NEW PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC!

We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to helping you.

Patient Signature: _____

Date: _____

PATIENT APPLICATION SURVEY

Name: _____ Age: _____ Gender: M F

Home Address: _____ Home Ph: (_____) _____

City, State, Zip: _____ Cell Ph: (_____) _____

E-Mail: _____@_____ Work Ph: (_____) _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Occupation: _____ Employer Name: _____

How did you hear about us? _____

In Case of Emergency:

Name: _____ Relationship: _____

Work Ph: _____ Home Ph: _____Cell Ph: _____

PURPOSE OF THIS VISIT

Reason for this visit: _____

Is this purpose related to an auto accident / work injury? YES NO If so, when: _____

Describe: _____

Please describe the pain & its location: _____

When did this condition begin: _____ / _____ / _____ When did you first notice it? _____

Is this condition getting worse? YES NO Is this condition: __Constant __ Comes & Goes __ Activity Related

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? YES NO Describe: _____

Have you experienced this condition before? YES NO If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

Do you have any additional health care concerns? _____

AUTHORIZATION CARE

I authorize and agree to allow the doctor to take radiographs of my spine and/or extremities, work with my spine through the use spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or Physical Therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctor's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor for all services rendered.

_____	_____	_____
Patient's Name Printed	Patient's Signature	Date

HIPAA GUIDELINES

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information. We may have to disclose your PHI to another healthcare provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

We may need to use your health information within our own practice for quality control or other operational purposes. We may need to use your PHI to remind you of appointments, send you a birthday card, send you a thank you, acknowledge your referral, send you a welcome to the office letter, invite you to participate in office workshops, or send promotional information. We have a more complete notice that provides a detailed description of how your PHI may be used or disclosed. You have the right to revise that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice.

_____Initial

YOUR RIGHTS

You have the right to request that we do not disclose your PHI to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your PHI please let us know in writing. We are not required to agree with your restrictions. However, if we agree with your restrictions, the restriction is binding upon us. You may revoke your consent to us at any time; however, your revocation must be in your request. If you were required to give your authorization as a condition of obtaining insurance, they may have the right to your PHI if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of notice if requested.

_____		_____
Sign Name	Date	Provider Representative

HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES KANG CORRECTIVE CHIROPRACTIC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Kang Corrective Chiropractic to use my name, address, phone numbers, and clinical records to contact me with birthday cards, holiday related cards, health related e-mails, messages & information about treatment alternatives, or other health relation information as well as any advertisements, newsletters, or patient of the week/month postings.

I give permission to Kang Corrective Chiropractic to treat me in an open room where other patients are also being treated I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or physical therapist in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Kang Corrective Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I, _____, understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

*The right to review the notice prior to signing this consent

*The right to object to the use of my health care information for directory purpose

*The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

Name: _____

Signature: _____

Date: _____