New Patient Information

1605 Rock Prairie Road Ste 315, College Station, Texas 77845. Tel 979-694-2026 / 979-695-1976 Fax 979-694-6403
1100 Rayford Road Ste. 300, Spring, Texas 77386 Tel 281-367-7313 Fax 281-367-7275

Today's Date:		
Patient Name:	Date of Birth:	Gender: Male / Female
Street Address:	Social Security #:	
City, State, Zip:	Weight:	Height:
Home telephone:	Marital Status:	No. Children:
Alternate phone number: Work	Occupation:	
Alternate phone number: Cell	Email Address:	
May we leave messages on your answering machine? Yes / No		
May we email you? Yes / No		
Name of Legally Responsible Representative:		
Relationship to Patient:		
Street Address:		
City, State, Zip:	Telephone:	

Insurance Information

Company Name:	Card Holder Social Security #:
Name of primary insured:	ID number:
Claims Address:	Group number:
City, State, Zip:	Company Telephone:

Referring Provider/Physician Information

Physician Name:	Is this the primary care giver? Yes / No
Street Address:	If not, name of PCP:
City, State, Zip:	Telephone:

Patient Medical History

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

When did the problem start?	How did it start? (Suddenly or Gradually)
What makes it worse?	
What makes it better?	
If Injury: Work Related Motor Vehicle Accident	Date of Injury:

Have you had any treatment for it? Yes / No

Describe treatments performed:

Please rate your pain scale of **1-10** (1-Mild, 10-Unbearable):

ALLERGIES: Describe whether: skin, local, gut, anaphylactic and Mild, Moderate or Severe

List all Present Illnesses/ Recent Diagnosis:

Have you ever had an endoscopic procedure? Yes No	Reason:	Date:

Past Medical History:

Past Surgical History:

CURRENT MEDICATIONS, VITAMINS AND SUPPLEMENTS: (Medications include the dosage and frequency of use):**

Do you take any of the following medications? Coumadin/ Warfarin Plavix Aspirin NSAIDs

CURRENT PHARMACY (LOCATION): (Name, Address, Phone);

SOCIAL HISTORY:

Do you smoke? Yes No How long: Packs per day:	Do you drink: Yes No How many per day/week?

Do you exercises? Yes / No Describe:

REVIEW OF SYTEMS: Do you have any of the following, please circle all that apply

CONSTITUTIONAL SYMPTOMS: Fever, Weight Change (Increase, Decrease) # of LBS ____ IN ____ MONTHS, Fatigue, Appetite Change (Increase, Decrease), Decrease in strength/exercise tolerance

***EYES*:** Double Vision, Blurring, Trauma, Glasses, Contacts, Dry eyes, Watering or tearing, recent change in vision

***ENT & MOUTH*:** Deafness, Sinusitis, Ringing in ears, Dizziness, hearing aid, current changes in hearing, gingival bleeding

***CARDIOVASCULAR*:** Chest pain, Palpitations, Calf Pain While Walking (Claudication), Irregular Heart Beats, Defibrillator, Pacemaker , Dizziness in standing

***RESPIRATORY*:** Shortness of Breath, Wheezing Cough, Coughing Blood

***GI*:** Diarrhea, Constipation, Abdominal Pain, Abdominal Cramp, Vomiting, Bloody Stool, Reflux, Difficulty swallowing

***GU*:** Hesitancy, Incontinence, Pain on Urination, Frequent Urination, Menstrual Problems, Pregnancy

***MS*:** Old Fracture, Sprains, Joint Pain, Joint Swelling, Arthritis, Stiffness, Atrophy

***SKIN*:** Change in color or temperature, Rashes, Lesions, Scars, Masses, Ulcers, Dermatitis, Eczema

***NEURO*:** Problems with speech or swallowing, Stroke, Changes in sensation, Seizures, Weakness, Visual Changes, Balance, Memory, In-coordination problems, Numbness tingling in extremities, Headaches, Vertigo, Head Injury

***PSYCH*:** Depression, Mood Changes, Hallucinations, Sleep Disturbances , Change in though content, Suicidal

***ENDOCRINE*:** Excessive Thirst, Hyper/hyperactivity, Growth Changes, Hair Changes

HEMATOLOGIC/LYMPHATIC: Bleeding tendency, Lymph node pain/enlargement, anemia, blood clot

FAMILY HISTORY:

Does anyone in your family have any of the following PLEASE CIRCLE and INDICATE WHO

