On Staff Chiropractic Physicians
Winchester Hospital
A Member of Beth Israel Lahey Health

Winchester Chiropractic Center
300 Trade Center Suite 4460
Woburn, MA 01801
Telephone (781)933-5051 | Fax (781)933-5054
winchesterchirocenter@gmail.com
winchesterchirocenter.com

WINCHESTER CHIROPRACTIC CENTER
PATIENT INFORMATION – MOTOR VEHICLE ACCIDENT

PERSONAL INFORMATION

Name: ____
First Name   Middle Name   Last Name

Sex: ☐Male ☐Female   Date of Birth: ________________   Height: ____________   Weight: ____________

Home Address: ____
Street   City   State   ZIP

Home Telephone: ______________________   Work Telephone: ______________________

Marital Status: ________________   Employer: ______________________________

EMERGENCY CONTACT

Name: ____
First Name   Middle Name   Last Name

Relationship: ______________________   Telephone: ______________________

MOTOR VEHICLE ACCIDENT INSURANCE INFORMATION

Date of Accident: ________________   State Where Accident Occurred: ______________________

Your MVA Insurance Company Name: ______________________________   Claim # ____________

Policy # ______________________   Claims Adjuster: ______________________

Claims Adjuster Telephone: ______________________   Your Attorney: ______________________

Address: ____
Street   City   State   ZIP

Telephone: ____

YOUR HEALTH INSURANCE INFORMATION

Name of Insurance Company: ____

Policy # ______________________   Group # ______________________

Subscriber's Date of Birth: ______________________   Subscriber's Employer ______________________

Date of Injury: ________________ (If applicable)

Please describe anything you do that improves your condition or worsens it:

____

____

Please check off and describe how this problem interferes with your work and/or personal life

- ☐ Home Activities Affected: ______________________________
- ☐ Work Activities Affected: ______________________________
- ☐ Have you missed any work days? ☐ Yes ☐ No If yes, dates missed: ______________________________
- ☐ Recreational Activities Affected: ______________________________
- ☐ Rest or Sleep Affected: ☐ Yes ☐ No

HEALTH HISTORY

SURGICAL HISTORY

PLEASE LIST YOUR SURGICAL HISTORY INCLUDING DATES IF YOU KNOW THEM:

______________ ______________ ______________

______________ ______________ ______________

Have you ever received Chiropractic care? ☐ Yes ☐ No If yes, please list the doctor's name, location of office and for what problems: ______________________________

MEDICATIONS

LIST MEDICATIONS INCLUDING VITAMINS YOU ARE CURRENTLY TAKING:

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

ALLERGIES

PLEASE LIST YOUR KNOWN ALLERGIES:

______________ ______________ ______________

FAMILY HISTORY

IF YOU HAVE A FAMILY HISTORY OF ANY MEDICAL PROBLEMS, PLEASE LIST THEM:
EXAMPLE: Cancer, High blood pressure, Diabetes, Stroke, Clotting disorders, High cholesterol etc.

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Number of Children: ______________ Name of spouse: ______________________________

Do you smoke? ☐ Yes ☐ No If yes, how much? __________ Do you drink? ☐ Yes ☐ No If yes, how much? __________

Do you exercise? ☐ Yes ☐ No If yes, how much? ______________________________

FINANCIAL RESPONSIBILITY

Who is responsible for your bill? ☐ I am ☐ Spouse ☐ My Employer ☐ Insurance

☐ Other: ______________________________

Type of Insurance: ☐ Worker's Comp. ☐ Health ☐ Automobile

Insurance Company Name & Address: ______________________________

____

Patient's
Signature: ______________________________ Date: ______________

On Staff Chiropractic Physicians
Winchester Hospital
A Member of Beth Israel Lahey Health

Winchester Chiropractic Center
300 Trade Center Suite 4460
Woburn, MA 01801
Telephone (781)933-5051 | Fax (781)933-5054
winchesterchirocenter@gmail.com
winchesterchirocenter.com

MOTOR VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date: ____________________

Patient Name: ____

Date of Accident: ______________________ Time of Accident: ____________ ☐a.m ☐p.m

____

____

____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the Accident vehicle? ________

ACCIDENT SITE

Road/Street Name: ______________________

City/State: ______________________

Nearest intersection with road/street: ______________________

Driving conditions: ☐Dry ☐Wet ☐Icy ☐Other ________

Which direction were you headed? ______________________

Speed you were travelling? ______________________

VEHICLE

Make and model of vehicle you were in:

____

Were you wearing a seatbelt? ☐ Yes ☐No
  If yes, what type? ☐ Lap ☐Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐No
  If yes, did it/they inflate properly? ☐ Yes ☐No

Did your seat have a headrest? ☐ Yes ☐No
  If yes, what was the position of the headrest?
  ☐ Low ☐Midposition ☐High

OTHER VEHICLE
(If applicable)

Make and model of other vehicle ______________________

Which direction was other vehicle headed? ______________________

Speed other vehicle was traveling ______________________

IMPACT

Did your car impact another vehicle? ☐Yes ☐No

Did your car impact a structure? ☐Yes ☐No

If yes, explain ______________________

____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐No If yes, explain ______________________

Was impact from:

☐ Front ☐Rear ☐Left ☐Right ☐Other ______________________

At the time of impact were you:
☐ Looking straight ahead ☐ Looking to the right
☐ Looking to the left ☐ Looking down
☐ Looking up

Were both hands on the steering wheel? ☐Yes ☐No
  If no, which hand was on the wheel? ☐Right ☐Left

Was your foot on the brake? ☐Yes ☐No
  If yes, which foot was on the brake? ☐Right ☐Left

Were you: ☐Surprised by impact ☐Braced for impact

POLICE

Did the police come to the accident site? ☐Yes ☐No
Were there any witnesses? ☐Yes ☐No
Was Police report filed? ☐Yes ☐No
Was a traffic violation issued? ☐Yes ☐No
  If yes, to whom? ______________________

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐Yes ☐No If yes, for how long? ____________________

Please describe how you felt immediately after the accident:

____

____

TREATMENT

Did you go to the hospital? ☐Yes ☐No

When did you go? ☐Immediately after accident ☐Next day ☐2 days or more after the accident

How did you get to the hospital? ☐Ambulance ☐Private transportation

Name of hospital ____________________ Name of doctor ____________________

Diagnosis ____

____

Treatment received ____

X-rays taken ____

SYMPTOMS / INJURIES

Have you been able to work since this injury? ☐Yes ☐No How many work days have you missed? ____________

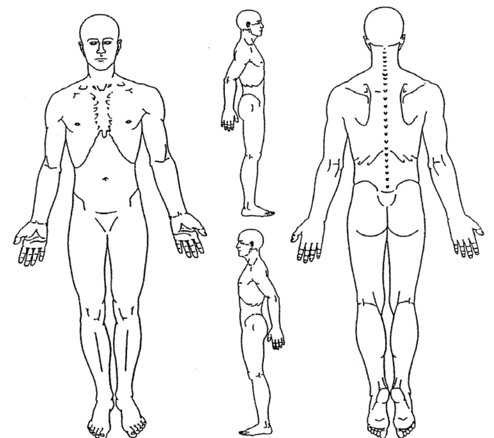
Prior to the injury were you able to work on an equal basis with others your age? ☐Yes ☐No

If you have had any of the following symptoms since your injury, please ☐check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other ________

How often do you have this pain? ____________________

Is it constant or does it come and go? ____________________

Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Movements that are painful to perform: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Date

____
Please print name of Patient, Guardian or Personal Representative

____
Relationship to Patient

On Staff Chiropractic Physicians
Winchester Hospital
A Member of Beth Israel Lahey Health

Winchester Chiropractic Center
300 Trade Center Suite 4460
Woburn, MA 01801
Telephone (781)933-5051 | Fax (781)933-5054
winchesterchirocenter@gmail.com
winchesterchirocenter.com

REVIEW OF SYSTEMS

Please mark P for in the past, C for Currently have

______ Headache
______ Stroke
______ Neck Pain
______ Jaw Pain, TMJ
______ Shoulder Pain
______ Upper Back Pain
______ Mid Back Pain
______ Low Back Pain
______ Hip Pain
______ Scoliosis
______ Numb/Tingling arms, hands, fingers
______ Numb/Tingling legs, feet, toes
______ Pregnant (Now)
______ Frequent Colds/Flu
______ Convulsions/Epilepsy
______ Tremors
______ Chest Pain
______ Shortness of breath
______ Pain w/Cough/Sneeze
______ Foot or Knee Problems
______ Incontinence

______ Sinus/Drainage Problem
______ Swollen/Painful Joints
______ Skin Problems
______ ADD/ADHD
______ Allergies
______ Facial Drooping
______ Dizziness
______ Numbness of Face
______ Loss of Balance
______ Fainting
______ Slurred Speech
______ Double Vision
______ Blurred Vision
______ Ringing in Ears
______ Hearing Loss
______ Depression
______ Irritable
______ Mood Changes
______ Eating Disorder
______ Trouble Sleeping
______ Prostate Problems

