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Personal Information & HIPPA Statement of Privacy Rights

Given Name: _____ Date: _____

Address: _____

Email: (carefully print) _____ Cell # _____

Alias/ Nickname: _____ Social Security # _____

Spouse/Partner: _____ Home phone: _____ Other Phone: _____

Dependent Parent/Guardian attending appointment: _____

Primary/ Specialist/ Referral Physician: _____ Phone: _____

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

Insurance: Out of Network PPO Payor/Plan: _____ # _____

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Provide your **INSURANCE CARD** with this form if using your benefits

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Provide your **DRIVER'S LICENCE 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 (HIPPA Compliance)

I have received or reviewed the HIPPA 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)