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

Patient registration

Name______________________________________MI________Last Name _______________________________________

DOB ____ Gender: Male Female Other

Driver license #: _____________________________ SSN:___________________________

Email____

Address ____

City____State________________Zip _______________________

Cell Phone____Home Phone ____

Marital Status (Circle Answer): Single Married Separated Divorced Widowed

Patient employer:____

Have you lost any time from work? Yes No Do you need a note for work? Yes No

Have you seen any other doctors for this condition? Yes No

Who?____Phone:___________________________

Prior Injuries ____

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

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

List any conditions, tests or exams in **last 10 years** we should know about. (Surgeries,falls,head injuries,broken bones,dislocations,etc.

Emergency contact

Emergency contact name ____

Phone_________________________________

Relationship ____

Address ____

City____State_______________Zip_________________

How did hear about us?(Circle answer) Doctor Friend Family member Insurance Website Social media Other____________

Whom may we thank for referring you? ____

Surgeries (please list the surgery and the year it was done)

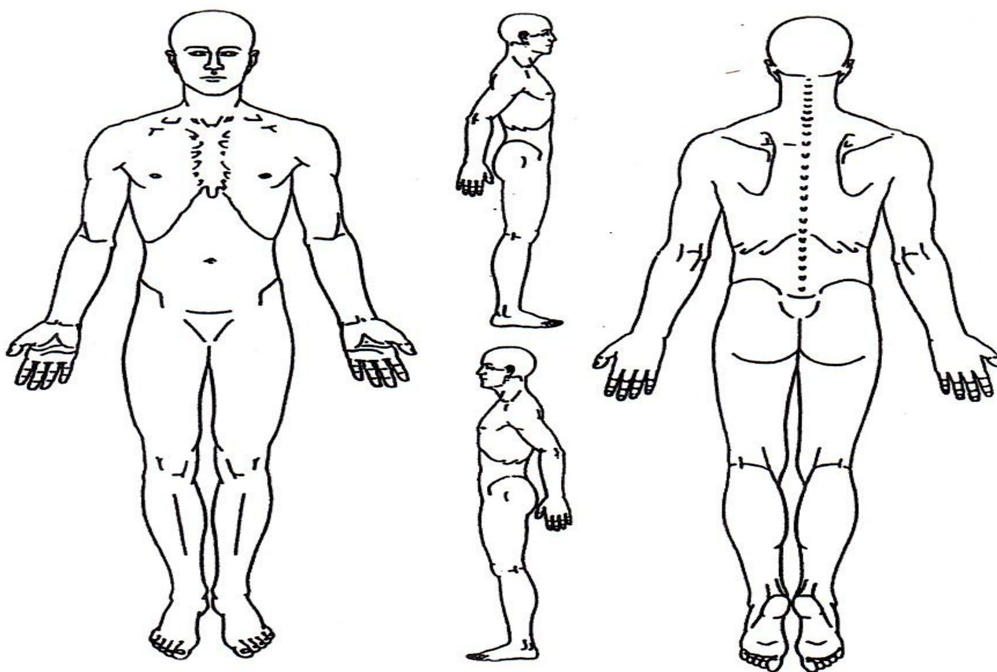
Accidents (pleases list brief description and the year it happened)

Fractures (please list what was fractured and the year it happened)

Indicate on the diagrams below the location/s on body and circle type of sensation/s you have been experiencing. Circle all that apply:

Ache Burning Cramping Dull Numbness
Sharp Shooting Spasm Stinging Tingling
Throbbing
Other______________________________

Mark where pain is:



Please describe complaints and start Date : ____/_____/_______

____

____

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

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