Consent for Use or Disclosure of Health Information

Dr. Ryan D. Snyder • Mt. Hempfield Chiropractic • 5 Callahan Rd. • Greenville, PA 16125 • (724) 588-1044

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or hospital if it's necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may have to disclose your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this.

Printed Name

Authorized Person or Representative

Signature

Date

Date

OVER PLEASE ➞

Appointment Reminders, Thank-You Board and Health Care Information Authorization

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Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Your Chiropractor posts a Thank-You Board in the office to show public appreciation for those patients who refer friends and family members to the office for care. By signing this form you are giving us authorization to post your name (first initial and last name) on this board.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders. information about treatment alternatives, or other health related information at any time (§ 164.524)

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient Name Printed	Date
Patient Signature	Authorized Provider Representative
Personal Representative Printed	Personal Representative Signature

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New Patient Registration

First Name_____ Last Name_____ MI_____

Street_____ City_____ State_____ Zip_____

SS#_____ Birthday ____ / ____ / ____ Nickname_____

Marital Status: M S D W Sex: M F Children & Ages_____

Primary Phone ( ) _____-_____ Secondary Phone ( ) _____-_____

Employer_____ Work Phone ( ) _____-_____

E-mail Address_____

Insurance Information:

How did you hear about this office? _____

Type of care you are most interested in?

☐ Relief Care (Designed to relieve immediate trouble)

☐ Control Care (Designed to relieve and stablize immediate trouble)

☐ Total Health (Designed to stabilize immediate trouble and improve overall health and stay well)

☐ I prefer the doctor to select the care that he feels is best for me.

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Consultation Information

Please print or circle appropriate answers.

Name_____ **Date**_____

Chief Complaint

What seems to be the trouble?_____

When did it start?_____

How did it start?_____

Have you had previous trouble with this? Y N _____

Have you seen any other doctors for this condition? Y N (If yes, list names and when) _____

Have you tried any home remedies?_____

What makes it feel worse? _____

What makes it feel better? _____

Personal History

Have you ever had an auto accident? Y N If yes, describe _____

Have you ever had surgery? Y N Describe_____

Other accident history? (falls, sports, work) _____

Medication you currently take_____

Do you take Vitamins? Y N List_____

Do you smoke? Y N Do you consume alcohol daily? Y N

Family Doctor _____ Last time you saw them_____

Social History

Have you had to change the way you work because of this condition? Y N If yes, how? _____

What do you do for fun? _____

What type of job do you have? Sitting Standing in one spot Constant movement

Family History

Mother's health? _____

Father's health? _____

Brothers & Sisters health? _____

Doctor's Use

SIGNATURE ON FILE

Please be advised that this office will verify your insurance benefits with your insurance company as a COURTESY TO YOU. We STRONGLY encourage YOU to review and understand YOUR insurance benefits prior to seeking treatment. We also encourage you to review the explanation of benefits you will receive from your insurance company. Should you disagree with the insurance reimbursement, denial and/or member liability of your claim(s), it is YOUR responsibility to contact YOUR insurance company to resolve the matter.

WE WILL NOT BE HELD RESPONSIBLE FOR ANY INACCURATE OR MISQUOTED BENEFITS AND/OR INFORMATION WE RECEIVE FROM YOUR INSURANCE COMPANY. YOU ARE THE SUBSCRIBER, THEREFORE YOU ARE SOLEY RESPONSIBLE FOR THE CONTRACT BETWEEN YOURSELF AND YOUR INSURANCE COMPANY.

I have read and understand all of the above. I agree to provide the doctor's office with valid and accurate information regarding my insurance. I agree to be financially responsible for any and all fees that my insurance company deems as member liability.

_____ I authorize use of this form on all my insurance submissions.

_____ I authorize release of information to all my insurance companies.

_____ I understand that I am responsible for my bill.

_____ I authorize my doctor to act as my agent in obtaining payment from my insurance companies.

_____ I authorize payment direct to my doctor.

_____ I permit a copy of this authorization to be used in place of the original.

Name (print please)_____ Date _____

Signature_____ Medicare # _____

To be completed by parent or guardian if patient is a minor

As legal parent or guardian, I (print parent/guardian name) _____

hereby authorize Dr. Ryan D. Snyder to treat (print minor's name) _____.

This individual is a minor nd requires my consent to undergo chiropractic treatment.