MOMENTUM CHIROPRACTIC **AUTO COLLISION QUESTIONNAIRE**

PATIENT NAME: **TODAY'S DATE:**

Date of Collision: / / **LOCATION: (Street/City)**

CIRCLE WHAT APPLIES TO YOU

Were you ... Driver Front Seat Passenger Back Seat Passenger / Drivers Side Back Seat / Passenger Side Back Seat / Middle Pedestrian

CIRCLE WHAT APPLIES TO YOU

Point of Impact: Front Rear Driver Side Passenger Side Front Quarter Panel Rear Quarter Panel

Damaged areas:

Estimated Cost of Damage/Repairs: $

CIRCLE WHAT APPLIES TO YOU

Did your car strike another vehicle? YES NO

Did the other vehicle strike yours? YES NO

Was there more than 1 impact? YES NO

Did your vehicle have to be towed? YES NO

If YES, how did you get home?

Did you obtain a Rental Vehicle? YES NO

Were you wearing a seat belt? YES NO Lap Shoulder Harness

DID YOU know you were going to be hit before impact? YES NO DID YOU lose consciousness YES NO

Was your vehicle stopped at the time of impact? YES NO Was your vehicle in motion at the time of impact? YES NO If YES, approximate speed: _____MPH

If your vehicle was in motion, was it: Slowing Down Gaining Speed Steady Pace AT IMPACT my right foot was on the : Accelerator Break Pedal Neither

Did anything move about the cabin at impact? YES NO _____

CIRCLE WHAT APPLIES TO YOU

Road Conditions:: WET DRY ICY SUNNY OTHER: _____ Time of collision: AM PM _____:_____ (Approximately)

Who arrived on the scene? Police Fire Department Ambulance Tow Truck No One Dispatched Exchanged Insurance & Left Hit & Run

If Police Arrived on Scene, was an accident Report generated? YES NO Who was found to be at fault?: _____

Were you evaluated at the E.R.? YES NO If yes, Transported by : Ambulance Personal Vehicle What hospital? _____

What services were performed at ER? Exam XR CT MRI SURGERY DISCHARGED with Medication Name_____

Have you been seen by any other medical facility for the injuries? YES NO If Yes, who?_____

PLEASE DRAW A DIAGRAM OF THE COLLISION & WRITE A BRIEF DESCRIPTION: _____

_____

Patient's Auto	A
Other Auto	B
Third Auto	C

Direction of Travel

CONTINUATION OF DESCRIPTION / NOTES / OTHER:

MOMENTUM CHIROPRACTIC **AUTO COLLISION QUESTIONNAIRE**

PATIENT NAME: **TODAY'S DATE:**

Date of Collision: / /

AUTOMOBILE INSURANCE COVERAGE

Washington State Law provides the directive and when an auto collision occurs, it must be indicated on the billing form, as such, personal health insurance will not cover these auto related charges unless there is no other insurance available to cover injury costs. Even if the collision is not your fault, you will first look to utilize your own auto coverage and initiate a claim using the PIP (Personal Injury Protection) portion of your auto policy or uninsured portion to cover medical costs, and at the time of settlement, your insurance company is reimbursed where applicable. If there is no PIP available, you will need to make financial arrangements.

AUTO INSURANCE OF THE VEHICLE YOU WERE IN

DRIVER of the car you were in: ME _____ Registered Owner: ME _____

Relationship to Registered Owner _____

YEAR of VEHICLE: _____ MAKE OF VEHICLE _____ MODEL OF VEHICLE: _____

INSURANCE COMPANY NAME: _____ PHONE #: _____

AGENT: _____

CLAIM #: _____ CLAIMS ADJUSTOR: _____

Does your policy include PIP coverage? YES NO **IF YES.** Have you set up the PIP/MEDICAL Claim with your carrier? YES NO

(In the State of Washington, all auto policies come with PIP, UNLESS, you sign a waiver stating you decline this coverage. The insurance must be able to provide this signed waiver to verify that you do not have this coverage.)

