

**GLASGOW CHIROPRACTIC LLC / 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 LLC 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. (If you would like a obtain a copy of this notice, please feel free to ask the front desk)

**Patient Print Name** \_\_\_\_\_

**X Patient/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**GLASGOW CHIROPRACTIC LLC / GLASGOW SPINE AND WELLNESS / WILMINGTON SPINE CENTER**

**Who is responsible for your bill? You and:**    Personal Insurance    Medicare    Workers Comp    Auto

**HMO/PPO Limitation of Liability**

Your insurance plan may have limitation for services covered in our office. According to your specific plan, the following services may not be covered:

- ◆Examinations    ◆Re-exams    ◆Diagnostic Tests    ◆Acupuncture    ◆Rehabilitation    ◆Massage
- ◆Vitamins, Supplements, or Supports    ◆Modalities (such as EMS, Ultrasound, Hot/Cold packs)

**Please initial by the following:**

\_\_\_\_\_ Should any of these determinations be made by your plan, you agree that you have been informed before the services were rendered and you agree to be responsible for payment of the specific services listed above.

**SIGNATURE ON FILE**

**Please initial by the following:**

\_\_\_\_\_ Payment is expected at the time of service in the form of a deductible, co-payment or co-insurance payment.

**It is illegal to waive these fees.**

\_\_\_\_\_ Your insurance policy is a contract between you and the insurance company, and you are responsible for any unpaid or denied claim and for any collection fees, court costs, and attorney’s fees if your account is turned over for collection.

\_\_\_\_\_ If your insurance company sends you checks, it is your responsibility to deliver them to our office.

\_\_\_\_\_ I understand that I am responsible for my bill

\_\_\_\_\_ I authorize use of this form on all my insurance submissions

\_\_\_\_\_ I authorize release of information to all my insurance companies

\_\_\_\_\_ I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies

\_\_\_\_\_ I authorize direct payment to my doctor

\_\_\_\_\_ I permit a copy of this authorization to be used in place of the original

\_\_\_\_\_ “I hereby authorize you to furnish information to my insurance company concerning my care. I further hereby assign all insurance payments for services rendered to me or my dependents.”

**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**

\_\_\_\_\_  
**Printed Name/Legal Representative & Relationship**

**DATE:** \_\_\_\_\_

**WITNESS:** \_\_\_\_\_ **DATE:** \_\_\_\_\_