______ Impotence/Sexual Dysfun
______ Loss of Bowel/Bladder Control
______ Digestive Problems
______ Diarrhea/Constipation
______ Menopausal Problem
______ Hepatitis (A, B, C)
______ Bleeding Disorder
______ Ulcers
______ Heartburn
______ Heart Problems
______ High Blood Pressure
______ Low Blood Pressure
______ Asthma
______ Difficulty Breathing
______ Lung Problems
______ Kidney Trouble
______ Gall Bladder Trouble

______ Cancer: If yes, what type ____

On Staff Chiropractic Physicians
Winchester Hospital
A Member of Beth Israel Lahey Health

Winchester Chiropractic Center
300 Trade Center Suite 4460
Woburn, MA 01801
Telephone (781)933-5051 | Fax (781)933-5054
winchesterchirocenter@gmail.com
winchesterchirocenter.com

NECK DISABILITY INDEX

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday - life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present - day situation.

SECTION 1 - Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally, but it causes extra pain.
☐ It is painful to look after myself, and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self-care.
☐ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 - Lifting

☐ I can lift heavy weights without causing extra pain.
☐ I can lift heavy weights, but it gives me extra pain.
☐ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
☐ I can lift only very light weights.
☐ I cannot lift or carry anything at all.

SECTION 4 - Reading

☐ I can read as much as I want with no neck pain.
☐ I can read as much as I want with slight neck pain.
☐ I can read as much as I want with moderate neck pain.
☐ I can't read as much as I want because of moderate neck pain.
☐ I can't read as much as I want because of severe neck pain.
☐ I can't read at all.

SECTION 5 - Headaches

☐ I can do as much work as I want.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I can't do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

SECTION 6 - Concentration

☐ I can concentrate fully without difficulty.
☐ I can concentrate fully with slight difficulty.
☐ I have a fair degree of difficulty concentrating.
☐ I have a lot of difficulty concentrating.
☐ I have a great deal of difficulty concentrating.
☐ I can't concentrate at all.

SECTION 7 - Work

☐ I can do as much work as I want.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I can't do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

SECTION 8 - Driving

☐ I can drive my car without neck pain.
☐ I can drive as long as I want with slight neck pain.
☐ I can drive as long as I want with moderate neck pain.
☐ I can't drive as long as I want because of moderate neck pain.
☐ I can hardly drive at all because of severe neck pain.
☐ I can't drive my care at all because of neck pain.

SECTION 9 - Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed for less than 1 hours.
☐ My sleep is mildly disturbed for up to 1-2 hours.
☐ My sleep is moderately disturbed for up to 2-3 hours.
☐ My sleep is greatly disturbed for up to 3-5 hours.
☐ My sleep is completely disturbed for up to 5-7 hours.

SECTION 10 - Recreation

☐ I have no neck pain during all recreational activities.
☐ I have some neck pain with all recreational activities.
☐ I have some neck pain with a few recreational activities.
☐ I have neck pain with most recreational activities.
☐ I can hardly do recreational activities due to neck pain.
☐ I can't do any recreational activities due to neck pain.

Patient Name: ____ Date: ______________________

Copyright: Vernon H. and Hagino C., 1987. Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. Journal of Manipulative and Physiological Therapeutics 1991; 14:409-415. Copied with permission of the authors.

On Staff Chiropractic Physicians
Winchester Hospital
A Member of Beth Israel Lahey Health

Winchester Chiropractic Center
300 Trade Center Suite 4460
Woburn, MA 01801
Telephone (781)933-5051 | Fax (781)933-5054
winchesterchirocenter@gmail.com
winchesterchirocenter.com

THE REVISED OSWESTRY LOW BACK PAIN 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 that more than one statement may relate to you, but PLEASE, JUST CHECK THE ONCE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - Personal Care

- ☐ I do not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 - Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight away.

SECTION 6 - Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

SECTION 7 - Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleping well.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of my pain.
- ☐ Pain has no significant effect on my social life aprt from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life, and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 - Travel

- ☐ I get o pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling, which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing degree of pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

PATIENT NAME: ______________________________ DATE: ______________

On Staff Chiropractic Physicians
Winchester Hospital
A Member of Beth Israel Lahey Health

Winchester Chiropractic Center
300 Trade Center Suite 4460
Woburn, MA 01801
Telephone (781)933-5051 | Fax (781)933-5054
winchesterchirocenter@gmail.com
winchesterchirocenter.com

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been informed of the following:

1. That the process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment "Supportive Therapies" may be applied by the chiropractor or by staff under their direction or supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold;
3. I have been informed on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or ignition of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment. The listed possible consequences and possible complications have been explained to me by the chiropractor;
4. I acknowledge that the chiropractor has made no guarantee of a positive outcome from treatment;
5. I have been afforded ample opportunity for questions and answers; and
6. The condition, possible benefits, risks of the treatment procedures, options, and financial obligations have been explained to me by the chiropractor.

