

**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:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Massage | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Body Contouring | <input type="checkbox"/> Scar Removal | <input type="checkbox"/> Laser Skin Renewal | <input type="checkbox"/> Laser Hair Removal |
| <input type="checkbox"/> Stretchmark Removal | <input type="checkbox"/> Laser Skin Revitalization | <input type="checkbox"/> 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 payment of my insurance benefits to be made directly to Glasgow Chiropractic LLC, for any services that are related to my work 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 Worker's Comp payor which were subsequently declared by them or my employer to be non-eligible claim.

Certification of Information

I certify that the initial information I have provided Glasgow Chiropractic LLC for treatment and payment under the Worker's Compensation Program 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

Printed Name/Legal Representative & Relationship

DATE: _____

WITNESS: _____ **DATE:** _____