Auto Accident

KENT MILLER, D.C. www.millerchiropractic.org **3504 W Davis St**
FAX:855-460-7005 PHONE:936-788-6565 **Conroe,TX 77304**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Protection* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes and,
- The right to request restriction as to how my health information maybe used or disclosed to carry out treatment, payment, or health care options.

_____ _____
Patients Signature Date

_____ _____
Parent or guardian Signature Date

HIPAA Consent Form

The health insurance Portability and Accountability Act of 1996(HIPAA), established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment,or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health information regarding treatment, payment, or health care operations, in order to provide health care that is your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your health information, but this must be done in writing. Under this law, we have the right to refuse to treat you if should choose to refuse to disclose your personal health information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our Office Manager. You have the right to review our privacy notice, to request restrictions and revoke consent in writing

_____ _____
Patients Signature Date

_____ _____
Parent or guardian Signature Date

CONTENT TO TREAT MINOR

I hereby authorize the doctor(s) at discover *Chiropractic & Rehabilitation* and whom ever they designate as **assistants** to administer care to child.

Name of Child/ Minor: _____

Name of Parent/ Guardian:_____

_____ _____
Parent or guardian Signature Date

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Patient registration

Name_____MI_____**Last Name** _____

DOB _____(MM/DD/YYYY) **Gender(Circle Answer) :** Male Female Other

Email_____

Address _____

City_____**State**_____**Zip** _____

Cell Phone_____Home Phone _____

Emergency Contact: Name:_____ **Relation:**_____

Phone #_____ **Alternate Phone #**_____

Patient employer**:**_____

Have you lost any time from work?**(Circle Answer)** Yes No Do you need a note for work? Yes No

For Females: Are you pregnant? Yes or No Do you take birth control pills?_____

Do you have a **Pacemaker** or **defibrillator**? _____

Date of accident:_____-_____-_____ **MM-DD-YYYY**

Did you go to hospital/ER for your accident? Yes NO (leave blank if not applicable)

Please list NAME of Hospital or ER_____

If you went at a later date than accident please list here (MM-DD-YYYY) _____- _____- _____

How did you get to the hospital:_____

Auto Accident

Medication prescribed: _____

Did you receive any of these tests ? (Circle any tests apply)

bone scan CT Scan X-ray Ultrasound

Was there a police report filed(circle one): Yes NO

Were you wearing a seat belt? (*circle one that applies*)

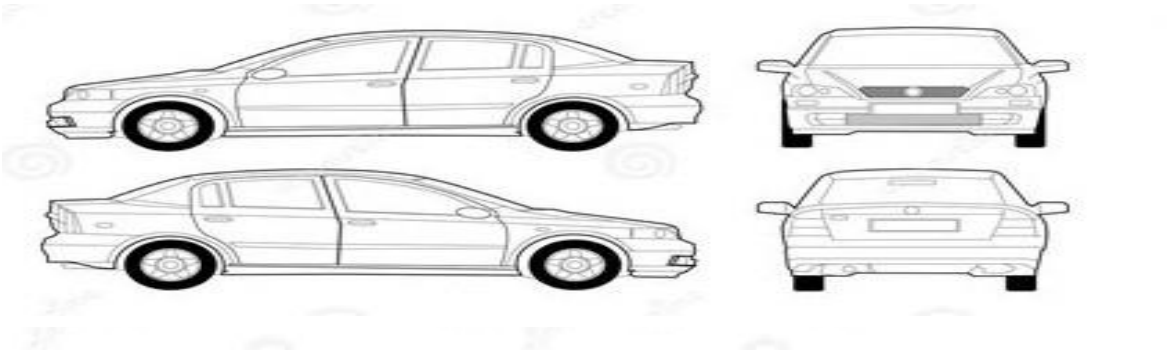
None lap belt only seat belt with shoulder harness

Was airbag deployed: (circle one) Yes NO

Your role was (circle one):

