



## Application for Patient Care

### PATIENT INFORMATION:

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex at Birth: Male/Female  
DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Home Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)  
Native Hawaiian or Pacific Islander / Other / I Decline to Answer  
**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer  
Preferred Language: \_\_\_\_\_ Marital Status: Single, Married, Divorced, Widowed  
Email Address \_\_\_\_\_ Preferred method of communication for patient reminders? **EMAIL/PHONE/MAIL**  
Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Can we contact your doctor regarding your care in our office? Yes / No  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Types of tasks performed/common movements: \_\_\_\_\_  
Spouses Name: \_\_\_\_\_ # of children? \_\_\_\_\_ Children's ages?: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### ACCIDENTS:

Have you had an auto accident?  0-6mo  6 mo-1 yr  1-3yrs  3+yrs  Never  
Have you had a recent fall/other accident?  0-6mo  6 mo-1 yr  1-3yrs  3+yrs  Never  
Have you ever received chiropractic care?  Yes  No How Many \_\_\_\_\_ Last Visit \_\_\_\_\_  
Have you ever received physical therapy?  Yes  No Last Visit? \_\_\_\_\_

### REFERRALS: How Did You Hear About This Office?

Walk-In/Drive-By  Radio: \_\_\_\_\_  
 Existing Patient: \_\_\_\_\_  Ad: \_\_\_\_\_  
 Internet: \_\_\_\_\_  Community Event: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_  Other: \_\_\_\_\_

### INSURANCE:

Do you have health insurance?  Yes  No Name of Carrier: \_\_\_\_\_ ID Number \_\_\_\_\_  
Do you have a secondary insurance?  Yes  No Name of Carrier: \_\_\_\_\_ ID Number \_\_\_\_\_

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

### *Assignment and Release (insured patients)*

I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Bare Center for Chiropractic Wellness and Integrative Healthcare and Physical Medicine, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

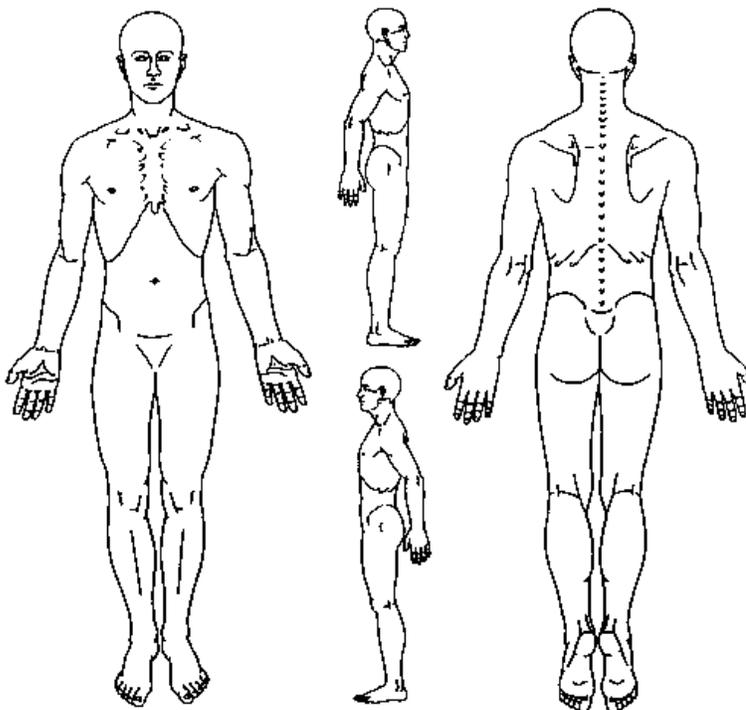
**SIGNATURE (X)** \_\_\_\_\_ **DATE** \_\_\_\_\_

I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature & frequency of care) **SIGNATURE (X)** \_\_\_\_\_ **DATE** \_\_\_\_\_

