	BDAY
	EMAIL
	PAGES
	INS TBR
	INS GDR
	SOAP
	VFOTO

Personal Information & HIPAA Statement of Privacy Rights

Given Name:_____ Date:_____

Alias/ Nickname:_____ Pronouns # _____

Date of Birth:_____ Age: _____ Height:_____ Weight:_____ Eyes:_____

Address:_____

Email: (carefully print) _____ Cell #_____

Spouse/Partner:_____ Cell # _____

Dependent/Minor patient's name:_____

Primary/ Specialist/ Referral Physician:_____ Phone:_____

Do you have MRI, X-Rays, reports, lab reports or other documentation available?:_____

Occupation:_____

Insurance: PPO plans ONLY (Not Medicare, EMO, HMO) or provide a superbill. SS# Last 4)_____

- ☐ Provide your INSURANCE CARD with this form if using your benefits
- ☐ Provide your DRIVER'S LICENCE/ ID CARD with this form, all patients

Special consideration (personal sensitivity/fear to treatment/care):_____

Who can we thank for your referral? How did you learn about us? _____

Acceptance of the Conditions and Scope of the Use of my Medical Information (HIPAA Compliance)

I have received or reviewed the HIPAA Notice of Privacy Practice (NPP) for Chiropractic care and understand the situations in which SPINE SYNC may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit. I understand that this office will properly maintain and distribute my records, and will use all due appropriate and legal means to protect my privacy as outlined in this Privacy Practices statement. I am entitled to receive (1) paper copy of the NPP upon request, or view it online: **www.spinesync.org/ downloads.**

Signature:_____ on behalf of:_____
(self/parent/guardian) (minor/dependent)