Abdominal Pain/ cramps	Heart Disease
Acid reflux/ heartburn	Hepatitis / HIV
Anemia	High Blood Pressure
Asthma or Lung Disease	High Cholesterol
Cancer (type)	Irritable Bowel Syndrome
Constipation	Kidney problems
Crohn's disease	Mitral Valve prolapse
Diabetes	Nausea/Vomiting
Diarrhea	Osteoporosis
Digestive disease	Polyps
Gastrointestinal Bleeding	Ulcers
GERD	Gout
Hearing Impaired	Bleeding Tendency
Blood Clot	**OTHER**:

Menstrual Flow: ___ Reg.___ Irreg. ___ Pain/Cramps ____ Days of flow ____Length of Cycle; 1st Day of Cycle Date:

Number of: ___ Pregnancies ___ Abortions ___ Miscarriages ___ Live Births

Birth Control Method:	Last PAP test: Date:
Last Mammogram: Date:	___ Pain/Bleeding after Sex ___ Flushing/Menopause

Year of Last Vaccine: _____ Tetanus/TD _____ Influenza (Flu) _____ Pneumonia _____ Hepatitis

Year of Last Test/Exam: _____ Colonoscopy _____ Rectal/Stool _____ Cholester ol _____TB Test
_____ Hepatitis _____ Eye Exam

How did you hear about us? ___ location ___ yellow pages ___ insurance ___ internet ___ doctor (Name: _____)
___family/friend (Name:_____) ____ Other: _____

I understand that this form must be completed in its entirety. I understand that if all of the above information is not completed, a claim may not be able to be filed to my insurance company therefore, making me fully responsible for any charges incurred.

_____ _____

Patient/Guarantor Signature Date

Check in time: _____

FOLLOW UP/INITIAL: Daily Visit Intake Form

Printed Name: _____ Date: _____

Indicate who you are seeing today (circle one): CASHION / DE LEON / WALKER / CROCKER

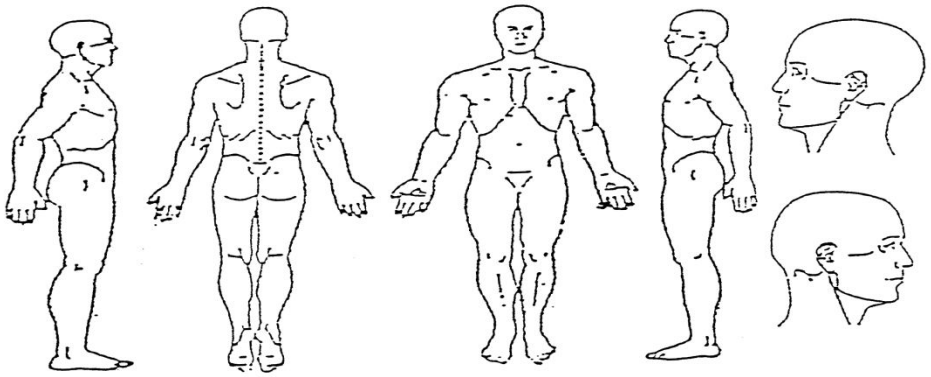
The region(s) of complaint (circle): NECK / SHOULDER / ELBOW / WRIST / HAND / FINGERS

BACK (upper / lower) / HIP / KNEE / ANKLE / FOOT / TOES

OTHER (specify): _____

Visional Analog Drawing: *Please indicate with the symbols listed that most accurately reflect the symptoms you are currently experiencing in the specific locations*

N = Numbness
T = Tingling
A = Achy
S = Sharp
D = Dull
B = Burning
C = Cramping
L = Pulling / Tightness
F = Stiffness
O = Other (specify "other" below)
_____
_____



Visional Analog Scale: *Using the scale of 1-10 with 0=No symptoms/discomfort and 10=Worst possible, please circle the number that most accurately reflects the intensity of the symptoms you are currently experiencing*

NO PAIN / 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 / WORST EVER

*Please circle your perception of treatment progress with regard to your symptoms from your previous visit (if your last visit was **more than 3 months ago – OMIT the scale below**)*

MUCH BETTER --- IMPROVED --- UNCHANGED / SAME --- WORSE --- MUCH WORSE

QUESTIONS:

Any new symptoms since last visit? (circle): YES / NO

If yes, specify: _____

Any new health conditions / accidents / surgical procedures since last visit? (circle): YES / NO

If yes, specify: _____

Any new medications / other doctor visits / ER visits since last visit? (circle): YES / NO

If yes, specify: _____

Any specific questions regarding your condition or treatment you would like to discuss? (circle): YES / NO

