# Confidential Patient Health Record

## Personal History

Date: _____/_____/_______

Name: ________________________________________

Home Phone #:__________________

Address:_______________________________________

Cell Phone #:____________________

City:____________________ State:____ Zip:________

Email: __________________________

Social Security #: _______________ ☐ Male ☐ Female

Employer:_______________________

DOB:____/_____/_____ Age:________

Type of Work:_____________________

Circle One: M S W D Separated # of Children: ____

Business Phone: __________________

Name of Spouse:_____________________
*(if insurance under spouse's name)*

Spouse's Social Security ________________

Spouse's Employer: ____________________

Who referred you to our office: ________________________________

Who is responsible for your bill? ☐ Self ☐ Spouse ☐ Worker's Comp ☐ Auto Insurance

☐ Medicare ☐ Personal Health Insurance (name) _________________________

Is condition: ☐ Work Injury ☐ Auto Accident ☐ Home injury ☐ Fall ☐ Other:____________

**PLEASE PRESENT YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST**

### HIPAA Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Meyer Chiropractic Center 'Notice of Privacy Practices'. This Notice describes how Meyer Chiropractic Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. Your information will be disclosed to your insurance company and physician for billing purposes and to federal and state reporting agencies. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on the consent.

Initials ____________

## Assignment/Authorization

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I also give Meyer Chiropractic Center and Dr. Meyer the right to release any records, and pertinent material to any third party. I hereby instruct, direct, and authorize my insurance company to pay directly to Dr. Paul Meyer, Meyer Chiropractic Center, for any professional services.

MY SIGNATURE IS AN ACKNOWLEGEMENT THAT I HAVE READ THE POLICIES ABOVE AND AGREE TO ABIDE BY SAME.

PATIENT SIGNATURE____________________________________

If the patient is a minor: I hereby give Permission to the doctors of this office and whomever they designate to treat the patient. I am his/her guardian.

GUARDIAN SIGNATURE______________________________