# PATIENT HEALTH HISTORY

Please check to indicate if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

- |  |  |
|--|--|
| <input type="checkbox"/> Neck Pain/Stiffness   | <input type="checkbox"/> Pins/Needles in Arms  |
| <input type="checkbox"/> Back Pain/Stiffness   | <input type="checkbox"/> Pins/Needles in Legs  |
| <input type="checkbox"/> Arm/Hand Pain         | <input type="checkbox"/> Light Bothers Eyes    |
| <input type="checkbox"/> Leg/Knee Pain         | <input type="checkbox"/> Weight Change + / -   |
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Loss of Memory        |
| <input type="checkbox"/> Night Pain            | <input type="checkbox"/> Nausea                |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Loss of Taste         |
| <input type="checkbox"/> Cold Extremities      | <input type="checkbox"/> Fatigue               |
| <input type="checkbox"/> Nervousness           | <input type="checkbox"/> Chest Pain            |
| <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension               |
| <input type="checkbox"/> Jaw Problems          | <input type="checkbox"/> Fever                 |
| <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats           |
| <input type="checkbox"/> Fainting              | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Allergies             |
| <input type="checkbox"/> Stomach Problems      | <input type="checkbox"/> Shortness of Breath   |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Blurred/Double Vision |
| <input type="checkbox"/> Swollen Joints        | <input type="checkbox"/> Bowel/Bladder Changes |
| <input type="checkbox"/> Mood Changes          | <input type="checkbox"/> Trouble Concentrating |
| <input type="checkbox"/> Foot Trouble          | <input type="checkbox"/> Loss of Balance       |



Please check if you have ever had any of the following:

- |   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> ADD/ADHD                             | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart Attack      | <input type="checkbox"/> Mouth Sores or Bleeding Gums | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Aids/HIV                             | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Heart Problems    | <input type="checkbox"/> Multiple Sclerosis           | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Alcoholism                           | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hemorrhoids       | <input type="checkbox"/> Mumps                        | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Allergy Shots                        | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Hepatitis         | <input type="checkbox"/> Nosebleeds                   | <input type="checkbox"/> TMJ Pain           |
| <input type="checkbox"/> Anemia                               | <input type="checkbox"/> Colon Trouble       | <input type="checkbox"/> Hernia            | <input type="checkbox"/> Osteoporosis                 | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Anorexia                             | <input type="checkbox"/> Contacts/Glasses    | <input type="checkbox"/> Herniated Disc    | <input type="checkbox"/> Pacemaker                    | <input type="checkbox"/> Tremors            |
| <input type="checkbox"/> Appendicitis                         | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Herpes            | <input type="checkbox"/> Parkinson's Disease          | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Arthritis                            | <input type="checkbox"/> Dry Skin            | <input type="checkbox"/> High Cholesterol  | <input type="checkbox"/> Pinched Nerve                | <input type="checkbox"/> Tumors/Growths     |
| <input type="checkbox"/> Asthma/Wheezing                      | <input type="checkbox"/> Ear Infections      | <input type="checkbox"/> Hormone Imbalance | <input type="checkbox"/> Pneumonia                    | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Bad Breath/Bad Taste                 | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Insomnia          | <input type="checkbox"/> Polio                        | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Bleeding Disorders                   | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Kidney Problems   | <input type="checkbox"/> Prostate Problems            | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Blood Pressure: High or Low (circle) | <input type="checkbox"/> Gall Bladder        | <input type="checkbox"/> Liver Disease     | <input type="checkbox"/> Prosthesis                   | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Breast Lump                          | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Measles           | <input type="checkbox"/> Psychiatric Care             | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Broken Bones                         | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Menopausal Prob.  | <input type="checkbox"/> Rheumatoid Arthritis         | <input type="checkbox"/> Other: _____       |
| <input type="checkbox"/> Bronchitis                           | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Migraines         | <input type="checkbox"/> Rheumatic Fever              | _____                                       |
| <input type="checkbox"/> Bulimia                              | <input type="checkbox"/> Gout                | <input type="checkbox"/> Miscarriage       | <input type="checkbox"/> Scarlet Fever                | _____                                       |
|   | <input type="checkbox"/> Heartburn           | <input type="checkbox"/> Mononucleosis     | <input type="checkbox"/> Sexual Difficulty            |   |

