Dakota Family Chiropractic
John W. Prunty, D.C.
708 East Kay Ave.
Mitchell, SD 57301

Confidential Patient Information

(Please Print)

Date: ______________________
Full Name: ____
Name of Wife, Husband, or Guardian: ____
Address: ____
Residence and Mailing City State Zip Code
Telephone Numbers: Home ________________________ **Cell Phone** ________________________
Birthdate: __________ **Number of Children** _____ **Pregnant?** ________ **Due Date** ___________

Email Address: ____
(If you would like to receive our newsletter)
Emergency Contact's Name / Phone: ____
Occupation: ____
Employer's Name / Phone: ____

How did you hear about us: ☐ Newspaper ☐ Website ☐ Phone Book/Yellow Pages
☐ Other Healthcare Provider ☐ Other________________________
☐ Patient_____________________________________
(please provide name so we can send a thank you)

Most Recent Chiropractor Seen:
Name: ______________________________ **Address:** ________________________________
When: _______________________ **What was the diagnosis?** __________________________

Present Family Doctor: _____________________ **Date last seen:** _____________________________

Name of person responsible for payment: ____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dakota Family Chiropractic of Mitchell, PC may 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 Dakota Family Chiropractic of Mitchell, PC will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature ____ **Date** ______________________

Parent/Guardian Signature _________________________________ **Date** ______________________

(Cont on Back)

Check us out on the web at www.dakotafamilychiro.com

Health Insurance Portability Accountability Act (HIPAA)

Doctors and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time, however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in closed rooms, and in open room style, with other patients in the same room. Occasionally comments about your symptoms, improvement or lack there of may be discussed at your office visits.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time. (#164.524)

This notice is effective as of ___________. This authorization will expire seven years after the date in which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form when needed.

Patient Signature____________________________________Date____________