PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone ( )_____

Address _____ City_____ State_____ Zip_____

Age _____ Date of Birth _____ Sex _____ SSN _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Name on Policy(if other than self)_____

Responsible Party's Name _____

Address_____

Policy Holder's Name _____ Policy #_____

ATTORNEY

Name _____ Phone ( ) _____

Address_____ City_____ State_____ Zip_____

Were there any witnesses? Y / N Name(s) _____

NATURE OF ACCIDENT

Date of Accident_____ Time of Day_____

Were you ( )Driver ( )Passenger ( )Front Seat ( )Back Seat

Number of people in your vehicle _____ Were you wearing seat belts Y/N

What direction were you headed ( )North ( )East ( )South ( )West

on (name of street) _____

Were you struck from ( )Behind ( )Front ( )Left Side ( )Right Side

Approximate speed of your car _____ mph Other car_____ mph

Were you knocked unconscious Y / N If yes, how long _____

Were police notified Y / N

In your own words, please describe the accident _____

_____

_____

_____

Did you have any physical complaints BEFORE the accident Y / N If yes, please describe ____

_____

_____

_____

Please describe how you felt:

During the accident_____

Immediately after the accident_____

Later that day_____

The next day_____

Continued

What are your present complaints and symptoms_____

_____

Do you have any congenital (from birth) factors which relate to this problem Y / N If yes, please describe _____

_____

Do you have any previous illnesses which relate to this case Y / N If yes, please describe _____

_____

Have you ever been involved in an accident before Y / N If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received _____

_____

_____

Where were you taken after the accident_____

Have you been treated by another doctor since the accident Y / N If yes, please list doctor(s) name and address _____

_____

What type of treatment(s) did you receive _____

Since this injury occurred are your symptoms ( )Improving ( )Getting Worse ( )Same

CIRCLE SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

HEADACHE	IRRITABILTY	NUMBNESS IN TOES	FACE FLUSHED	FEET COLD
NECK PAIN	CHEST PAIN	SHORTNESS OF BREATH	BUZZING IN EARS	HANDS COLD
NECK STIFF	DIZZINESS	FATIGUE	LOSS OF BALANCE	STOMACH UPSE
SLEEPING PROB	HEAD SEEMS HEAVY	DEPRESSION	FAINTING	CONSTIPATION
BACK PAIN	PINS&NEEDLES ARMS	LIGTH BOTHERS EYES	LOSS OF SMELL	COLD SWEATS
NERVOUSNESS	PINS&NEEDLES LEGS	LOSS OF MEMORY	LOSS OF TASTE	FEVER
TENSION	NUMB IN FINGERS	EARS RING	DIARRHEA	

Symptoms other than above _____

Have you lost time from work as a result of the accident Y / N If yes, Please answer following questions

Last day worked _____

Type of employment _____

Present salary _____

Are you being compensated for time lost from work Y / N If yes, please state type of compensation you are receiving _____

Do you notice any activity restrictions as a result of this injury Y / N If yes, please describe in detail _____

_____

_____

Other pertinent information _____

_____

Date _____ Signature _____

Name _____ Date _____

MODIFIED ZUNG INDEX

PLEASE INDICATE FOR EACH OF THESE QUESTIONS WHICH ANSWER BEST DESCRIBES HOW YOU HAVE BEEN FEELING RECENTLY				
	RARELY OR NONE OF THE TIME (less than 1 day per week)	SOME OR A LITTLE OF TIME (1-2 days per week)	A MODERATE AMOUNT OF TIME (3-4 days per week)	MOST OF THE TIME (5-7 days per week)
1. I feel downhearted and sad	0	1	2	3
2. Mornings are when I feel best	3	2	1	0
3. I have crying spells or feel like it	0	1	2	3
4. I have trouble getting to sleep at night	0	1	2	3
5. I feel that nobody cares	0	1	2	3
6. I eat as much as I used to	3	2	1	0
7. I notice I am losing weight	0	1	2	3
8. I have trouble with constipation	0	1	2	3
9. My heart beats faster than usual	0	1	2	3
10. I get tired for no reason	0	1	2	3
11. My mind is as clear as it used to be	3	2	1	0
12. I tend to wake up too early	0	1	2	3
13. I find it easy to do the things I used to	3	2	1	0
14. I am restless and can’t keep still	0	1	2	3
15. I feel hopeful about the future	3	2	1	0
16. I am more irritable than usual	0	1	2	3
17. I find it easy to make a decision	3	2	1	0
18. I feel quite guilty	0	1	2	3
19. I feel that I am useful and needed	3	2	1	0
20. My life is pretty full	3	2	1	0
21. I feel that others would be better off if I were dead	0	1	2	3
22. I am still able to enjoy the things I used to	3	2	1	0
Reproduced, with permission. Main CJ, Et Al., 1984.				