Are you currently under drug and/or medical care?  Yes  No If yes, explain

\_\_\_\_\_

Reason for visit today: (Conditions, Symptoms, or anything you would like to discuss)

\_\_\_\_\_

**SIGNATURE (X)** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Personal Medical History:** (Circle if applies)

Diabetes High Blood Pressure Pacemaker  
Heart Disease Stroke Fibromyalgia  
Thyroid Other: \_\_\_\_\_

**Family History:** (Circle if applies and list the family member and the type of condition if applies)

Inflammatory Arthritis Heart Disease Cancer  
Stroke Diabetes  
Other: \_\_\_\_\_

**History of Trauma:**

Auto (Date): \_\_\_\_\_ Slip/Fall (Date): \_\_\_\_\_  
Auto (Date): \_\_\_\_\_ Sport: \_\_\_\_\_  
Auto (Date): \_\_\_\_\_ Work: \_\_\_\_\_  
Other: \_\_\_\_\_ Other: \_\_\_\_\_

**Please list any surgeries and/or hospitalizations you have had (type & date):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:** (Please place a check mark next to any known allergy that you have)

Milk  Eggs  Peanuts  Almonds  Cashews  Walnuts  Fish  Shellfish  Soy  
 Wheat  Gluten  Penicillin  Sulfa Drugs  Tetracycline  Codeine  NSAIDS  Phenytoin  
 Carbamazepine  Mildew  Mold  Dust  Fungus  Mites  Tree Pollen  Grass Pollen  
 Weed Pollen  Insects  Dog Dander  Cat Dander  Latex  Other Animal Dander   
OTHER: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (please fill in)

**Are you currently taking any medications?** (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

**Do you have any medication allergies?**

Medication Name	Reaction	Onset Date	Additional Comments

**List of Supplements:** \_\_\_\_\_

**Hobbies:** \_\_\_\_\_

**Have you had to give up your hobbies or modify performing them due to your pain? (Please Circle) Yes / No**  
**How Does Your Pain Impact Your Activities of Daily Living?**

**Home/Recreational:** \_\_\_\_\_  
\_\_\_\_\_

**Work:** \_\_\_\_\_  
\_\_\_\_\_

**Prior Chiropractic experience?** \_\_\_\_\_

**SIGNATURE (X)** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Social History:**

Do you exercise:  Frequently  Moderately  Occasionally  None

Have you had to give up exercising or modify because of your pain? Yes / No

Do your work activities mostly involve:  Sitting  Standing  Light Labor  Heavy Labor

Hours per day spent: Sitting \_\_\_\_\_ Standing \_\_\_\_\_

Do you sleep on your:  Back  Side  Stomach Do you use a cervical pillow?  Yes  No

What is your daily/weekly intake of the following?

Caffeine \_\_\_\_\_ cups/day Alcohol \_\_\_\_\_ drinks/week Cigarettes \_\_\_\_\_ packs/day

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

**I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete and accurate information during my exam.**

**SIGNATURE (X)** \_\_\_\_\_ **DATE** \_\_\_\_\_

**X-ray Questionnaire: For women only**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_

There is a possibility that I may be pregnant at this time.  Yes, I am definitely pregnant

No, I am definitely not pregnant at this time  I request that x-ray films not be taken because:

\_\_\_\_\_

**SIGNATURE (X)** \_\_\_\_\_ **DATE** \_\_\_\_\_

**FOR MINORS:**

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_,  
(Print Guardian Name) (Print Minor's Name)

have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive treatment. **Patients under the age of 16 must be accompanied by a parent/guardian.**

