

PATIENT HISTORY UPDATE

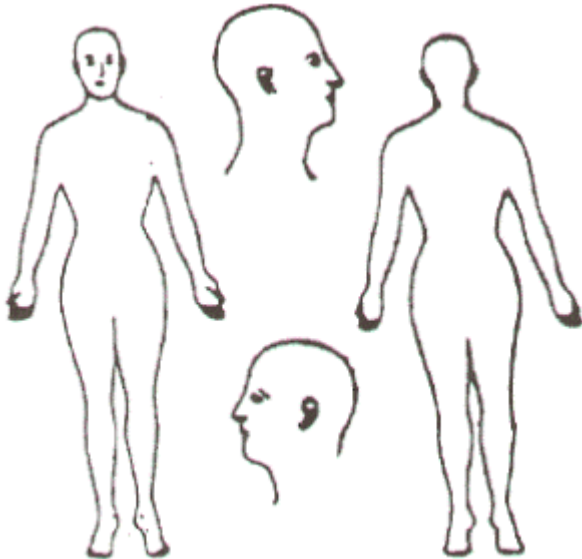
Name: _____ Date: _____
Address: _____
City, ST Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Insurance Co.: _____ ID#: _____ GROUP #: _____

NEW CONDITION

Presenting Symptoms: _____

How & When Did It Start: _____

Mark Where You Feel Pain



What functions are you unable to perform or induce pain upon performance.

1. _____
2. _____
3. _____
4. _____

RECENT HEALTH CONDITION

Recent falls, slips, accidents: _____

Recent Surgery: _____

Last visit to M.D.: _____

Reason: _____

Last adjustment: _____

Patient Signature: _____

**PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE
OPERATIONS**

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. Heritage Chiropractic Clinic's (HCC) Privacy Notice has been made available to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for HCC to provide treatment to me, and also necessary for HCC to obtain payment for that treatment and to carry out its health care operations. HCC explained to me that the Privacy Notice will be available to me in the future at my request. HCC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. HCC reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by HCC:
 - a) A postcard mailed to me at the address provided by me; and
 - b) Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. HCC may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for HCC to treat me and obtain payment for that treatment, and as necessary for HCC to conduct its specific health care operations.
5. I understand that I have a right to request that HCC restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, HCC is not required to agree to any restrictions that I have requested. If HCC agrees to a requested restriction, then the restriction is binding on HCC.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that HCC has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, HCC has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then HCC will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative*

Relationship

Date Signed ____/____/____

Witness: _____

*Attorney-In-Fact, Guardian, Parent if a minor