If yes, specify: _____

Has your insurance coverage, telephone number, or address changed since your last visit? (circle): YES / NO

If yes, specify: _____

Patient Signature: _____

DOCTOR notes:

- Any Associated Symptoms (if so, examine too)
  - Heart: chest pains, palpitations, syncope, orthopnea
  - Chest: dyspnea, wheezing, hemoptysis, cough
  - Abdomen: change in appetite, dysphagia, abdominal pains, bowel habit changes, emesis
  - Bowel / Bladder: urinary or fecal incontinence
  - EENT: vision changes, ringing within the ears, nasal congestion, sore throat
  - Psychiatric: depressive symptoms, changes in sleep habits, changes in thought content

Other Q's:

* Tobacco
* Fever / Fatigue
* DX testing / Labs
* Allergy
* Meds
* Past Med Hx
* Preg / Implants / Metal

CC:

Inspection

Palpation

Auscultation

Exam

Muscles Involved: R/L Suboccipital R/L Scalene R/L Pterygoid R/L Temporalis R/L Masseter R/L SCM R/L Trapezius R/L Levator Scapulae R/L Rhomboid R/L Supraspinatus R/L Deltoid R/L Teres mm. R/L Infraspinatus R/L Forearm Flexors R/L Forearm Extensors R/L Serratus Ant. R/L Lat. Dorsi R/L Erector Spinae Muscles R/L Psoas R/L Quadratus Lumborum R/L Biceps R/L Triceps R/L Brachioradialis R/L Gluteus Medius R/L Gluteus Maximus R/L Piriformis R/L Quadriceps R/L VMO R/L Hamstring R/L Gastrocnemius R/L Soleus

OTHER:_____

THERAPIST's NAME (printed) : _____ **(circle) 30min / 60 min**

97140 (MFR)→ x2 x4

THERAPY (circle OR write)

97014/ 97032 / G0283 Electrical Muscle Stimulation	**C**	**T**	**L**	**UE (R / L)**	**LE (R / L)**	**X ____ min**
97035 Ultrasound	**C**	**T**	**L**	**UE (R / L)**	**LE (R / L)**	**X ____ min**
97032 & 97035 Combination Therapy	**C**	**T**	**L**	**UE (R / L)**	**LE (R / L)**	**X ____ min**
97124 Percussion Instrument / Vibratory Massage	**C**	**T**	**L**	**UE (R / L)**	**LE (R / L)**	**X ____ min**
97010 Ice **/** Heat	**C**	**T**	**L**	**UE (R / L)**	**LE (R / L)**	**X ____ min**
97140 Manual Therapy / Mobilization	**C**	**T**	**L**	**UE (R / L)**	**LE (R / L)**	**X ____ min**

97810 Acupuncture: _____

97110 Therapeutic Exercise _____ **minutes**

97012 Mechanical traction: _____

Other code(s): _____

Manual Therapy : Lateral Breaks – Rotary – Combination / Modified Combination - Ant. to Post. – Post. to Ant. – Pisiform Contact- Thenar Contact – Side Posture – Activator – Gonstead - Flexion/Distraction (Cox) – Suboccip traction – OTHER: _____

RECOMMENDATIONS:

FOLLOW Ups: 1x 2x 3x 4x 5x ***PER* WK / MO ***FOR NEXT*** _____ WKs / _____ MOs**

Cashion and De Leon, L.L.P dba NP Clinic
Conditions of Services

PATIENT_____ **DOB**_____ **ACCT#**_____

Assignment of Benefits and Release of Patient Healthcare Information

I hereby authorize Cashion and De Leon, L.L P dba NP Clinic to release patient healthcare information, compiled from the medical records pertaining to my services, in accordance with the policy of the clinic and Texas law, to facilitate reimbursement by a health benefit plan or third party payor, including but not limited to, my insurance carrier, Medicare, Medicaid, and any other payer or agency.

I also hereby authorize payment of insurance benefits under the terms of my policy directly to Cashion and De Leon, L.L.P dba NP Clinic for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.

Financial Agreement and Statement of Responsibility

For and in consideration of services rendered or to be rendered by Cashion and De Leon, L.L.P dba NP Clinic, I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered charges. Payment in full is due at time services are rendered or payment arrangements are to be made before your appointment.

Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least *24 hours* in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

X_____ _____

Patient/Guarantor Signature Date

Statement to authorize payment of MEDICARE benefits

I certify that the information given by me in applying for payment under Title XVIII of the social security act is correct. I authorize any holder of medical information about me to release to the social security administration or its carriers, any information required to process my Medicare Claims. I request that payment under the medical insurance program be made to Cashion and De Leon, LLP dba NP Clinic for services provided to me.

