Back In Action

CHIROPRACTIC, LLC

Michael R. O'Donnell, D.C.
Dominic D. Schultz, D.C.
10443 Illinois Road ▪ Fort Wayne, IN 46814

♦REGISTRATION INFORMATION♦

PLEASE PRINT AND FILL IN COMPLETELY

PATIENT INFORMATION:

First Name_____ Middle Initial_____ Last Name_____

Preferred Name_____ Social Security Number _____

Home Phone_____ Cell Phone_____

Text Reminder (Circle One) Yes or No Cell Carrier (Circle One) Verizon Sprint AT&T Other: _____

Street Address_____City_____State_____Zip_____

Sex □ Male □ Female Birthdate_____Age_____ E-Mail Address_____

□ Single □ Married □ Widowed □ Divorced
□ Employed □ Retired □ Full-Time Student □ Part-Time Student ~ School _____

How Did you Hear About Us? _____

Employer _____Occupation_____Phone:_____

Employer Address_____ City_____ State____ Zip_____

POLICY HOLDER INFORMATION:

First Name_____ Middle Initial_____Last Name_____

Social Security Number _____ Birthdate _____

Home Phone_____Street Address_____

City_____ State_____ Zip_____

Employer _____Occupation_____Phone:_____

Employer Address_____City_____State_____ Zip_____

Emergency Contact Person_____

Phone_____**Relationship to Patient**_____

Assignment and Release

I assign directly to Back In Action Chiropractic, LLC all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. Furthermore, I authorize the release of my medical records to secure payment and/or to receive medical information pertaining to my case in this facility.

_____ _____

Signature of Insured/Guardian Date

Authorization for Chiropractic Treatment

I hereby authorize Dr. Michael R. O'Donnell and/or Dr. Dominic D. Schultz and the staff of Back In Action Chiropractic, L.L.C. to perform diagnostic tests and render care considered therapeutically necessary on the basis of findings during the course of my treatment. As of the date stated below, I have the legal right to select and authorize health care services for the patient named above. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify Back In Action Chiropractic, L.L.C.

I hereby certify that I have read and fully understand the above Authorization for Chiropractic Treatment. I also certify that no guarantee or assurance has been made as to the results that may be attained.

_____ _____

Patient or Guardian Signature Date

HIPAA Compliance Patient Consent

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

This notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use or disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The patient may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by (Please Print Name): _____

_____ _____

Patient or Guardian Signature Relationship to Patient

_____ _____

Witness Date