Driver of Vehicle Driver of motorcycle Back seat passenger Front seat passenger

What area of the vehicle impacted?(mark on vehicle below)



Which vehicle hit the other? (Circle that apply)

The other vehicle impacted patient's vehicle

Patient's vehicle Impacted other vehicle the patient's vehicle was hit by more than one vehicle

Accident Type (circle one):

18 wheeler Rear-ended Accident Sideswiped accident T-Bone Accident

Please describe the accident: _____

_____

_____

_____

_____

Height :_____ Weight : _____

Please list any Medical Conditions: _____

Write your description of what you are feeling:

_____

_____

_____

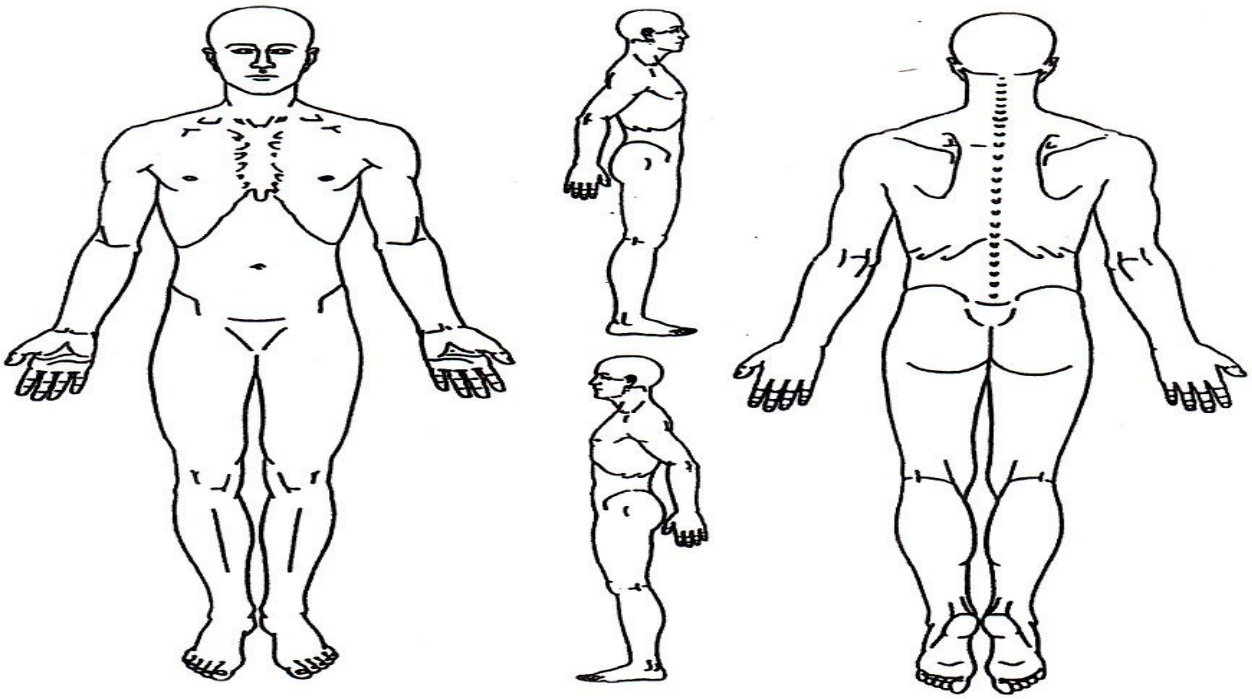
_____

Circle all that apply:

Ache	Burning	Cramping	Dull	Numbness
Sharp	Shooting	Sore	Spasm	Stinging
Tingling	Throbbing	Headaches		

Other_____

Indicate(X or circle) on diagram the pain location:



I UNDERSTAND and AGREE to authorize Dr. Miller and his employees to administer any examination procedures and treatments as they deem necessary.

Signature _____**DATE** _____