If you do not have automobile coverage that will pay your medical bills, please discuss the financial aspect of care with the billing office.

AUTO INSURANCE OF THE OTHER VEHICLE

3rd Party Insurance will generally issue a check to cover the cost of property damage immediately, however, we will not be billing them because they do not make medical injury payment until the time of settlement.

DRIVER'S NAME: _____ Registered Owner: SAME UNKNOWN _____

ADDRESS: _____ Relationship to Registered Owner _____

YEAR of VEHICLE: _____ MAKE OF VEHICLE _____ MODEL OF VEHICLE: _____

INSURANCE COMPANY NAME: _____ PHONE #: _____

CLAIM #: _____ CLAIMS ADJUSTOR: _____

LEGAL REPRESENTATION

Do you have an attorney? YES NO

If YES, NAME: _____ PHONE #: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

Paralegal: _____

NOTES:

PATIENT'S SIGNATURE & DATE

Whom may we thank for referring you to this office → _____?

PATIENT HISTORY

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____-____-____ Age: _____ ☐ Male ☐ Female

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

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number:***

Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen?_____

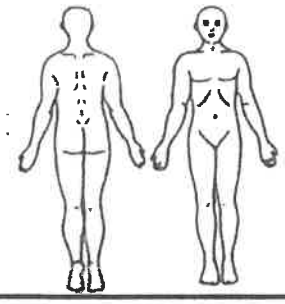
Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T= Tingling



What relieves your symptoms? _____

What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? _____ _ When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago?** _____What were the results. ☐ Favorable ☐ Unfavorable→ please explain. _____ _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for *Never have had*:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

SOCIAL HISTORY

1. **Smoking**: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. **Alcoholic Beverage**: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. **Recreational Drug use**: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect the following:

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
   If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)
   Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
2. **Any** other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

I hereby authorize payment to be made directly to Momentum Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible Momentum Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

Patient's Name: _____ **DATE:** ___/___/___

MOMENTUM CHIROPRACTIC
SUBJECTIVE REVIEW

PATIENT NAME:
DATE:

HEADACHES

CIRCLE WHAT APPLIES

DNA=Does Not Apply

FREQUENCY: Over the past week, (7 days) how often have you experienced a headache? DNA
DAILY-Intermittent DAILY-Constant 5-6x Wk 4-5x Wk 3-4x Wk 1-2x Wk Approximate date of last headache

LOCATION: RIGHT LEFT BOTH SIDES
Back of the head Side of the head Top of the head Forehead Eyes Sinuses OTHER:

TYPE OF PAIN:
Ache Dull Throbbing Pressure Sharp Sore Stabbing Migraine Dizziness Ringing in the ears Blurred vision Loss of Concentration
OTHER:

INTENSITY: Indicate your **range of intensity**; 0= no pain, 10= worst pain (EXAMPLE: 3-5 or 4-8) &/or your average pain
0 1 2 3 4 5 6 7 8 9 10 **AVERAGE PAIN INTENSITY:** **WORSE:** AM NOON PM

WHAT AGGRAVATES THE HEADACHE?
Noise Light Computer Use Reading Cell Phone Use Activity in general OTHER:

WHAT EASES THE HEADACHE?
Rest Medication/Name:_____ Hot Shower Cold Compress Massage Chiropractic Nothing OTHER:

NECK PAIN

FREQUENCY: Over the past week, (7 days) how often have you experienced neck pain? DNA
DAILY-Intermittent DAILY-Constant 5-6x Wk 4-5x Wk 3-4x Wk 1-2x Wk COMMENTS:

LOCATION: Middle Right Left Both Sides L>R R>L

TYPE OF PAIN:
Ache Dull Throbbing Sharp Sore Stiff Stabbing Burning Shooting Tight Heaviness of Head OTHER:_____

INTENSITY: Indicate your **range of intensity**; 0= no pain, 10= worst pain (EXAMPLE: 3-5 or 4-8) &/or your average pain
0 1 2 3 4 5 6 7 8 9 10 **AVERAGE PAIN INTENSITY:** **WORSE:** AM NOON PM

