Perry Chiropractic of Warner Robins
4027 Watson Blvd. Suite 180
Warner Robins, GA 31093
(478) 333-1773

PATIENT INFORMATION

First Name: ______________________ Last Name: ______________________

Middle Initial: ________ Suffix: ________ Nickname: ______________________

Address: ____

City: ______________________ State: ______ Zip Code: ______________

Primary Number: ______________ Secondary Number: ______________

Primary E-mail: ____

By providing my e-mail address, I authorize my doctor to contact me via the email address(es) provided

Birthday: ____/____/____ Age: ________ SSN: ______________

Gender (check one): □ Male □ Female □ Unspecified

Race: □ White □ Black/African American □ Hispanic □ American Indian/Alaskan □ Korean

□ Asian □ Native Hawaiian or Pacific Islander □ Japanese □ Guamanian or Chamorro □ Samoan

□ Chinese □Vietnamese □ Multi-Racial □ I chose not to specify □ Other ______________

Preferred Language: ____

Emergency Contact: ____________ Relationship: ____________ Phone #: ____________

Insurance Company: ______________________ Policy Number: ______________________

I AUTHORIZE A PAYMENT OF MEDICAL BENEFITS TO: PERRY CHIROPRACTIC OF WARNER ROBINS, OR THE BILLING PROVIDER, FOR SERVICES RENDERED

SIGNATURE: ______________________________ DATE: ______________

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIMS

SIGNATURE: ______________________________ DATE: ______________

PERSONAL AUTHORIZING CARE/RESPONSIBILITY:

SIGNATURE: ______________________________ DATE: ______________

HEALTH CARE AUTHORIZATION FORM

Patient's Name: ____

Patient's SS#: ________________________ Date of Birth: ______ / ______ / ______

THE PATIENT IDENTIFIED ABOVE AUTHORIZES PERRY CHIROPRACTIC OF WARNER ROBINS TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to PCWR to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, thank you cards, testimonials, marketing materials, information about treatment alternatives or other health related information.

- If PCWR contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.

- I give PCWR permission to treat me in an open therapy room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected heath information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

- By signing this form, I am giving PCWR permission to use and disclose my protected health information in accordance with the directives listed above.

SIGNATURE: ______________________________ DATE: ____________________

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or acted in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of PCWR. The written notice must contain the following information:

- Your Name, Social Security Number, Date of Birth
- A clear statement of your intent to revoke this AUTHORIZATION
- The date of your request
- Your signature

This revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by PCWR for its own use/disclosure of PHI.

(Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORATION. If you refuse to sign this AUTHORIZATOIN, PCWR will not refuse to provide treatment.

You have to right to inspect or copy the PHI to be used/disclosed.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU

______________________________ ______________________________

Print Name of Patient Date

______________________________ ______________________________

Signature of Patient Signature of Personal Representative

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Description of Representative's Authority to Act for Patient