Total Rehab Chiropractic LLC

Today's Date ____________________

Patient Information

Name ____
First MI Last

Address ________________________________ ____________________________
Street City State Zip

SS# ________-________ -_____________ Marital Status: M S D W Date of Birth: _________________

Home Phone ___________________________ Cell Phone ____________________________

Employment Related		Automobile Accident		Other
Circle:	If yes, date of injury:	Circle:	If yes, in what state:	
Y or N	________________	Y or N	_______________	

Employer Information

Occupation_________________________ **Student:** Part or Full Time

Employer ____ Work Phone______________________

Address ____ ______________________________
Street City State Zip

Physician Information

Primary Care Physician Name ____

Phone ________-__________-________________ Fax ________-__________-________________

Referring Physician Name ____

Phone ________-__________-________________ Fax ________-__________-________________

In Case of Emergency Information

Name _________________________________ Relationship to patient ________ Phone # __________________

Insurance Information

DMBMCSI
PR FORM
032707

Total Rehab Chiropractic LLC

Primary Health Insurance Information

Health Insurance Co Name ______________________________________ Ins Phone #_______________________

Group Number__________________________________ ID Number _________________________________

Primary Insured Name __________________________________ Insured Date of Birth _____________________

Relationship to insured __________________________________ Insured Phone # _________________________

Insured Address if Different from Patient:

Address ____

Street City ST Zip

Secondary Health Insurance Information

Health Insurance Co Name ______________________________________ Ins Phone #_______________________

Group Number__________________________________ ID Number_____________________________________

Primary Insured Name __________________________________ Insured Date of Birth _____________________

Relationship to insured __________________________________ Insured Phone # _________________________

Insured Address if Different from Patient:

Address ____

Street City ST Zip

Worker Compensation/Motor Vehicle Claim Information

Claim Number_______________________________ Name of Employer at time of injury _____________________

Have you completed and returned a Personal Injury Protection application to insurance company? _____________

Insurance Company Name ____

Address____

Street City ST Zip

Phone _______________________ Fax ______________________ Claims Adjuster ______________________

ATTORNEY: Name _________________________________ Phone # _________________________________

Attorney address: ____

Consent to Treatment

By signing at the bottom of the page, I hereby authorize the professional staff at ***Total Rehab Chiropractic LLC*** to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to. I also give assignment and instruction for direct payment to ***Total Rehab Chiropractic LLC.***

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) ____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: ***Total Rehab Physical Therapy*** for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that ***Total Rehab Physical Therapy*** complies with HIPPA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

HIPPA REGULATIONS A photocopy of this Assignment shall be considered effective and valid as the original.
I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPPA guidelines.

Patient Signature	Date
Patient Printed Name	Staff Witness Signature
Parent or Guardian Signature (if under 18)	Date
Parent or Guardian Printed Name	Staff Witness Signature

Total Rehab Chiropractic LLC

Name____ Date __________________________________

Past Medical History: *Please check appropriate answer*

	Yes	No	Comment
Heart Attack / Congestive Heart Failure	___	___	____________________
Irregular Heartbeat / Pacemaker	___	___	____________________
Cancer	___	___	____________________
Diabetes	___	___	____________________
Seizures	___	___	____________________
High Blood Pressure	___	___	____________________
Current Pregnancy	___	___	____________________
Metal Implants	___	___	____________________
Ulcers	___	___	____________________
Arthritis	___	___	____________________
Breathing Problems	___	___	____________________
Recent Weight Loss / Gain ____________________	___	___	
Allergies	___	___	____________________
Headaches	___	___	____________________
Bowel / Bladder Problems	___	___	____________________

Other Medical Conditions: ____
____

History of Present Injury / Illness: *Please circle the appropriate response*

1. Onset of illness was:	Gradual	Sudden	
2. Was there trauma involved?	Yes	No	
3. Have you had a previous episode of this problem?	Yes	No	
4. Are your symptoms getting:	Better	Worse	Same
5. What does activity do to your symptoms?	Better	Worse	Same
6. Have you experienced any of the following recently?	Dizziness	Headache	Nausea
	Numbness	Tingling	Spasms
7. Is your pain:	Constant	Occasional	
8. What relieves your pain?	Rest	Medications	Heat
	Ice	Walking	Other
9. Does coughing or sneezing affect your pain?	Yes	No	
10. Have you had physical therapy in the past?	Yes	No	
If yes, for what?	____		
11. Have you been seen by a chiropractor in the past?	Yes	No	
If yes, what for?	____		

Total Rehab Chiropractic LLC

HIPAA Notice of Privacy Practices

Total Rehab Chiropractic LLC
2515 E Glenn Ave. Suite 104
Auburn, AL 36830
334-821-2256

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 school 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 of 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.

Total Rehab Chiropractic LLC

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 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, of 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 the 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______