

**PERSONAL INFORMATION** (in compliance with federal government requirements for the EHR program)

**Patient Name** \_\_\_\_\_ **Male/Female** \_\_\_\_\_ **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **SS#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age** \_\_\_\_ **# of children** \_\_\_\_ **Married** \_\_\_\_\_ **Single** \_\_\_\_\_ **Divorced** \_\_\_\_\_ **Widowed** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone# H** \_\_\_\_\_ **C** \_\_\_\_\_ **Email address:** \_\_\_\_\_

**What phone number is your best contact number?:**  Home  Cell

**Occupation** \_\_\_\_\_ **Employed by** \_\_\_\_\_ **Phone#** \_\_\_\_\_

**Preferred language:** English Spanish Japanese Tagalog Arabic Korean Vietnamese Chinese Polish French  
Portuguese German Russian Italian Decline

**Ethnicity:** Hispanic or Latino Not Hispanic or Latino Decline

**Race:** American Indian or Alaska Native Asian Black or African American White Native Hawaiian or Other Pacific Islander  
Other Decline

**Smoking Status:** Never Smoked Former Smoker Current Smoker (If former or current smoker) Date began smoking: \_\_\_\_/\_\_\_\_/\_\_\_\_

**INSURANCE INFORMATION**

**Current Insurance Company** \_\_\_\_\_ **Name of Insured** \_\_\_\_\_

**Date of Birth of Insured (If insurance not in your name):** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Do you have a:** \_\_\_FLEX PLAN \_\_\_HSA \_\_\_HRA \_\_\_BENNY CARD (please check any applicable)

**NAME & PHONE# of PRIMARY CARE PHYSICIAN:** \_\_\_\_\_

**CONDITION**

**Check Symptoms You Have Noticed Recently**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> headaches       | <input type="checkbox"/> pain: neck, back, chest, shoulder, arm, leg                     | <input type="checkbox"/> numbness: hands, arms, legs, feet                         |
| <input type="checkbox"/> sinus/allergies | <input type="checkbox"/> pins & needles in: hands, arms, legs, feet                      | <input type="checkbox"/> stiffness/tightness: neck, back                           |
| <input type="checkbox"/> dizziness       | <input type="checkbox"/> changes in vision, smell, taste, hearing                        | <input type="checkbox"/> nervousness / anxiety attacks                             |
| <input type="checkbox"/> fainting        | <input type="checkbox"/> shortness of breath <input type="checkbox"/> light bothers eyes | <input type="checkbox"/> loss of memory <input type="checkbox"/> loss of balance   |
| <input type="checkbox"/> fatigue         | <input type="checkbox"/> depression <input type="checkbox"/> upset stomach               | <input type="checkbox"/> fever <input type="checkbox"/> cold sweats                |
| <input type="checkbox"/> irritability    | <input type="checkbox"/> sleeping problems <input type="checkbox"/> constipation         | <input type="checkbox"/> diarrhea <input type="checkbox"/> heartburn / acid reflux |

**FEMALE PATIENTS ONLY:** Are you Pregnant?  Yes, my due date is \_\_\_\_\_  No, I am not pregnant

1.) **What brought you in?** \_\_\_\_\_

**Current history: When did it start, and what caused it to happen?** \_\_\_\_\_

- **Is this current problem a result of an auto accident?**  yes  no
- **Is this current problem a result of a work injury?**  yes  no
- **WORK ACTIVITY** (outside the home) **Please check what applies**
  - Sitting
  - Standing
  - Light Labor
  - Heavy Labor

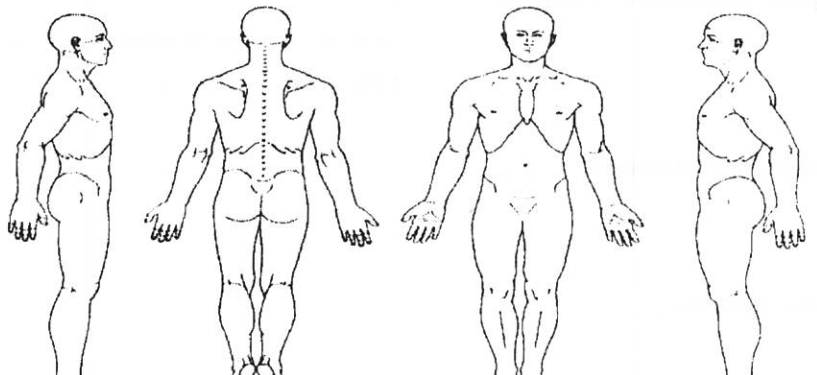
2.) **Pain quality & character. Check all that apply:**

- sharp  dull  shooting
- pinching  tingling  numbness
- radiating to \_\_\_\_\_
- other \_\_\_\_\_

3.) **Pain intensity scale: 1 (least) to 10 (worst)**

On Average \_\_\_\_\_ Right now \_\_\_\_\_  
At its worst \_\_\_\_\_ At its best \_\_\_\_\_

Show on diagram if pain radiates  
4.) **Location of pain** (mark directly on diagram)