TOTAL SCORE _____

Patient Signature _____

Name _____ Date _____

MODIFIED SOMATIC PERCEPTION QUESTIONNAIRE

PLEASE DESCRIBE HOW YOU HAVE FELT DURING THE PAST WEEK BY MAKING A CHECKMARK IN THE APPROPRIATE BOX. PLEASE ANSWER ALL QUESTIONS. DO NOT THINK TOO LONG BEFORE ANSWERING				
	Not at all	A little, slightly	A great deal, quite a bit	Extremely, could not have been worse
1. Heart rate increase	0	1	2	3
2. Feeling hot all over	0	1	2	3
3. Sweating all over	0	1	2	3
4. Sweating in a particular part of the body	0	1	2	3
5. Pulse in the neck	0	1	2	3
6. Pounding in the head	0	1	2	3
7. Dizziness	0	1	2	3
8. Blurring of vision	0	1	2	3
9. Feeling faint	0	1	2	3
10. Everything appearing unreal	0	1	2	3
11. Nausea	0	1	2	3
12. Butterflies in stomach	0	1	2	3
13. Pain or ache in stomach	0	1	2	3
14. Stomach churning	0	1	2	3
15. Desire to pass water	0	1	2	3
16. Mouth becoming dry	0	1	2	3
17. Difficulty swallowing	0	1	2	3
18. Muscles in neck aching	0	1	2	3
19. Legs feeling weak	0	1	2	3
20. Muscles twitching or jumping	0	1	2	3
21. Tense feeling across forehead	0	1	2	3
22. Tense feeling in jaw muscle	0	1	2	3
Reproduced, with permission. Main CJ, 1983.				

TOTAL SCORE _____

Patient Signature _____

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel more than one statement relates to you, but PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 – Pain Intensity A. The pain comes and goes and is very mild B. The pain is mild and does not vary much C. The pain comes and goes and is moderate D. The pain is moderate and does not vary much E. The pain comes and goes and is severe F. The pain is severe and does not vary much	SECTION 6 – Standing A. I can stand as long as I want without pain B. I have some pain while standing, but it does not increase with time C. I cannot stand for longer than 1 hour without pain D. I cannot stand for longer than ½ hour without pain E. I cannot stand for longer than 10 minutes without pain F. I avoid standing, because it increases pain straight away
SECTION 2 – Personal Care A. I would not have to change my way of washing or dressing in order to avoid pain B. I do not normally change my way of washing or dressing even though it cases some pain C. Washing and dressing increases the pain, but I manage not to change my way of doing it D. Washing and dressing increases the pain and I find it necessary to change my way of doing it E. Because of the pain, I am unable to do some washing and dressing without help F. Because of the pain, I am unable to do any washing or dressing without help	SECTION 7 – Sleeping A. I get no pain in bed B. I get pain in bed, but it does not prevent me from sleeping well C. Because of pain, my normal nights sleep is reduced by less than ¼ D. Because of pain, my normal night's sleep is reduced by less than ½ E. Because of pain, my normal night's sleep is reduced by less than ¾ F. Pain prevents me from sleeping at all

