MASON CHIROPRACTIC
5181 Baltimore Drive, La Mesa, CA 91942
(619) 589-7869

Name: _____ Social Security #: _____
First **MI** **Last**

Address: _____ City: _____ State: ___ Zip Code: _____

Date of Birth: _____ Home Phone #: _____ Cell Phone #: _____

E-mail: _____ Occupation: _____ Employer: _____

Employer Address: _____ City: _____ State: ___ Zip Code: _____

Employer Phone #: _____ Patient's Preferred Language: _____

Can we text your cell phone if we need to get in contact with you? **Yes / No** Type of phone (iPhone / Android): _____

How were you referred to us? _____ **Do you have health insurance? Yes / No**

****Are you here because of an <u>auto-accident</u> or <u>work</u> injury? Yes / No Date of injury: _____**

In Case of Emergency

Your Nearest Contact: _____ Relationship to Contact: _____
First **MI** **Last**

Contact's Address: _____ Contact's Phone #: _____

- Are you presently taking any vitamins or medication?
  (If so, please list name and length of time taken)

- Do you have any allergies?
  (If so, please list)

- Have you had X-rays or an MRI taken recently?
  (If so, what kind? And when?)

- Have you ever had surgery?
  (If so, please list type and year)

- Have you or any of your family members had any serious medical conditions or diseases?
  (If so, please list)

- **What is your primary reason for today's visit?**

Patient/Patient Guardian Signature: _____ **Today's Date:** _____

Notice: Patient Privacy **Last Update: January 1st, 2018**

At Mason Chiropractic, we are committed to preserving the privacy of your health information. In fact, we are required by law to protect the privacy of your health information and to provide you with a notice describing:

How medical information about you may be used and disclosed and how you can get access to that information. Please review it carefully.

We may be required or permitted by certain laws to use or disclose your health information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your health information that we maintain, amending or correcting that information, obtaining and accounting of our disclosures of your health information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information and complaining if your rights have been violated.

In our reception area, we have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our current Notice, please ask someone at the front desk and they will provide you with a copy.

If you have any questions, concerns, or complaints about the Notice or your health information, please contact Wesley, our Privacy Officer of our office at:

5181 Baltimore Drive
La Mesa, CA 91941-3679
(619) 589-7869

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that Mason Chiropractic's "Notice of Privacy Practices" has been provided to me. I understand I have a right to review Mason Chiropractic's Notice of Privacy Practices prior so signing this document. The Notice of Privacy Practices describes the the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Mason Chiropractic. The Notice of Privacy Practices of Mason Chiropractic is also provided upon request at the main administration desk (front desk) of the practice.

This Notice of Privacy Practice also describes my rights and Mason Chiropractic's duties with respect to my protected health information. Mason Chiropractic reserves the right to change the privacy practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient/Personal Representative Date

_____

Print Name of Patient/Personal Representative

_____

Relationship to Patient/Personal Representative

MASON CHIROPRACTIC

1. Assignment of Benefits: I assign my medical insurance benefits to Dr. Robert C. Mason, and request that payment under my insurance plan to be made directly to him at: Mason Chiropractic, 5181 Baltimore Drive, La Mesa, CA 91941.

2. Financial Responsibility: I understand that my medical insurance will be billed for services rendered to me at Mason Chiropractic (if applicable), and I may be responsible for a co-payment, and/or deductible, after my insurance has paid. In the event that my insurance company fails to pay the entire claim(s) for any reason, I understand and agree that I will be personally and fully responsible for the payment of these services.

3. Consent for Treatment: I have read the available explanation of chiropractic treatment and may request a copy of it at any time. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

4. Consent to Disclose Medical Record: I hereby give authorization for the above named provider, to disclose to my insurance companies, any information regarding my medical or financial records for the services rendered by Mason Chiropractic to comply with my insurance audits.

I have read and agree to the above.

_____ _____

Patient's Signature Date