5.) Time factors. Does the pain vary throughout the day?  Yes  No (if yes) How long does it usually last? Is it worse/better in the morning/night, ect. \_\_\_\_\_

6.) Provoking factors and effects on functional status and quality of life. Certain movements/activities unable to perform or that make the symptoms worse?  Yes  No (if yes) Explain:(For example, sitting, standing, laying, lifting, driving, recreation, work, sleeping, personal care, social life, etc.) \_\_\_\_\_

7.) Have you received any of the below for this condition?:

Chiropractic Care:  Yes  No (if yes) Name of provider: \_\_\_\_\_  
Medical Care:  Yes  No (If yes) Where: \_\_\_\_\_  
Physical Therapy:  Yes  No (if yes) Where: \_\_\_\_\_

8.) What type of bed do you sleep on? \_\_\_\_\_ How old is the bed?(approximately) \_\_\_\_\_

9.) Do you sleep on your  Side L/R  Back  Stomach  Restless

10.) How many pillows do you use under your head? 1 2 3 More

11.) Please list current prescription medications:

<u>Drug</u>	<u>Condition</u>	<u>Dosage(e.g. 5mg tablet once per day)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

12.) Do you have any drug allergies?  Yes  No. (if yes) List drug(s) and reaction(s) \_\_\_\_\_

13.) Please list current Vitamins or Nutritional Supplements:

<u>Vitamin or Supplement</u>	<u>Dosage</u>
_____	_____
_____	_____
_____	_____
_____	_____

14.) Any recent falls, accidents or surgeries or been diagnosed with a new condition or disease?  Yes  No  
(if yes) Describe: \_\_\_\_\_

15.) Has anyone in your family had this type of condition or problem?  Yes  No (If yes)

<u>Who (Relationship)</u>	<u>When</u>	<u>Treatment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

16.) Any major health issues (heart, cancer, diabetes, etc.)or additional notes? \_\_\_\_\_

17.) How did you hear about our office:  Radio  Phonebook  Website  Local Familiarity  
 Friend - who can we thank? \_\_\_\_\_  
 Newspaper – which one? \_\_\_\_\_  Other \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_, D.C.

**PERSONAL MEDICAL HISTORY**

Name: \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Chiropractic Services (date last seen) \_\_\_\_\_

Physical Therapy (date last seen) \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |                       |  |                              |  |
|-----------------------|--|------------------------------|--|
| AIDS/HIV              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety               | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
| Appendicitis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis             | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
| Anticoagulant therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
|                       |  | Pacemaker                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia               | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
| Benign Bone Tumors    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                       |  | Prostate Problem             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical dependency   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
| Chicken Pox           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                       |  | Rheumatic Fever              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression            | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
| Diabetes              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                       |  | Sexually transmitted disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stress                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                       |  | Suicide Attempt              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fractures             | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
|                       |  | Thyroid Problems             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Goiter                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gonorrhea             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, growths              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                       |  | Typhoid Fever                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
| Hepatitis             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hernia                | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
| Herniated Disk        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Herpes                | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |
| High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping cough (pertussis)   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                       |  |                              |  |
| Kidney Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | OTHER _____                  |  |
|                       |  | _____                        |  |
| Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                        |  |
|                       |  |                              |  |
| Measles               | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |

**Patient Signature** \_\_\_\_\_ **(OVER→)**

**Provider Signature** \_\_\_\_\_ **DC**

**FAMILY MEDICAL HISTORY**

Please list any of your close relatives: (sisters, brothers, parents, grandparents, children, uncles, aunts) that has or has had any of the following diseases:

- AIDS/HIV \_\_\_\_\_
- Allergies \_\_\_\_\_
- Angina pectoris (heart related chest pain), arrhythmia or heart attack \_\_\_\_\_
- Bleeding disorders \_\_\_\_\_
- Cancer \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Emphysema \_\_\_\_\_
- Glaucoma \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Hepatitis \_\_\_\_\_
- Kidney disease \_\_\_\_\_
- Liver Disease \_\_\_\_\_
- Migraine headaches \_\_\_\_\_
- Multiple Sclerosis \_\_\_\_\_
- Osteoporosis \_\_\_\_\_
- Parkinson's Disease \_\_\_\_\_
- Polio \_\_\_\_\_
- Psychiatric disease \_\_\_\_\_
- Rheumatoid Arthritis \_\_\_\_\_
- Stroke \_\_\_\_\_
- Tuberculosis \_\_\_\_\_
- Venous thrombosis (blood clots) or atherosclerosis \_\_\_\_\_
- Other chronic diseases \_\_\_\_\_

If any of your close relatives has died from any of the above, at which age did they die?

\_\_\_\_\_

\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*Office Use only\*\*\*\*\*

Provider Signature: \_\_\_\_\_ DC

### Insurance Assignment and Financial Responsibility

Our office is pleased to accept your Insurance assignment, as soon as your exact coverage is verified by the responsible party. We will file your claim and assist you in every way we can.

