GLASGOW CHIROPRACTIC / GLASGOW SPINE AND WELLNESS
WILMINGTON SPINE CENTER
Confidential Patient Health Record

(Please print in **BLACK** ink only)

NAME:_____ Home Phone_(_____)_____
ADDRESS/PO BOX:_____ Work Phone _(_____)_____
CITY:_____STATE:_____ZIP:_____ Cell Phone (_____)_____
E-Mail_____

_____ **Please initial** to receive email and text appointment reminders, office updates and specials.

Gender: Male/Female

Birth Date_____/_____/_____ Occupation_____

SSN_____ Employer_____

Marital Status_____ # Children_____ Spouse's Name_____

Emergency Contact_____ Contact's Phone_(_____)_____

How were you referred to our office?_____

I am seeking:

□ Chiropractic □ Acupuncture □ Massage □ Rehabilitation

□ Body Contouring □ Scar Removal □ Laser Skin Renewal □Laser Hair Removal

□ Stretchmark Removal □ Laser Skin Revitalization □ Interventional Pain Management

Primary Physician Name_____ Phone_(_____)_____

Is your visit due to an accident? Y N Date of Injury:_____/_____/_____
Type of Injury:_____

Present Complaints:_____
_____

Other doctors seen for this problem:_____

Significant Health History
_____
_____

CONSENT TO TREAT: My signature stands proof that I give Glasgow Chiropractic my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient Print Name_____

X Patient/Guardian Signature_____Date_____/_____/_____

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Payor Authorization (Initials required for all 3 statements)

_____ **Assignment of Insurance Benefits**
I authorize that the patient of my insurance benefits to be made directly to Glasgow Chiropractic LLC, for any services that are related to my auto injury.

_____ **Guarantee of Payment**
I understand that I will be personally responsible for all amounts due to services billed by Glasgow Chiropractic LLC to a Personal Injury Protection Payor which were subsequently declared by them non-eligible claim.

_____ **Certification of Information**
I certify that the initial information I have provided Glasgow Chiropractic LLC for treatment and payment is accurate and truthful. I will advise Glasgow Chiropractic LLC immediately if there is a change of my coverage claim status.

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name: _____ **Date of Birth:** _____

Please initial by the following:

_____ I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **Glasgow Chiropractic L.L.C.,**

_____ I understand that the Notice describes the uses and disclosures of my protected health information by **Glasgow Chiropractic L.L.C.,** and informs me of my rights with respect to my protected health information.

X_____
Patient Signature/Legal Representative/Guardian

_____ **DATE:**_____
Printed Name/Legal Representative & Relationship

WITNESS:_____**DATE:**_____