Axelson CHIROPRACTIC & REHAB

PATIENT REACTIVATION

GENERAL INFO

Today's Date _____ DOB _____

Patient Name _____

Address _____

City/State/Zip _____

Cell/Home # ( )_____

Work # ( ) _____ Ext _____

Email _____

Would you like an appointment reminder? Y / N

If so, by: □ Email □ Text Message
If Text, who is your cell phone carrier? _____
Reminder: □ 1 Day □ 4 Hours □ 2 Hours before appt

INSURANCE INFO

Has your INS changed? Y / N

Primary INS Co _____

Name of Insured _____

Relationship to Insured _____

Insured's DOB _____

Insured's Employer _____

Secondary INS Co _____

MEDICAL INFO

Please list any NEW allergies, medical conditions or procedures since your last visit (include dates if possible):

_____

_____

In case of emergency, whom should we contact? _____

Relationship: _____ Phone Number(s) _____

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I have completed this form correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further changes to the information I have provided.

Signature _____ Date _____

REASON FOR VISIT

Reason for today's visit: Primary Complaint _____

Other Complaints _____

When did condition begin? _____ The discomfort is: □ getting worse □ constant □ comes & goes

Does it interfere with Daily Activities: □ Sleep □ Walking/Running □ Sitting □ Standing □ Lifting
□ Work □ Social Activities □ Personal Care □ Other _____

Explain _____

_____

Please rate your discomfort at its worst: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Please rate your discomfort at its best: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Have you had this or a similar condition in the past? Y / N Explain _____

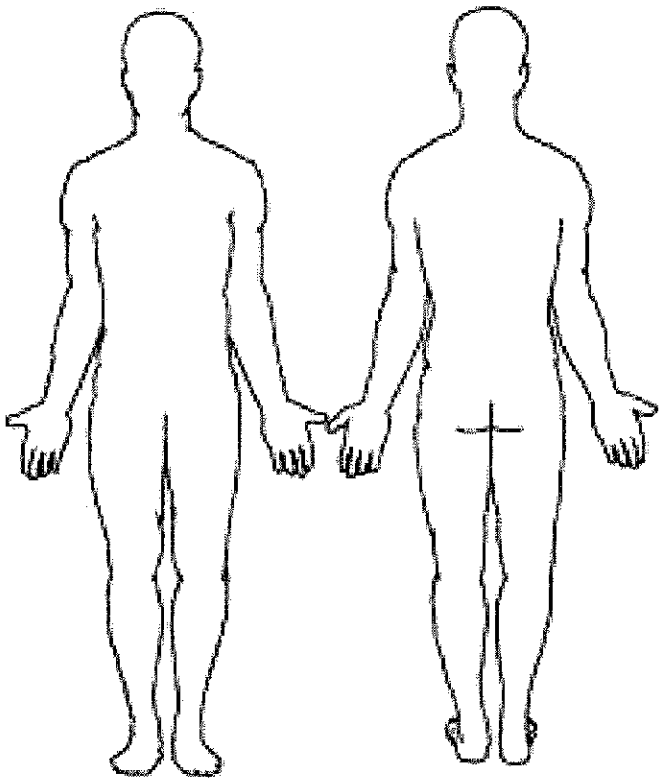
_____

DESCRIBE THE DISCOMFORT

Please mark the diagram below by placing the appropriate symbol at the site of discomfort.

	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol:	NNN	PPP	BBB	AAA	SSS

⬭ Circle any other area not represented by a symbol.



Axelson
CHIROPRACTIC & REHAB

GENERAL RELEASE OF MEDICAL RECORDS

Patient's Name (printed) _____ **DOB:** _____

I hereby request and authorize: _____

Phone: _____ Fax: _____

to disclose my protected health information as indicated below:

Description of information to be disclosed*

_____ X-Ray Images/Reports _____ MRI Images/Reports

_____ Most Recent Notes _____ Most Recent Bloodwork

_____ OTHER _____

***Please send the most recent record unless otherwise specified**

A photocopy of this authorization will be accepted with the same authority as the original.

Reason for requested use or disclosure: continuance of care

This information is to be disclosed to: Axelson Chiropractic & Rehab
Address: 901 Newman Road
New Bern, NC 28562
Phone: 252-633-3334
Fax: 252-637-4483

TO BE READ AND SIGNED BY PATIENT

I understand the following:

a. I may revoke this authorization at any time by providing written notice to the practice.
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c. The practice will not determine treatment or payment based on my signing this authorization.
d. No one has pressured me to sign this authorization.
e. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law.
f. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
g. I have right to request a copy of this authorization.

Patient's Signature: _____ **Date** _____

***This authorization shall be in force and effect until one year from date signed**

Axelson
CHIROPRACTIC & REHAB

901 Newman Road
New Bern, NC 28562
252-633-3334

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information (PHI)

Axelson Chiropractic may use or may disclose my PHI to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. _____ Patient Initials

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

I have received a copy of the Notice of Patient Privacy Policy. _____ Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your PHI. This office may or may not agree to restrict the use or disclosure of your PHI. If we agree to your request, the restriction will be binding with this office. Use or disclosure of PHI in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment

Axelson Chiropractic has private treatment rooms and an open therapy room. I consent to treatment & authorize the staff to perform any necessary services needed during diagnosis and treatment. _____ Patient Initials

I understand that I am required to make payment for all services rendered at the time of visit (whether covered or non-covered by insurance) and I am ultimately responsible for my account. _____ Patient Initials

Revocation of Consent

You may revoke this consent to the use and disclosure of your PHI. This must be done in writing. Any use or disclosure that had occurred prior to the date on which your revocation of consent is received will not be affected.

Authorized Disclosure of PHI

I authorize the following person(s) to access my PHI (please list their name and their relationship to you):

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

*This authorization will be valid for five years from the date signed unless revoked in writing or when a new authorization form is completed and signed. At that time, the updated authorization will replace this one.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Date of Birth

_____ _____
Witness Signature Date