including consultation and examination, for documentation purposes, if necessary.

My Protected Health Information may be disclosed to: _____

Financial Policy

(Please Initial all notices)

_____ I understand that I am financially responsible for any balance. Our office participates with all major health plans. We will file primary and secondary claims for you. All deductible and copays are your responsibility.

_____ If your plan requires a referral, it is your responsibility to obtain that referral prior to your visit.

_____ For any services rendered, I authorize the assignment of benefits (payments) from my insurance to come direction to Preston Chiropractic and Rehabilitation, LLC.

Insurance

Do you have health insurance? ☐ **Yes** ☐ **No**

If no, payment is expected at time of service. We accept Cash, Check, Visa or Mastercard.

Primary Insurance: _____ Secondary Insurance: _____

If yes, are you the policy holder? ☐ **Yes** ☐ **No**

If No, please provide policy holder's information: Name of Policy Holder: _____

Relationship to Patient: _____ Date of Birth: / /

Address _____
Street City State Zip Code

Print Name: _____ **D.O.B.** / /

Signed: _____ **Date** / /