1. Your insurance contract is between you and your insurance company. You are fully responsible for any amount not paid by your insurance.
2. Since by taking your insurance assignment, we have to wait for payment, this courtesy may be withdrawn if circumstances warrant it.
3. Your insurance company should pay on claims filed within 30 days: if they require additional paperwork filled out by you (accident/injury information, co-ordination of benefits or any other forms), you are obligated to fill out any and all forms sent to you and return them within 10 days.

**We will apply any insurance payments toward the cost of your care and the remaining balance will be your responsibility. Please be aware that as Providers of Health Care, we are governed both by law and industry standards including insurance company requirements to keep adequate records. Forms used in our office provide history, subjective and objective communication and other information used to ascertain "medical necessity" of care. Therefore it is necessary for "Intake Forms", (forms filled out by you), to be done both initially and periodically throughout your treatment.**

#### ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic. I also authorize this clinic to release any information pertinent to my case to any insurance company adjustor and attorney involved in this case; and hereby release this clinic of any consequence thereof. The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

**Meaning of Assignment** : For purposes of this agreement, accepting assignment of the **Medicare Part B** payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the Medicare carrier, shall be the full charge for the service covered under Part B. We shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.

A photocopy of this assignment shall be considered as effective and valid as the original.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

#### FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payments, co-insurances and services rejected by my insurance company.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**OVER→**

## **Informed Consent to Chiropractic Care**

I hereby request and consent to the performance of chiropractic manipulation or adjustments and other chiropractic procedures, including various modes of physical therapy or physical medicine procedures, and diagnostic x-rays (gowns maybe used during diagnostic x-rays and/or other procedures), on me (or on the patient named below for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic manipulations or adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all possible 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 upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition.

My Primary Physician will be:

Dr. B.M. Benchley, D.C.

Dr. J. Jordan, D.C.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

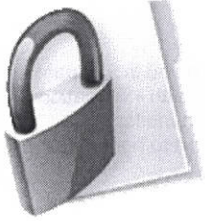
*To be completed by the patient's representative, if necessary, e.g., if patient is a minor or physically or otherwise legally incapacitated.*

Signature of Patient's Representative: \_\_\_\_\_ Date: \_\_\_\_\_

# Protecting Your Confidential Health Information is Important to Us

## Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**



## Our Promise!

Dear Patient:

This is not meant to alarm you - quite the opposite! It is our desire to communicate to you that we are taking the Federal laws (HIPAA – Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

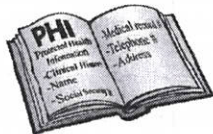
## So what has changed?

### Why a privacy policy now?

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers, but also with the internet, phone, faxes, copy machines and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your health information only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.



BENCHLEY CHIROPRACTIC CLINIC  
701 Beech St • Clare, MI 48617  
(989) 386-2384

## How your Health Information may be used

### To Provide Treatment

We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.



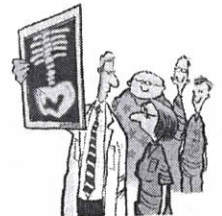
### To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail to sent electronically.

We will be sure to only work with companies with a similar commitment to the security of your health information.

### To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.



### In Patient Reminders



Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern chiropractic care can provide. They may include postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

### Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

## Public health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

## For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.



## Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency where you are unable to tell us what you want, we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.



## To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purpose of determining a cause of death and preparing for a funeral.

## Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

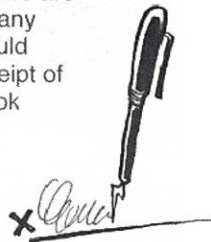
## Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

## Patient Acknowledgment

Patient Name: \_\_\_\_\_

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions, we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this form. We look forward to seeing you again soon!



\_\_\_\_\_  
Patient Signature

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)

## Patient Rights

This new law is careful to describe that you have the following rights related to your health information.



## Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

## Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

## Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.



## Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

## Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

## Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our Notice. If we change our privacy practices, we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

**BENCHLEY CHIROPRACTIC CLINIC**

**Authorization to Disclose Protected Health Information /  
Communication Preference**

Please type or print all requested information with the exception of signatures.

I authorize Benchley Chiropractic Clinic staff to disclose the health information indicated below:  
to the individual or organization below:

Recipient's Name		Relationship to Patient	
Company Name (if applicable)			
Street Address			
City	State	Zip	Phone/Fax

- Complete Hardcopy Medical File
- X-rays
- Billing/Balance Information

- Test Results
- Appointment information
- All Information

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

\_\_\_\_\_  
Patient/Guardian Name

\_\_\_\_\_  
Date

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In order to comply with Title II of the current Health Insurance Portability and Accountability Act (HIPAA), we must have expressed consent to leave a message for you on a machine or with another individual (i.e. relative, caregiver) regarding your appointments.

Please indicate your contact preferences below.

You may call the following number(s) regarding appointments:

PHONE

- Home \_\_\_\_\_
- Work \_\_\_\_\_
- Cell \_\_\_\_\_
- Other \_\_\_\_\_

LEAVE MESSAGE?

- Yes  NO
- Yes  NO
- Yes  NO
- Yes  NO

\_\_\_\_\_  
Patient/Guardian Name

\_\_\_\_\_  
Date

