Kilgore Integrated Health
1100 Stone Road Suite 258
Kilgore, TX 75662

903-984-5522

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Kilgore Integrated Health or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.
I have received a copy of the Notice of Patient Privacy Policy. _____ Patient Initials

Requesting Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Date

_____ _____
Witness Signature Date

Patient Health History

Today's Date [/ /] **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name _____ **Called Name** _____

Last Name _____ **Middle Name** _____ **Suffix** _____

Mailing Address _____

City _____ **State** _____ **Zip Code** _____

Primary Phone _____ **Secondary Phone** _____

Mobile Phone _____

Email _____

SSN: _____

Best way to contact you: ❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Email

Date of Birth [/ /] **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other

Spouse's Name: _____ **Birthday:** _____

Employment Status *(check one)*

❑ Employed ❑ Student ❑ Retired

Occupation: _____

Race *(check one)*

❑ White ❑ Black/African American ❑ American Indian ❑ Asian
❑ Native Hawaiian ❑ Other Pacific Island ❑ Alaskan Native ❑ Declined to State

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language _____

Whom may we thank for referring you? _____

Continued ...

Current Medications, including dosage if known.

If there are no current medications, check here: ☐

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

List any known allergies you have. If no allergies are known, check here: ☐

1. _____ 3. _____
2. _____ 4. _____

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐ Never been a smoker

If yes, how often do you smoke: ☐ Current every day smoker ☐ Current sometimes smoker

If yes, what is you level of interest in quitting smoking?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No interest Very interested

Briefly list your chief complaint: _____

_____

Past Medical History:

Please list any medical problems you have or had (e.g., diabetes, high blood pressure, cancer …)

Problem How long have you had this problem

1. _____
2. _____
3. _____
4. _____
5. _____

6. _____

7. _____

8. _____

Family History:

Are there any diseases that run in your family?

Disease	Family member affected
1.	
2.	
3.	
4.	
5.	
6.	

To be completed by clinic staff:

Height: _____ inches **Weight:** _____ pounds **BP:** _____/_____

BMI: _____

Staff Signature: _____

-Over-

CONSENT FOR TREATMENT AND USE OF PROTECTED HEALTH INFORMATION

I certify that the information that I have provided on my intake paperwork is accurate, complete and true.

I authorize Kilgore Integrated Health and any associates, assistants, and any other health care providers it may deem necessary, to treat my condition. I have had an opportunity to discuss with the provider(s) or other clinic personnel the nature and purpose of the different procedures and treatment options. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for Kilgore Integrated Health to retrieve my medication history. I understand that this will become part of my medical history.

I understand that there are certain degrees of risk associated with the treatments offered by Kilgore Integrated Health. If an injection is recommended, I understand a procedure specific consent will be provided for my review. I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy. These risks occur rarely but are not limited to fractures, disc injuries, strokes, and strains/sprains. I understand these risks and am willing to accept and consent to the risk associated with the care that I am about to receive.

I acknowledge that I have had the opportunity to review Kilgore Integrated Health Notice of Privacy Practices, which is displayed for public inspection at its facility. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize Kilgore Integrated Health to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any provider(s) I may be referred to. I also authorize Kilgore Integrated Health to release any information required in obtaining procedure authorization or the processing of any insurance claim.

I understand that Kilgore Integrated Health will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female patients: By my signature on this form, I hereby attest that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time.

Signed: _____ Date: _____

Witness: _____

Patient Name _____ Date: _____

Office Financial Policy

It is the policy of Kilgore Integrated Health to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This measure reduces your out-of-pocket expense and allows you to place your family under care.

If you **DO NOT HAVE INSURANCE:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100.00 at any time or care may be terminated. Our payment plans can make care an affordable part of your family budget.

If you **HAVE INSURANCE:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100.00 or care may be terminated. Our payment plans can make care an affordable part of your family budget.

You are considered a cash (no insurance) patient until you have completed your insurance forms and your coverage has been verified and accepted. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, reasonable and customary by most insurance companies, and are therefore covered up to the maximum allowance determined by each carrier.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits for chiropractic care is once a month or less frequently, you will not be eligible for insurance assignment of chiropractic benefits. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

If you discontinue care for any reason other than by discharge by your provider, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

A photocopy or electronic version of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case.

Patient's Printed Name: _____

Signed: _____ Date: _____

Witness: _____ Date: _____