SECTION 3 – Lifting A. I can lift heavy weights without extra pain B. I can lift heavy weights, but it causes extra pain C. Pain prevents me from lifting heavy weights off the floor D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned e.g. on a table E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned F. I can only lift very light weights, at most	SECTION 8 – Social Life A. My social life is normal and gives me no pain. B. My social life is normal, but increases the pain C. Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. dancing D. Pain has restricted my social life and I do not go out very often E. Pain has restricted my social life to my home F. I have hardly any social life because of the pain
SECTION 4 – Sitting A. Pain does not prevent me from walking any distance B. Pain prevents me from walking more than one mile C. Pain prevents me from walking more than ½ mile D. Pain prevents me from walking more that ¼ mile E. I can only walk while using a cane or crutches F. I am in bed most of the time and have to crawl to the toilet	SECTION 9 – Traveling A. I get no pain while traveling B. I get some pain while traveling, but none of my usual forms of travel make it worse C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel D. I get extra pain while traveling which compels me to seek alternative forms of travel E. Pain restricts me from all forms of travel F. Pain prevents all form of travel except that done lying down
SECTION 5 – Sitting A. I can sit in any chair as long as I like without pain B. I can only sit in my favorite chair as long as I like C. Pain prevents me from sitting more than one hour D. Pain prevents me from sitting more than ½ hour E. Pain prevents me from sitting more than 10 minutes F. Pain prevents me from sitting at all	SECTION 10 – Changing Degree of Pain A. My pain is rapidly getting better B. My pain fluctuates, but is definitely getting better C. My pain seems to be getting better, but improvement is slow D. My pain is neither getting better or worse E. My pain is gradually worsening F. My pain is rapidly worsening

DOCTOR'S LIEN AND PAITENT RECORDS RELEASE

ATTORNEY _____ DOCTOR _____

_____ _____

_____ _____

TO: My Attorney	RE: Doctor's Lien and Patient Records

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of my case history, examination, diagnosis, treatment, and prognosis of myself in regards to the accident in which I was involved on _____ (date).

I further hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing said doctor for medical services rendered to me by both reason of this accident and by reason of any other bills that are due to the doctor's office and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect and fully compensate said doctor. And, I hereby further give a lien on my case to said doctor against

any and all proceeds of my settlement, judgement, claim, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by said doctor for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of the doctor awaiting payment. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee. In the event no settlement, judgement or verdict is rendered in my favor, or in the event that said settlement, judgement or verdict is insufficient to pay the full amount of the doctor's fees, that I will owe all unpaid fees immediately. Reasonable attorney fees and costs may be collected in the event of breach of this lien. Any and all alterations, modifications, releases, and/or cancellations of or to this lien must be made in writing, signed by doctor.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Date_____ Patient's Signature _____

The undersigned, being attorney of record for the above patient, does hereby acknowledge receipt of the above lien and does agree to honor same to protect doctor.

Date_____ Attorney's Signature _____

Attorney: Please date, sign, and return one copay to doctor's office at once

Health Care Center

3525 Mitchell Road – PO Box 608
Bedford, IN 47421

_____
_____
_____
_____

_____/_____/20___

To whom it may concern:

Claim # _____

I hereby request that the name, Health Care Center, be included on the check for payment of services for our patient _____ rendered for chiropractic care at the Health Care Center, issued by the third party insurance company, for the above listed Claim Number.

Sincerely,

_____ _____

Signature of patient Signature Insurance Co. Representative

_____ _____

Printed Name Date Printed Name Date

Please fax this completed form back to the Health Care Center as soon as possible. Thank you.

812-275-4419 (fax)

HEALTH CARE CENTER

PATIENT INFORMATION

Please print and answer the following questions as accurate and complete as possible.

Today's Date: _____

PERSONAL INFORMATION

Name: _____ Age:_____ Sex: M F

(first) (MI) (Last)

Address: _____

City:_____ State: _____ Zip: _____

Home Phone: _____ Date of Birth _____/_____/_____ SS#_____-_____-_____

Cell Phone: _____ Business/Employer: _____ Work Phone: _____

Email Address: _____ Would you like to receive our newsletter? Y N

Type of work performed: _____ Marital Status: M S W D

Spouse's Name: _____ Children: Sons:_____ Daughters:_____

Emergency Contact:_____ Phone: _____

Who is your Family Physician:_____ Phone: _____ City: _____

How were you referred to this office:_____ Would you like report sent to your family physician: Y N