\_\_\_\_\_  
**(SIGNATURE)**

\_\_\_\_\_  
**(PRINTED NAME)**

\_\_\_\_\_  
**(DATE)**

# **NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE**

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

For any YES answer, please explain under comment and notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES  
Comment: \_\_\_\_\_
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES  
Comment: \_\_\_\_\_
3. Do your hands or arms fall asleep regularly? NO YES  
Comment: \_\_\_\_\_
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES  
Comment: \_\_\_\_\_
5. Do you suffer from a loss of handgrip strength? NO YES  
Comment: \_\_\_\_\_
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES  
Comment: \_\_\_\_\_
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES  
Comment: \_\_\_\_\_
8. Do your legs or feet fall asleep regularly? NO YES  
Comment: \_\_\_\_\_
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES  
Comment: \_\_\_\_\_
10. Do you suffer from cold hands or feet? NO YES  
Comment: \_\_\_\_\_
11. Have you tried any medications such as anti-inflammatory? NO YES  
If yes, what kind of medication? \_\_\_\_\_
12. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES  
If yes: When? For how long? What kind? \_\_\_\_\_
13. Have you had an MRI? NO YES  
If yes: When? Who ordered it? What was it ordered for? \_\_\_\_\_  
\_\_\_\_\_
14. Have you used any splint or braces or other prescribed treatment by an MD? NO YES  
If yes: When? What kind? Who ordered it? \_\_\_\_\_  
\_\_\_\_\_
15. If you have tried any treatment or medications, did this make your problem better? NO YES  
Comment: \_\_\_\_\_

**NOTE: Your health information will be kept strictly confidential.** Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

## **TERMS OF ACCEPTANCE AND CONSENT FOR CARE**

We will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition.

**Consent to Treat:** I request and give consent to my physician to provide and perform such medical/ surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties, or guarantees as the results or cures have been made to me or relied upon me.

**Consent to Testing:** I am fully aware that the physician may order testing that he/she deems appropriate in my treatment. I am aware Integrative Healthcare and Physical Medicine plays a large role in verifying insurance benefits on my behalf, and although most testing is verified, it is my responsibility to know my insurance coverage. If I refuse any diagnostic testing/ labs/ urine screening, I understand that the physician has the right to terminate the patient / physician relationship at any time.

**H.H.S:** Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES is available to me immediately upon request.

**Medicare Certification:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and / or the Medicare program or its intermediaries of carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

**Chiropractic Care:** The primary focus of chiropractic care is the detection and correction of vertebral subluxation. This is the misalignment of one or multiple spinal bones with interference to the nervous system. Any interference to the nervous system may or may not cause various different symptoms.

Through specific chiropractic adjustments, we reduce and/or correct these subluxations. It may be necessary to examine an individual each time a new injury occurs and often x-rays are necessary to maintain the utmost safety when dealing with your body. The risks of physical medicine, chiropractic care or massage therapy are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

**Soreness:** I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

**Dizziness:** Temporary symptoms like dizziness and nausea can occur but are relatively rare.

**Fractures/Joint Injury:** I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

**Physical Therapy Burns:** Some therapies used in this office generate heat & may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

**Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

I also understand that the fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There is a fee for copying of the xrays this is \$25.00.

Also, for your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the front desk check-out stations.

I have read and I accept the terms above and understand them fully. I hereby give consent to Integrative HealthCare & Physical Medicine, Ocala and Bare Center for Chiropractic Wellness to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

*I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.*

I, \_\_\_\_\_ have read and fully understand the above statements.  
(PRINT NAME)

**SIGNATURE (X)** \_\_\_\_\_ **DATE** \_\_\_\_\_

### *Special Financial Information Section*

Many insurance companies require physicians to attempt to collect any unpaid portion of the annual deductible and/or co-payment and/or regular treatment fees from the patient. However, certain conditions may permit a physician's office to waive (partially or fully) the collection of these amounts. One of the conditions is the patient's financial hardship. Based upon discussions with me, this office has determined that due to my financial hardship, I am unable to pay (partially or in full) the deductible and/or the co-payment and/or regular treatment fees. If I were forced to pay the annual deductible and/or the co-payment and/or the regular treatment fees, I would not be able to receive the necessary treatment for my health condition(s). Due to these circumstances, this office is waiving (partially or in full) my obligation for payment of charges for the services rendered in this office. However, if based upon future discussions with me regarding my financial situation, this office determines that my situation has improved enough to enable me to fully pay the annual deductible and/or co-payment and/or regular treatment fees, this office will require payment of charges incurred at that time.