Therefore by signing below:

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor (s) involved in my case;

Patient Signature: ______________________________ Date: ________________

On Staff Chiropractic Physicians
Winchester Hospital
A Member of Beth Israel Lahey Health

Winchester Chiropractic Center
300 Trade Center Suite 4460
Woburn, MA 01801
Telephone (781)933-5051 | Fax (781)933-5054
winchesterchirocenter@gmail.com
winchesterchirocenter.com

CONSENT TO TREAT

I consent to be treated by the Chiropractor(s) and staff of Winchester Chiropractic Center.

Sign: ____ Date: ______________________
Patient or Personal Representative

ASSIGNMENT OF INSURANCE BENEFITS

I request payment of insurance and/or Medicare benefits be made on my behalf to (Corporation).

I understand all copayments are due on the date of service.

I understand I am financially responsible for any treatment or balances not paid by my insurance company.

Sign: ____ Date: ______________________
Patient or Personal Representative

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of Notice of Privacy Practices.

Sign: ____ Date: ______________________
Patient or Personal Representative

CERTIFICATE & ASSIGNMENT

I certify that I, and/or my dependent(s) have insurance coverage with __________________________ and assign directly to the above named clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

PAYMENT POLICY

The above named clinic may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any changes for professional services rendered by the above named clinic.

Signature: __________________________________

On Staff Chiropractic Physicians
Winchester Hospital
A Member of Beth Israel Lahey Health

Winchester Chiropractic Center
300 Trade Center Suite 4460
Woburn, MA 01801
Telephone (781)933-5051 | Fax (781)933-5054
winchesterchirocenter@gmail.com
winchesterchirocenter.com

OFFICE APPOINTMENTS AND CANCELLATION POLICY

APPOINTMENTS

Please arrive on time for appointments. The office does its best to stay on schedule and your cooperation is essential. If you are unable to attend, please reschedule as soon as possible and notify the office as soon as you are aware a change is needed.

CANCELLATION/NO SHOW POLICY

This policy is to ensure that patients have access to care when needed and to avoid the added expenses to our office due to cancellations and no-shows. This policy is beneficial to both patient and doctor as is helps in keeping costs down and allows us to serve our patients efficiently and with the highest level of care and preserve the valuable time of all involved.

If you need to reschedule your appointment or cancel for any reason, please do so in a timely manner so that we may adjust our schedule to allow another patient to use that time slot.
If you fail to give 24 hours notice or do not call at all, we reserve the right to bill you for that time reserved for you. The Cancellation/Nos Show Fee is $25.00 for a standard chiropractic visit or re-exam and $50.00 for a new patient evaluation. We understand there may be unpredictable and unique circumstances that cannot be avoided. Please contact us to explain and discuss any situation which may cause you to cancel or reschedule.

By signing below, I confirm that I have read the above office policies and agree to adhere to them as an active patient of the Winchester Chiropractic Center.

________________________________ ________________

Signature Date

On Staff Chiropractic Physicians
Winchester Hospital
A Member of Beth Israel Lahey Health

Winchester Chiropractic Center
300 Trade Center Suite 4460
Woburn, MA 01801
Telephone (781)933-5051 | Fax (781)933-5054
winchesterchirocenter@gmail.com
winchesterchirocenter.com

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

Patient Name: ______________________________

Date of Birth:________________ E-mail Address: ______________________________

I______________________________, hereby authorize and request ______________________________to release my health information (PHI) to:

Winchester Chiropractic Center
300 Trade Center Suite 4460
Woburn, MA 01801
Telephone (781)933-5051| Fax (781)933-5054
winchesterchirocenter@gmail.com
winchesterchirocenter.com

In addition to the authorization for release of my PHI described above this Authorization, I furthermore acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment, and prognosis to the following individual(s):

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

I understand that I am entitled to a copy of Winchester Chiropractic Center's Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the website www.winchesterchirocenter.com or from the office directly.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect one year from today's date at which time this authorization expires.

______________________________ ______________

Signature of Patient Date