Confidential Patient Data

Today's Date:_____

Name:_____Date of Birth:_____
Address:_____ City:_____ State:_____ Zip:_____
Cell Phone:_____ Work Phone: _____
Home Phone:_____
E-mail Address:_____
Last four of Social Security #:_____ Age:_____ ❑ Male ❑ Female
Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Other _____
Name of Spouse or Nearest Relative:_____ Phone:_____
Relationship to patient: ❑Spouse ❑Parent ❑Child ❑Other_____
Your Occupation_____ Your Employer:_____
Referred to this Office by: ❑Friend/Family Member - Name?_____
❑Google ❑Yelp ❑ Bing ❑Facebook ❑Yellow Pages ❑ Mail ❑Clinic Location ❑Other_____
Do you have an attorney?_____
Payment for Services will be by: ❑Cash ❑Check ❑Credit Card ❑Health Insurance
❑Automobile Insurance ❑Worker's Compensation
Name of Insurance Co.:_____Insured's Employer: _____
Insured's Social Security #:_____ Employer's Phone #:_____
Are you covered by more than one insurance company? ❑Yes ❑No
Insurance company Name _____

FOR OFFICE USE ONLY

VITALS
Height_____ **Weight**_____

Blood Pressure_____ **Temperature**_____

Brookside Radiology Consultants, Inc.
P.O. Box 349
Buzzards Bay, MA 02532
Phone: 508-743-5691
Fax: 774-302-4713

X-Ray Assignment Agreement and Consent

I understand that my doctor is submitting my X-Rays for radiological interpretation and report by John R. Henry, DC DACBR, a radiologist certified by the American Chiropractic Board of Radiology.

I give my consent to Brookside Radiology Consultants, Inc. for use and disclosure of my Protected Health Information for the purpose of treatment, payment or healthcare operations of the Practice. I acknowledge that I have received or reviewed and understand the Notice of Privacy Practice of Brookside Radiology Consultants, Inc. which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice. **My signature authorizes the release of medical information.**

_____ _____

Print Name Patient Signature

_____ _____

Today's Date Parent/Guardian Signature

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Birth Date: _____ Age: _____ Sex: M F

To be completed by office staff:

Referring Doctor: _____ Date of Films: _____

Clinical Concern: _____

Comments: _____

X-Ray Studies Submitted: _____

Mayfield Chiropractic Clinic

HIPAA Privacy Rule

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness_____

Printed Name of Individual or Legal Representative _____

Date: _____

Creation Date: 3-20-18
Effective Date: 3-20-18
Last Revision Date: 4-5-18

Mayfield Chiropractic Clinic

1400 Royal Ave.
Monroe, LA 71201

Phone 318-323-7246 **Fax 318-323-7265**

INFORMED CONSENT

I consent to the performance of chiropractic examination and to medically necessary diagnostics, x-rays, adjustments/ manipulation, and other chiropractic procedures including physical treatment modalities, therapeutic exercise, and massage therapy on me or on_____. I understand these services will be performed by licensed doctors of chiropractic who may be employed by or engaged in practice in this clinic as well as by their associates and assistants and massage therapists as is appropriate.

I understand the practice of neither chiropractic nor medicine is an exact science, and that my care involves the making of judgments based upon the facts as they are understood by the doctor. I understand an undesirable result does not necessarily indicate an error in judgment, that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor believes is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care and manipulation including, but not limited to, fractures, disc injuries, strokes, dislocations, and soft tissue injuries.

I have read or have had explained to me the above content. I acknowledge I am welcome to continue to ask further questions about its content and to receive further explanation. By signing below, I acknowledge I am willing to accept and consent to the risk associated with the care that I am about to receive and for any future conditions for which I seek treatment.

_____ _____

Patient Signature **Patient Name - printed**

_____ _____

Date **Relationship to or authority if not Signed by Patient**

MAYFIELD CHIROPRACTIC CLINIC

P.O. Box 14922
1400 Royal Avenue (71201)
Monroe, LA 71207-4922
Phone (318) 323-7246
Facsimile (318) 323-7265
GREGORY J. MAYFIELD, D.C.

BILLING AND PAYMENT OPTIONS

In connection with your chiropractic Treatment, payment may be made by any of the following methods. Please indicate your method of payment below:

____Self pay: If you have no available insurance coverage, payment will be due at the time services are rendered.

____Health Insurance: We will bill your health insurance provider if, at the time of service, we are a contracted provider with that insurance company. However, you must remit all payments due as a result of any deductible, co-insurance and/or co-payments per the insurance plan. These payments as well as payments for services not covered under the plan are due at the time each service is rendered.

____Third Party Fault: In the event that a third party is at fault for your injury and you wish for us to bill that third party or your automobile medical payments carrier instead of your health insurer, then we will attempt to collect from the third party at the full cost of our services. However, in the event that the third party recovery is unsuccessful, then you will be responsible for the full amount of the outstanding medical bill.

Patient's printed name: _____

Patient's signature: _____

Patient's representative: _____
(if minor)

Relationship to patient: _____

Name of attorney: _____
(if represented)

Date: _____

Mayfield Chiropractic Clinic
Patient Consent to Telehealth Services

Telehealth services involve the use of electronic communications to enable health care providers to deliver health care services to patients using interactive video and audio communications. This document outlines the potential benefits and risks associated with telehealth services and confirms your consent to the use of telehealth services in your health care.

I, _____, understand the following:

1. The laws that protect the confidentiality of my personal information also apply to telehealth.
2. I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. The same standard of care that would apply to an in-person visit also applies to telehealth.
4. My health care information may be shared with other individuals for scheduling and billing purposes.
5. There are certain risks associated with telehealth, including delays in treatment occurring due to deficiencies or failures of equipment, interruptions of service or other technical difficulties, or the breach of privacy of personal health information caused by failure of security protocols.
6. Certain technical failures may necessitate the rescheduling of my appointment or the continuation of my visit by alternative means.
7. I am responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telehealth visit, and I understand that health plan payment policies for telehealth visits may be different from policies for in-person visits.
8. This document will become a part of my health record.

I hereby give my informed consent for the use of telehealth services in my health care. I have personally read this form (or had it explained to me) and fully understand and agree to its contents. My questions about telehealth services have been answered to my satisfaction, and the risks, benefits, and alternatives to telehealth services have been shared with me in a language I understand. I am located in and will remain in the state of Louisiana during my telehealth encounter(s).

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature (if applicable) Date

P.O. Box 14922
1400 Royal Avenue
Monroe, LA 71207-4922
Phone (318) 323-7246
Facsimile (318) 323-7265
GREGORY J. MAYFIELD, D.C.

Request to Release Medical Records

Date: _____

Patient Name: _____

Social Security Number: _____

Date of Birth: _____

By signing my name below, I am requesting the copies of:

( ) All Medical Records

( ) Lab and Diagnostic results only

( ) MRI Reports

( ) CAT Scan Reports

( ) X-ray Reports

to be released to me.

Signed: _____
Signature of Patient/ Parent/ Legal Guardian