Complete Health Chiropractic Center

Dr. William R. Tomalinas, D.C.
685 South Mountain Blvd.
Mountain Top, PA 18707

Consent for Use or Disclosure of Health Information

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure and understand that we have and always will respect the privacy of your health information.
There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or hospital if necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Your chiropractor 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 or other health related information. If this contact is made by phone and you are note at home, a message will be left on your answering machine or voice mail. By signing this notice you are giving us authorization to leave detailed messages and to contact you with these reminders and information.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use of disclosure to your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding to us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization. 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.

I have read your consent policy and agree to terms. I am also acknowledging a copy of this notice will be filled in my permanent chart.

Patient Signature:_____ Date:_____

"I request that payment of authorized Medicare benefits or Chiropractic Insurance benefits be made either to me or on my behalf to Dr. William R. Tomalinas for any services rendered to me by Dr. William R. Tomalinas. I authorize any holder of medical information about me be released to the centers of Medicare and its agents or the Health Insurance company, any information needed to determine these benefits or benefits payable for related services."

Patient Signature:_____ Date:_____

WELCOME TO OUR OFFICE

Last name_____ First_____ MI_____

Date of Birth_____ Age_____ Sex: ☐ M ☐ F Email Address_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone _____ Employer Phone _____

Preferred Language _____ Preferred method of communication (Check One) ☐ Email ☐ Phone ☐ Mail

Smoking Status (Check One) ☐ Every Day Smoker ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked Start Date _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Name of Spouse_____

Notify in Case of an Emergency_____
(other than your home number) (name) (relationship) (phone)

Race (Check One) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White (Caucasian)
☐ Native Hawaiian or Pacific Islander ☐ Decline to Answer

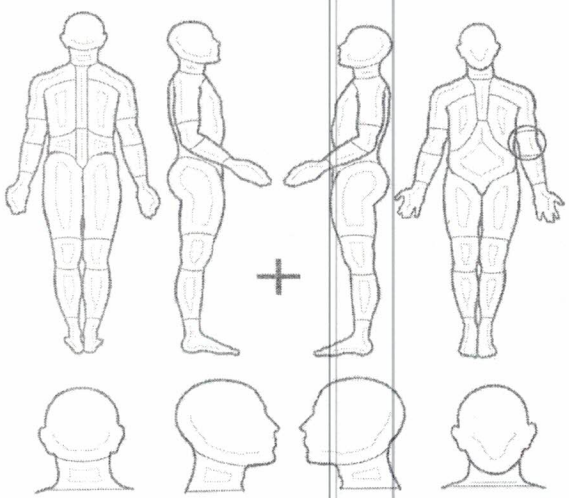
Ethnicity (Check One) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Height_____ Weight _____ Blood Pressure (Doctor will take) _____

List of medications (Exact spelling and dosages) _____

_____

List any medication allergies _____



Place an "X" on the drawing to the left on the areas causing you pain.

PAIN SCALE Circle the number that best describes your pain level

0 1 2 3 4 5 6 7 8 9 10 (0=none / 10=severe)

What brings you to our office? _____

Where is the pain located? _____

When and How did it start? _____

Can you perform daily activities? ☐ Yes ☐ No

If not, please describe _____

Family History: Father: ☐ Living ☐ Deceased Mother: ☐ Living ☐ Deceased
☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular/Stroke ☐ Other_____

Please list any surgeries/diseases_____ List any accidents_____

I certify that the above information is complete and accurate. If the health plan information is not accurate or if I am not eligible to receive a health care benefit through my insurance carrier, I understand that I am liable for all charges or services rendered. I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage at any time prior to an office visit at this facility.

Signature_____ Date_____