Prebish Chiropractic Centre
310 Capital Ave S.W. Battle Creek. MI 49037
Ph: 269.965.3367 Fax: 269.965.5753
www.prebishchiropractic.com / prebishchiropractic@gmail.com

Welcome!

Thank you for selecting our chiropractic office!

We will strive to provide you with the best possible care. To help us meet all of your healthcare needs, please fill out this form completely. If you have any questions or need assistance please ask us - we are happy to help.

Patient Information (confidential)

Name: _____ Date of Birth _____ S.S. # _____

Address: _____ City: _____ State: _____ Zip: _____

Cell # _____ Alternate # _____ Preferred Contact: text ☐ cell ☐ e-mail ☐ work ☐ Marital Status: _____

E-Mail: _____ May we send the following: ☐ Exercise plan ☐ Announcements ☐ Statements ☐ Newsletters

Occupation: _____ Employer: _____ Job Title: _____

Emergency Contact: _____ Relation to Patient _____ Phone # _____

Name(s) of person(s) authorized to discuss protected health information /account info _____ Phone # _____

How did you hear about our office ? _____ Who may we thank for referring you? _____

Primary Care Physician's Name / Practice Name _____ Permission to Contact? Yes ☐ No ☐

Have you ever received Chiropractic Care ? Yes ☐ No ☐ Dr.'s Name _____ Last Visit ? _____

Please present your Driver's License or photo ID *and any insurance cards.* The patient or guardian is responsible for charges incurred. We will bill the insurance using the information you have given us. If you fail to present accurate information at the time of service we cannot guarantee correct processing of your claims. You may be responsible for charges incurred if billing information is incorrect.

Insurance Information: Primary Insurance: _____ Relationship to Policy Holder? _____

Secondary insurance: _____ Relationship to Policy Holder? _____

_____
Date

**HIPAA REQUIRED FORM ** NOTICE OF PRIVACY PRACTICES

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 describes how we may use and disclose your protected health information (PHI) to carry out our treatment, payment or healthcare operations (TPO) or for other puposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that may be related to your past present or future physical or mental health or condition and related care services.

I understand that as a part if my healthcare, Prebish Chiropractic Centre/ Dr. Andrew Yockey originates and maintains paper and/or electronic records containing my health history, examinations, test results, diagnosis and treatment. I understand that this information serves to: *•Plan my Care and Treatment •To communicate among health care professionals who contribute to my care •be a source of information for applying my diagnosis to my bill •serve as a means by which a third party payer can verify services were provided as billed.*

If it is necessary I consent to the disclosure of my PHI to another health care provider or 3rd party payer for the purposes mentioned above. I consent to disclosure for the purposes noted and authorize disclosures via fax or E-mail.

_____
Signature of patient or legal guardian Date