WHAT AGGRAVATES THE NECK?
Desk Work Activities Computer Use Reading Cell Phone Use Driving Quick Movements Intimacy Watching TV/Movie Some Sleep Postures
OTHER:

WHAT EASES THE NECK PAIN?
Rest Medication/Name_____ Hot Shower Cold Compress Massage Chiropractic Physical Therapy Acupuncture
Gentle Stretching OTHER:

UPPER/MID BACK PAIN

FREQUENCY: Over the past week, (7 days) how often have you experienced upper-mid pain? DNA
DAILY-Intermittent DAILY-Constant 5-6x Wk 4-5x Wk 3-4x Wk 1-2x Wk COMMENTS:

LOCATION: Middle Right Left Both Sides L>R R>L

TYPE OF PAIN:
Ache Dull Throbbing Sharp Sore Stiff Stabbing Burning Shooting Tight Knot OTHER:

INTENSITY: Indicate your **range of intensity**; 0= no pain, 10= worst pain (EXAMPLE: 3-5 or 4-8) &/or your average pain
0 1 2 3 4 5 6 7 8 9 10 **AVERAGE PAIN INTENSITY:** **WORSE:** AM NOON PM

WHAT AGGRAVATES THE UPPER-MID BACK?
Desk Work Activities Computer Use Lifting Pushing Pulling Overhead Activities Driving Quick Movements Intimacy Standing Sitting Cooking
Vacuuming Getting Dressed Exercise Washing Dishes Activities that require use of arms Some Sleep Postures OTHER:

WHAT EASES THE UPPER-MID BACK PAIN?
Rest Medication/Name_____ Hot Shower Cold Compress Massage Chiropractic Physical Therapy Acupuncture
Gentle Stretching OTHER:

MOMENTUM CHIROPRACTIC — SUBJECTIVE REVIEW

LOW BACK

CIRCLE WHAT APPLIES

DNA=Does Not Apply

FREQUENCY: **Over the past week, (7 days)** how often have you experienced low back pain? DNA
DAILY-Intermittent DAILY-Constant 5-6x Wk 4-5x Wk 3-4x Wk 1-2x Wk

LOCATION: Middle Right Left Both Sides L>R R>L

TYPE OF PAIN: Ache Dull Throbbing Sharp with Movement Sore Stiff Stabbing Burning Shooting Tight Knotted
OTHER:

INTENSITY: Indicate your **range of intensity;** 0= no pain, 10= worst pain (EXAMPLE: 3-5 or 4-8) THEN your average Pain if applicable
0 1 2 3 4 5 6 7 8 9 10 **AVERAGE PAIN INTENSITY:** **WORSE:** AM NOON PM

WHAT AGGRAVATES THE LOW BACK?
Desk Work Activities Computer Use Lifting Pushing Pulling Sitting _____MINS Driving Walking _____ MINS Quick Movements Intimacy
Standing _____ MINS Bending Exercise Vacuuming Laundry Some Sleep Postures Yard Work Work Related Activity OTHER:

WHAT EASES THE LOW BACK PAIN?
Rest Medication/Name_____ Hot Shower Cold Compress Massage Chiropractic Physical Therapy Acupuncture
Stretching OTHER:

ARMS/SHOULDER

FREQUENCY: Over the past week, (7 days) how often have you experienced numbness, tingling or pain in your arms or shoulder? DNA
DAILY-Intermittent DAILY-Constant 5-6x Wk 4-5x Wk 3-4x Wk 1-2x Wk NONE COMMENTS:

LOCATION: **Right** **Left** ARM SHOULDER Entire Arm Elbow Down Hand Only Fingers Only Specific Fingers:

SYMPTOM: Numbness Tingling Weakness OTHER:

INTENSITY: Indicate your **range of intensity**; 0= no pain, 10= worst pain (EXAMPLE: 3-5 or 4-8) THEN your average Pain if applicable
0 1 2 3 4 5 6 7 8 9 10 **AVERAGE PAIN INTENSITY:**

WHAT TRIGGERS THE NUMBNESS/TINGLING? Unknown Activities with arm elevated Driving Sleeping on Arm
OTHER:

LEGS/SCIATIC

FREQUENCY: Over the past week, (7 days) how often have you experienced numbness, tingling or pain in your legs? DNA
DAILY-Intermittent DAILY-Constant 5-6x Wk 4-5x Wk 3-4x Wk 1-2x Wk NONE COMMENTS:

LOCATION: **Right** **Left** Gluteal Entire Leg Knee Down Foot Only Toes Only Specific Toes: _____

SYMPTOM: Numbness Tingling Weakness Sharp Burn OTHER:

INTENSITY: Indicate your **range of intensity**; 0= no pain, 10= worst pain (EXAMPLE: 3-5 or 4-8) THEN your average Pain if applicable
0 1 2 3 4 5 6 7 8 9 10 **AVERAGE PAIN INTENSITY:**

WHAT TRIGGERS THE NUMBNESS/TINGLING?
Unknown Sitting _____MINS Standing _____ MINS OTHER:

OTHER

LIST ANY OTHER SYMPTOMS NOT PREVIOUSLY DISCUSSED:

PATIENT/GUARDIAN SIGNATURE: **DATE:**

MEDICATION LOG

Name : _____ Date : _____

Medication	Dosage	Date	Frequency	

MOMENTUM CHIROPRACTIC
628 3RD st Puyallup, Wa 98372
253-606-8533

Informed Consent for Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working with, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at other Chiropractic Partners offices.

I have had an opportunity to discuss with the doctor of chiropractic named below, and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.

I understand and am informed that, as with the practice of medicine chiropractic carries some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I consent to rely on the doctor's best judgment, exercised during the course of treatment that is in my best interest, based upon the known facts.

I have read, or have had read to me, the above consent, I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

To be completed by patient:

Print Patient Name: _____ **Date Signed:** _____

To be completed by Patient's representatives, if necessary, e.g. if patient is a minor or is physically or mentally incapacitated.

Patient Signature: _____ **Date Signed:** _____

HIPAA Notice of Privacy Practices

Advance Health Chiropractic
DBA: Momentum Chiropractic
628 3rd St Se
Puyallup, WA 98372
(253) 845-6636

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.

State Mandated Exemptions

- We are required by Washington State Law to disclose health information to the Department of Labor and Industries or a self-insured employer for workers' compensation or crime victims' claims.
- We can disclose health information to an employer about light duty work without a patient authorization.
- We can disclose health information to an employer without a patient authorization if that information is about a workplace injury or illness, a workplace medical surveillance, or a return-to-work examination.
- Because this disclosures to the department or self-insurer are required by law, patients cannot object to or request that we restrict those disclosures, (45 CFR §§ 164.512,164.522(a)(1)(v)).

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.**

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.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____Signature:_____Date:__

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records, examination results, medication dose changes, and claims information.
This information may be released to:

☐ - Spouse _____

☐ - Child(ren) _____

☐ - Other _____

☐ - Information is not to be released to anyone other than me.

Messages

Please call ☐ my home phone is _____ ☐ my cell phone is _____

If unable to reach me:

☐ - You may leave a detailed message

OR

☐ - Please leave a message asking me to return your call

☐ - Do not leave messages on my phone mailbox.

The best time to reach me is (day of week)_____ between (time)_____

E-mail Messages

☐ - Use my e-mail address to send messages for me to contact the nurse for information **OR**
☐ - Use my e-mail to leave detailed messages and information.

■ Attach lab results to the e-mail message.

My e-mail address is _____

This Release of Information will remain in effect until terminated by me in writing.
This release ***specifically excludes*** any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Patient Signature: _____ Date: ____/____/____

Witness Signature:_____ Date: ____/____/____