CURRENT HEALTH CONCERNS

Reason for today's visit (be specific): _____

When did this begin: _____ Experienced Previously: Y N

Is Condition: Job Related Auto Related Injury Other:_____

Other Doctors seen for this problem: _____

Previous Doctor's Opinion/Diagnosis: _____

Were any X-rays/MRI's done: Y N Where Done: _____

Other or Secondary complaints: _____

PAST HEALTH HISTORY

Major Surgeries/Operations: HEAD NECK/THROAT CHEST/HEART/LUNG

BACK ABDOMINAL

OTHER:_____

Previous Fractures or Broken Bones: YES NO
What:_____
Previous Falls or Accidents: YES NO
When:_____
Previous Hospitalizations: YES NO
Why:_____
Previous Chiropractic Care: YES NO Who:
_____
Medications Now Taking:
_____
_____
_____

PATIENT NAME:_____ DATE OF BIRTH:
_____

Below is a list of diseases and disorders that may seem unrelated to the purpose of your appointment. However, the following information may affect your response to our care as well as our approach to handing your case. Please complete the following as thoroughly as possible.

CHECK ANY OF THE FOLLOWING THAT APPLIES TO YOU:

Allergies	Kidney Problems	Gout	Addictions past/present
Diabetes	Osteo-Arthritis	Chronic Fatigue	Intake or Use:

Cancer	Epilepsy	Lupus	Alcohol
Heart Problems	AIDS or ARC	ALS/MS	Tobacco (chew or smoke)
Stroke	Frequent Illnesses	Parkinson's	Caffeine
Pacemaker	Fibromyalgia	Rheumatoid Arth	Drugs of Abuse

Do you exercise regularly? YES NO Are you dieting? YES NO Since:_____

CHECK ANY PROBLEM AREAS THAT YOU HAVE HAD IN THE PAST YEAR:

MUSCLES/SKELETON
Low Back
Middle Back
Neck
Arm(s)
Leg(s)
Shoulder(s)
Knee(s)

GENITALS
Jaw-TMJ
General Stiffness

NERVE SYSTEM
Headaches
Nervousness
Depression
Numbness/Tingling
Muscular Weakness
Dizziness
Fainting
Convulsions/Seizures
Stress
Shaking/Tremors

CIRCULATION/BREATHING
Chest
Breathing
Blood Pressure
Heart
Lungs
Poor Circulation

DIGESTION/ELIMATION
Poor Appetite
Excessive Thirst
Nausea
Diarrhea
Constipation
Hemorrhoids
Weight Loss/Gain
Gas/Bloating
Heartburn

MALES ONLY
Prostate Problems
Testicular Problems
Erectile Dysfunction

EYE-EAR-NOSE-THROAT
Eyes
Dental
Throat
Ear(s)
Nose
Sinus

URINARY/
Pain Upon Urination
Infrequent Urination
Frequent Urination
Weak Urine Stream
Bladder Control

FEMALES ONLY
Menstrual Problems
Low Back Pain w/ Periods
Breast Lump(s)/Problems
Hot Flashes
Postmenopausal

ARE YOU PREGNANT?
YES NO NOT SURE

FAMILY HISTORY: (I.E. heart, cancer, stroke, diabetes, blood pressure, etc.)
Mother's Side:_____