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# PRIVACY REPORT

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Integrative Healthcare & Physical Medicine, Ocala and Bare Center for Chiropractic Wellness, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care. If we are ordered by the courts or another appropriate agency.

*This practice is a multi specialty practice with multiple providers, you may at anytime be treated by any and/or all of them. In this situation it is possible to be provided, be billed, and receive records from either BARE CENTER FOR CHIROPRACTIC WELLNESS or INTEGRATIVE HEALTHCARE AND PHYSICAL MEDICINE, OCALA. I give both entities permission to request records, perform services and bill out for services received by me.*

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Preston Bare. If you would like further information about our privacy policies and practices please contact: Dr. Preston Bare

This notice is effective as of January 1, 2018. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**HIPAA-COMPLIANT  
AUTHORIZATION TO RELEASE PATIENT INFORMATION  
PURSUANT TO 45 C.F.R. §164.508**

Patient's Full Name: \_\_\_\_\_

Date: \_\_\_\_\_

Patient SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**I authorize the following organization, individual, or entity to disclose protected health information identified below:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Information Requested:** The Patient identified above authorizes the disclosure of all protected medical information in any form (including oral, written and electronic) to the Requestors listed below, and Requestors' re-disclosure of the data and information to its agents, consultants, counsel, and whomever Requestors deems reasonable and necessary to further the administration of the Requestor's suggested treatment and care of the Patient. Patient expressly requests that all covered entities under HIPAA identified above shall disclose full and complete protected health information concerning the Patient, relating to the time period beginning on \_\_\_\_\_ and ending on \_\_\_\_\_, inclusive. This includes, but is not limited to, the following:

- All medical records, including, but not limited to: inpatient & emergency room treatment; all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, examination reports, office and doctor's handwritten notes, and records received from other physicians or health care providers
- All laboratory, histology, cystology, pathology, radiology, CT scan, MRI, echocardiogram reports
- All radiology films
- All pharmacy prescription records.

The Patient hereby authorizes the above information be released or disclosed to:

**Integrative Healthcare & Physical Medicine, Ocala Ph. (352) 369-6325**

**Bare Center for Chiropractic Wellness**

**3773 S. Pine Ave. Ocala, FL 34471**

**Fax (352) 369-6329**

**I understand the following:**

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- I understand that, after information is released under this authorization, it may be re-disclosed by the recipient, and if re-disclosed, the information will no longer be protected by federal or state privacy rules.
- I understand that I am entitled to receive a copy of this authorization.
- My treatment, payment for treatment and enrollment or eligibility for benefits cannot be conditioned on the signing of this authorization.
- This authorization will expire one (1) year from the date signed below.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

IF THIS AUTHORIZATION IS SENT BY FAX, IT IS INTENDED ONLY FOR THE USE OF THE PERSON OR OFFICE TO WHOM IT IS ADDRESSED, AND CONTAINS PRIVILEGED OR CONFIDENTIAL INFORMATION PROTECTED BY LAW. ALL RECIPIENTS ARE HEREBY NOTIFIED THAT INADVERTENT OR UNAUTHORIZED RECEIPT DOES NOT WAIVE SUCH PRIVILEGE, AND THAT UNAUTHORIZED DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS PROHIBITED. IF YOU HAVE RECEIVED THIS FAX IN ERROR, PLEASE DESTROY THE ATTACHED DOCUMENT(S) AND NOTIFY THE SENDER OF THE ERROR BY CALLING (352) 369-6325. IF YOU DO NOT RECEIVE ALL OF THE PAGES, OR IF YOU HAVE ANY PROBLEMS WITH THIS TRANSMISSION, PLEASE CALL (352)369-6325.