



## Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree to how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA Notice that is available to you at the front desk before signing this consent form.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance company requires for payment.
2. The patient has a right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care provided to the patient at this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

**I have read and understand how my Patient Health Information will be used and agree to these policies and procedures.**

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Dr. Joshua J. Hague, D.C, CFMP**  
**976 Grand Ave.**  
**St. Paul, MN 55105**

## Patient Information

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Primary: (\_\_\_\_) \_\_\_\_\_ Alternate: (\_\_\_\_) \_\_\_\_\_

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Sex: M / F # of Children: \_\_\_\_

Occupation: \_\_\_\_\_ Employed By: \_\_\_\_\_

How Were You Referred To Our Office? \_\_\_\_\_

Have You Ever Had Chiropractic Care Before? Y / N If yes, when? \_\_\_\_\_

Marital Status: S M D W Spouse Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Most Recent Auto Accident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ E-mail: \_\_\_\_\_

☐ I do not wish to receive an e-mail newsletter

*For those who will be using insurance to cover any portion of care:*

Insurance Provider: \_\_\_\_\_ Primary Insured: \_\_\_\_\_

Primary Insured DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insurance ID #: \_\_\_\_\_ Insurance Group #: \_\_\_\_\_

*Office Use Only:*

Onset: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Diagnosis Codes: \_\_\_\_\_

**Patient Type:**

☐ Self Pay ☐ Auto/W.C. / P.I. ☐ Insurance (type): \_\_\_\_\_ Copay: \_\_\_\_\_