Father's Side: _____

Any Other Problems Not Listed Above:_____

SIGNATURE: _____ DATE: _____

PAIN DRAWING

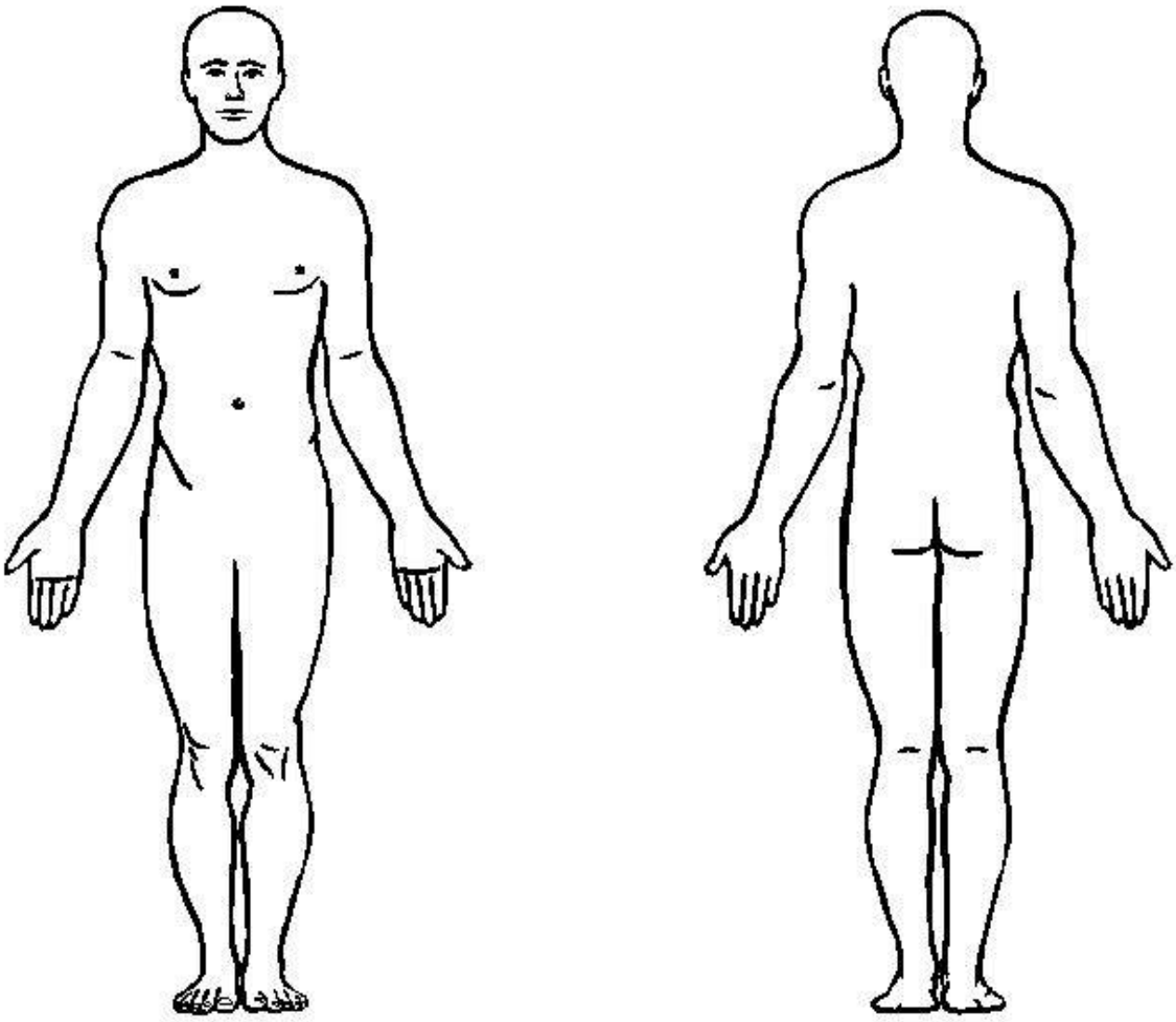
Name: _____ Date: _____

Date of Birth: _____ Examiner: _____

TELL US WHERE YOU HURT

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

ACHE > > > > >	NUMBNESS = = = =	PINS & NEEDLES O O O O
BURNING X X X X	STABBING / / / / /	THROBBING ~ ~ ~ ~ ~



ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration for treatment rendered or to be rendered, assigns to the physician or facility named below to following right, power and authority.

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster, for the purpose of processing my claim for benefits and payment of service rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned to exclusive irrevocable right to any cause of action that exists in my favor against any insurance company for benefits to the extent of your bill for total services if such benefits are owed within the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance or state statute. I, as the patient and/or the responsible part, further agree to cooperate and provide information as needed, and appear as needed wherever, to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named below, you are hereby tendered demand for pay in full the bill for services rendered by the physician/facility named below within 60 days following your receipt of such bill which I/we owe personally which are not payable under the terms of your policy. This demand specifically conforms to this state's insurance code, providing for attorney fees, penalty, court costs, collection costs, and interest from judgement, upon violation.

