Patient Information

Date: _____

How did you hear about us? ☐ Patient ☐ Physician ☐ Attorney ☐ Google ☐ Other_____

Last Name: _____ **First** Name: _____ Middle: _____

Address: _____ Apt/Lot# _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Birth Date: _____ Social Security# **XXX - XX -** _____

Email Address: _____

Employer: _____ Employer # _____

>>> Spouse's Name & #: _____

>>> -or- Emergency Contact Name & #: _____

Emergency Contact's relationship: Significant Other Parent Child Friend Other _____

Main Complaint: _____

_____

Date of Accident: _____ -or- Date of Symptom Onset: _____

Description of Accident: _____

_____

_____

_____

Have you consulted anyone else for this condition?

☐ YES ☐ NO

Physicians Name: _____

Location: _____

Allergies? _____

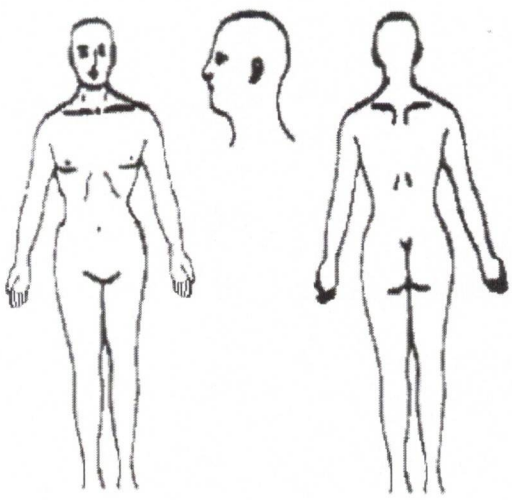
Please Mark Pain Scale with an X

NO Pain Severe Pain

0 I I I 5 I I I 10

Method of Payment: ☐Cash-Check-Card ☐ Insurance

Mark Areas: Pain = X Numbness = O



Gulfview Chiropractic & Wellness Center

Dr. Charles Halley

Patient Name_____ Date of Birth _____

General Consent to Treat

I voluntarily consent to medical care of a routine/emergency nature form the authorized professional staff of Gulfview Chiropractic for myself or the above-mentioned minor for whom I am the parent/guardian. I authorize the release of any and all medical records and information obtained through my medical evaluation to those individuals that my doctor feels appropriate for my continued medical care. I understand that I have the right to a full disclosure of the nature of any medical treatment received or proposed to be rendered and the risks, if any, involved and alternative means available. It is understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

Payment Agreement

I understand and agree that any charge incurred during my treatment by the professional staff of Gulfview Chiropractic is due and payable upon date of service and my sole financial responsibility and that I may pay with Cash, Check or the posted and routinely accepted Debit Card or Credit Card.

HIPAA

The undersigned does hereby acknowledge that he/she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

I have read the above and understand my financial obligation.

Patient Signature_____Date_____

Spouse/Guarantor Signature/Relationship_____

Witness _____ Date_____

Gulfview Chiropractic and Wellness

In accordance to HIPAA practices, I authorize my medical information to be released to the following person(s):

___ NO other person

☐ Spouse_____

☐ Doctor_____

☐ Doctor_____

☐ Child_____

☐ Child_____

☐ Child_____

☐ Child_____

☐ Other_____

☐ Other_____

☐ Other_____

_____ _____

Signature Print Name

_____

Date

Patient Request for Records

I hereby authorize the release copies of my records and x-rays and request that they be sent to:

Dr. Charles Halley

Gulfview Chiropractic & Wellness

8323 US Highway 19
Port Richey, FL 34668

gulfview.chiropractic@gmail.com

Fax (727) 842-3524

Print Name of Patient: _____

Signature of Patient: _____

SSN: XXX-XX-_____ **Date of Birth (DOB):** ____-____-_____

FOR OFFICE USE ONLY

Date: _____-_____-_____

To: _____

(Doctor/Hospital)

Address: _____

City: _____ **St:** _____ **Zip:** _____

Phone: (____)_____-_____ **Fax:** (____)_____-_____