STOW-KENT CHIROPRACTIC CLINIC, INC.
Dr. Michael A. Shimmel, Clinic Director

CONFIDENTIAL PATIENT INFORMATION

Date___/___/______

Name________________________________Sex____Age____Home Phone____________

Address__________________________City_____________State_____Zip Code_________

Cell Phone__________________________Email_____________________________________

Social Security #__________________________Birth Date______________________________

Marital Status M S D W (Please Circle One) How may Children?____________________

Employer_________________________________Occupation ___________________________

Address__________________________________Office Phone__________________________

Insurance Company____________________________Policy #__________________________

Name of Spouse________________________________Occupation_______________________

Employer_________________________________Office Phone___________________________

Patient's Nearest Relative___________________________Relation_____________________

Address__________________________City_______________State____Zip Code_________

Referred By____

Please list the dates and reasons you have been hospitalized (as well as can be remembered):____

PAYMENT IS EXPECTED AT THE TIME OF VISIT!!!

Name of Person Responsible for Payment____

Are you insured? YES NO Company____

I understand that Stow-Kent Chiropractic Clinic, Inc. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Stow-Kent Chiropractic Clinic, Inc. will be credited to my account on receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature___________________________________

Guardian's Signature_________________________________

STOW-KENT CHIROPRACTIC, INC.
DR. MICHAEL A. SHIMMEL D.C.
2991 GRAHAM RD.
STOW, OHIO 44224
330-686-1333

NAME: ______________________________ DATE: ________________

I hereby state that the condition I am being treated for at Stow-Kent Chiropractic Clinic is not the result of any type of accident, sickness, or work-related injury that another party is liable for:

______________________________ ____/____/____
Signature of policy holder Date

______________________________ ____/____/____
Signature of claimant, if other than policy holder Date

______________________________ ____/____/____
Signature Witness Date

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the physicians at Stow-Kent Chiropractic Clinic to release any Information acquired in the course of my examination or treatment.

____
Name Relationship Phone

____
Signature

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize payment directly to the physicians at Stow-Kent Chiropractic Clinic for all chiropractic and/or medical benefits. I understand that I am financially responsible for the charges not covered by this authorization.

____
Signature

HIPAA HAPPENINGS

This notice describes how your health information may be used and how you can gain access to this information. Please review it carefully.

Our Promise to You our Valued Patient...

This is not meant to alarm you. Quite the opposite. We want to assure you that we take the new Federal HIPAA (Health Insurance Portability and Accountability Act) laws seriously. These laws are written to protect the confidentiality of your health information. We trust you will never delay treatment in our offices because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why a Privacy Policy Now?

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review not only how your information is used within our computers, but also with the Internet, phones, fax machines and any device used to copy or transfer that data.

We want to advise you that we have developed policies and procedures for our practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information. We will assure our adherence to those laws and we want you to understand our procedures and your rights as a valued patient. Your health information will be communicated only for the purpose of conducting health care business and obtaining payment for services. Be assured that without your written permission, your health information will not be used for any other purpose.

How your Health Information May Be Used to Provide Treatment

Within our offices, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all the office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health professionals providing you treatment.

To Obtain Payment

Your health information may be included with an invoice for the purpose of collecting payment for services provided to you in this office. We may do this with insurance forms filed for you by mail or electronically. We will make every effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experience by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, and associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or members of your family. These communications are an important part or our philosophy of partnering with our patients to be sure they receive the best care chiropractic can provide. They may include postcards, newsletters, flyers, and telephone or electronic reminders such as email (unless you tell us that you prefer not to receive reminders.)

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security.

For Law Enforcement

As permitted or required by state or Federal law, we may disclose your health information to proper authorities for the purpose of law enforcement including, under certain circumstances, if you are a victim or a crime or in order to report a suspected crime.

Family, Friends, and Caregivers

We may share your health information with those you tell us will be assisting you with your home hygiene, care, treatment or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, if you are unable to tell us what you want, we will use our very best judgment when sharing your health information with anyone participating in your care.

Medical Research

Advancing health care knowledge often involves learning from the careful study of health histories or prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements, and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Rights

This law is careful to describe that you have the following rights related to your health information. Be assured that our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Information

You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately with or without family members present or through sealed mail communications. We will make all reasonable effort to honor your request.

Inspect and Copy Your Health Information

You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request.

Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested sealed and or delivered to any authority for review.

Documentation of Health Information

You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment, or health care operations. Our documentation procedures will enable us to provide information on your health information usage from April 14th, 2003 and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes.
You have the right to express concerns of complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing, any concerns you may have regarding the privacy of your health information.

Patient Acknowledgment

Patient Name(s): ______________________________

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Thank you very much for taking time to review how we are carefully using your health information. If you have questions, please let us know. If not, we would appreciate your acknowledging by signature that you have received, thoroughly reviewed and understand this policy.

______________________________ Date __/__/__

Patient Signature

STOW KENT CHIROPRACTIC INC
2991 GRAHAM RD
STOW,OH 44224
330 686 1333

CONSENT TO RELEASE INFORMATION

Primary Care Physician Name	Address	Phone

I,______________________________ grant Stow-Kent Chiropractic permission to share findings with my other health care practitioners if we feel there is a medical need.

YES______ I would like you to send an initial/progress report to my PCP named above.

NO_______ I do NOT want you to send an initial/progress report to my PCP.

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Patient Signature **Date** **Print Patient Name**