Please Fill Out Completely

Hardy Chiropractic
Laron L. Hardy, D.C.

Name____ Age______ Preferred Name ______________________________
(First) (Middle) (Last)

Address____ City________________________ State_____ Zip_______________

Date of Birth____/____/____ Married_____ Single_____ Employer ____

Email____ Are You Pregnant? Yes _____ No_______ N/A______

Home Phone (_____) _________________Work Phone (____) __________________Social Security Number_______-_____-_______

Cell Phone (____) ____________________Cell Phone Carrier (For Appt. Reminder Text) Ex: Verizon, T-Mobile_________________

Who Referred You To Our Office? ____

All billing statements, etc. are emailed. Are you able to receive statements via email? Yes ☐ No ☐

Authorization and Assignment of Benefits

You, Hardy Chiropractic and Dr. Laron L. Hardy, are authorized by me to release any information you deem appropriate concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred at Hardy Chiropractic by me. I also request payment of government benefits either to myself or to the party who accepts assignment on the CMS-1500 form used to file my insurance.

I authorize payment of medical benefits to the physician or supplier listed on the CMS-1500 form used by Dr. Hardy and Hardy Chiropractic for services described on the said CMS-1500 form.

I authorize and assign the direct payment to Hardy Chiropractic of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I give assignment and lien against any claims against a third party whose negligence may have caused my injury, up to the amount of the bill for treatment.

In the event any insurance company obligated by contractual agreement to make payment to me or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit.

If insurance payment is not received within 60 days from the time insurance is filed, I understand that I will be billed for the remaining balance.

I understand that interest in the amount of 1.5% per month will accrue for any balance over 30 days and that any balance over 90 days will be turned over to collections. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

You agree, in order for us to service your account or to collect monies you may owe, Hardy Chiropractic and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Hardy Chiropractic, its employees and/or agents may contact me/us as described above.

You may share my health and account information with the following people:____
(We cannot speak with anyone concerning your case or your bill unless they are listed above.)

Signed____ Date______/____/______

*I have received Hardy Chiropractic's Health Information Privacy Notice (HIPAA) Signed:*____

Chiropractic Case History

Name____ Date_____________________________________

1. Primary Complaint: ____

Complaint began when and how? ____

2. Secondary Complaint:____

Complaint began when and how?____

Please check all that apply: ___dull ___aching ___sharp ___shooting ___burning ___throbbing ___deep ___nagging

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____________________________________

Do you have any numbness or tingling in your body? Where? ____

Grade pain level (0 = no pain, 10 = worst) ____0 ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

Frequency of complaint, how long does it last: ____

What makes it better: ___________________________________What makes it worse: ____________________________________

What have you done for this complaint: ____

Major illnesses you've had in your life: ____

Previous injury or trauma:____

Medications currently taking | Reason for taking

____ ____________________________________

____ ____________________________________

Previous Surgeries:____

Job description: _______________________________________ Recreational activities:_____________________________________

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Signature ____ Date ______/___/_______

Parent or Guardian Signature (if patient is minor)____ Date _____/___/______

HIPAA Notice of Privacy Practices

Laron L. Hardy, D.C. – Hardy Chiropractic 2699-A Sandlin Road, SW – Suite 3 Decatur, Alabama 35601 Phone: 256-355-1049

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. **You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

I authorize Hardy Chiropractic and it's agents to give information regarding my treatment at Hardy Chiropractic to family members, work associates or others over the telephone. I also authorized Hardy Chiropractic and it's agents to leave information regarding my treatment on my home, cellular, and office voicemail and other messaging systems that may be appropriate. This information may include, but not limited to, appointment reminders and incoming calls concerning your treatment and appointment times.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.