THIRD PARTY LIABILTY: If patient(s)' treatment for injuries are the result of the negligence of any third party, then patient(s) grant a lien and assignment of cause of action against any right of recovery from such third party(s) to the extent of the bills for treatment, in favor of the physician/facility named below.

INSURANCE AGREEMENT: I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. This demand specifically conforms to this state's insurance code, providing for attorney fees, penalty, court costs, and interest from judgement, upon violation. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

A photocopy of this instrument shall serve as original.

X_____ _____

Signature of patient and/or responsible party Date

HEALTH CARE CENTER
3525 Mitchell Road, Bedford, IN 47421

Informed Consent

Name: _____ Date of Birth: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign it if there is anything that is unclear.

The nature of chiropractic treatment: The primary treatment I use as a Doctor of Chiropractic is spinal manipulation therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joins. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment: As a part of the analysis, examinations, and treatment, you are consenting to the following procedures if indicated in your treatment, spinal manipulation therapy, ultrasound/laser therapy, hot/cold therapy, electrical stimulation, exercise, massage therapy, graston technique, spinal decompression, radiographic studies, range of motion testing, muscle strength testing, palpation, orthopedic testing, postural analysis, vital signs, basic neurological testing, EMS.

The material risks inherent in chiropractic treatment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one if five million cervical adjustments. The other complications are generally described as rare.

The availability and nature of other treatment options: Other treatment options for your condition may include, self-administered, over the counter analgesics, and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, hospitalizations, and surgery. If you choose one of the above noted "other treatment" options, you should be aware that there are risks and benefits to such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Please check appropriate block and sign below.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I State that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date:_____ Date: _____

Patient's Name: _____ Doctor's Name: _____

Signature: _____ Signature: _____

Signature of Parent or Guardian if a minor: _____

HEALTH CARE CENTER

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby request and authorize _____ to furnish to

Health Care Center
3525 Mitchell Road
PO Box 608
Bedford, IN 47421
Phone: 812-275-4419 Fax: 812-275-8044

Access to or copies of the medical records (specified below) for the following person:

Patient's Name : _____
(Last) (First) (Middle/Maiden)

Address: _____

Date of Birth:_____ Social Sec. No: _____

Phone Number: _____

__ Admission History and Physical	__Discharge Summary	__Progress Notes
__Consultations	__Lab Reports	__Pathology Reports
__ Xray Reports	__ Xray Films	__ Therapy Notes
__ Diagnostic Test Results	__Clinic Notes	__ Specify other below

_____

For the purpose of: _____

I understand that this authorization is subject to written revocation at any time except to the extent that action has been taken based upon it.

Date: _____ Signature: _____
(patient)

Signature: _____
(parent/guardian) (relationship)

Witness: _____
(if patient is unable to sign) (reason)

Information used or disclosed because of this authorization may be further disclosed by the recipient and would therefore be no longer protected.

Acknowledgement of HIPAA Privacy Notice and Designation of Disclosure

Acknowledgement of Health Care Center's Notice of HIPAA Privacy
I have received or read a copay of the notice of HIPAA Privacy for the Physician's Practice

_____	_____	_____	_____
(Patient Name)	(Date of Birth)	(Signature of Patient/Guardian)	(Date)

Designation of certain relative, close friends, and other caregivers

I agree that the practice may disclose my health information to a family member, close personal friend, or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, the Health Care Center will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner.
Check all that apply

____Home Telephone/Answering Machine	____Home Address
____Work Telephone/Voice Mail	____Work Address
____OK to leave message with detailed information	____OK to mail my home address
____OK to leave message with Doctor's name	____OK to mail my work/office address
____Leave message with call back numbers only	____Other

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name: _____ Relationship to Patient: _____

Print Name: _____ Relationship to Patient: _____

Print Name: _____ Relationship to Patient: _____

The following person(s) are NOT allowed to receive my Patient Health Information:

Print Name: _____ Print Name: _____

Please note that if the above sections are NOT completed, we will assume that we have your approval to contact you using any of these methods.

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for, Patient Health Information to the minimum necessary to accomplish the intended purpose.

These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Uses and disclosures for treatment, payment, and health care operations may be permitted without prior consent.