Physicians Health and Rehab PC **Phone (573) 883-2442**
21995 Highway 32, Sainte Genevieve, MO 63670 **Fax (573) 883-2281**

New Patient Registration

Name _____Age _____ Date _____

Address _____ City _____ State_____ Zip_____

Phone (Home) _____ Date of Birth _____ Sex: M F

Marital Status: S M D W Social Security # _____

Driver's License #_____

Occupation Employer _____ Phone (Work)_____

Insurance Company_____ Phone_____

Insured's Name _____Insured's Date of Birth _____

Insured's ID. # or S.S. # _____

Spouse's Name _____Spouse's Occupation _____

Spouse's Employer _____Spouse's Phone (Work)_____

Spouse's Insurance Co. _____ Phone_____

Spouse's Social Security # _____

Present condition due to an injury? __ Yes __ No __ On the Job __ Auto Accident __ Other _____

Has the accident been reported? __ Yes __ No __ To Employer __ Auto Carrier __ Other _____

Your Email address_____

Who may we thank for referring you to our office? _____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have more detailed account of our policies and procedures concerning privacy of your PHI we encourage you to read the HIPPA Notice that is available to you at the front desk before signing this consent.

1. The Patient understands and agrees to allow Physicians Health and Rehab to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been and submitted in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient;s written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For security and right of privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Physicians Health and Rehab to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature_____ Date:_____

Spouse's or Guardian's Signature:_____ Date:_____