X_____ _____

Patient/Guarantor Signature Date

Consent to Medical Treatment by a Family Nurse Practitioner

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services from a physician assistant. I fully understand that a *family nurse practitioner* IS NOT A PHYSICIAN. I further acknowledge that the general medical services provided to me by a *family nurse practitioner* are in conjunction with a collaborating physician and their collaborative agreement to provide services at Cashion and De Leon, L.L.P dba NP Clinic both professionally and legally, for acts of such allied health personnel rendered during the care and treatment of his/her patients.

X_____ _____

Patient/Guarantor Signature Date

Release of Patient Healthcare Information

I hereby authorize Cashion and De Leon, L.L P dba NP Clinic to release patient healthcare information, in accordance with the policy of the clinic, as is necessary to health care providers to facilitate reimbursement by a health benefit plan or personnel of another health care entity for the sole purpose of providing current continuum of care including, but not limited to fax, mail or electronic submission.

X_____ _____

Patient/Guarantor Signature Date

Do you have an advanced directive (living will)? _____ **Yes** _____**No**

If yes, please bring a copy into our office for our files.

If no, and you would like information on and advanced directive, please speak with your physician.

The above authorizations are valid unless you specify otherwise or revoke them in writing.

CONSENT FORM

(For Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations)

I understand that as part of my healthcare, either Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and medical health information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the Practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon. Any patient, guardian or personal representative has the right to request to receive confidential communications of protected health information by alternative means or at alternative locations. Such request must be in writing and the practice must accommodate reasonable request.

With this consent, Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic, may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and operations (TPO); such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic may e-mail to me appointment reminder cards and patient statements. I have the right to request that Cashion and De Leon, L.L.P dba NP Clinic restrict how it uses or discloses my patient health information (PHI) to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement

By signing this form, I am consenting to either, Cashion and De Leon, L.L.P dba NP Clinic and or BCS Chiropractic to use and disclosure of my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic may decline to provide treatment to me.**

Print Patient Name: _____ Account Number:_____

Signature of Patient or Legal Guardian: _____ Date:_____

Hipaa Consent Form 802 (form2)

This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

NOTICE OF INFORMATION PRACTICES

1. Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic may use and disclosure protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool, or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.

2. Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.

3. Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.

4. Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic will abide by the terms of this notice currently in effect at the time of the disclosure.

5. Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic will provide each patient with a copy of any revisions of it's Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.

6. Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes.

7. Any patient, guardian or personal representative has the right to inspect and obtain copies of their medical record.

8. Any patient, guardian or personal representative has the right to request amendments be made to their medical record.

9. Any patient, guardian or personal representative has the right to request to receive confidential communications of protected health information by alternative means or at alternative locations. Such request must be in writing and the practice must accommodate reasonable request.

10. Any patient, guardian or personal representative has the right to request a six-year accounting of all disclosures of their medical record The history will be provided within 60 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12-month period.

11. Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested, but if the Practice does agree, the Practice must abide by those restrictions.

12. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the following address and /or phone number Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic., 1605 Rock Prairie Road Suite 315, College Station, Texas 77845, Telephone (979) 694-2026 (979) 695-1976 Fax (979) 694-6403 OR 1100 Rayford Road Ste. 300, Spring, Texas 77386, Telephone (281) 367-725 or Fax 281-367-7313. All complaints will be addressed and the results will be reported to the Privacy Officer.

13. It is the policy of Cashion and De Leon, L.L.P dba NP Clinic and BCS Chiropractic that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.
The effective date: September 1, 2011

Name of Patient: _____

Signature of Patient or Legal Guardian _____ Date : _____

Consent to Use of Electronic Mail

Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic would like to give you the chance to communicate with your doctors, other healthcare providers (such as nurses), and administrative services by electronic mail (email).

Sending private patient information by email, however, has a number of risks that you should think about.

Risks of Email

- Email may be instantly sent worldwide and be received by many intended and unintended recipients.
- Those who get email can pass on messages to anyone without the original sender's permission or knowledge.
- Users can easily misaddress an email.
- Backup copies of email may exist even after the sender or the recipient has erased their copy. All emails will be kept in your medical record. This means that all people who have access to the medical record will be able to see the emails.
- You should not use your employer's email system to send or receive private medical information. If you choose to send or receive an email from your workplace, there is a chance your employer could read the message.
- Email messages may not be answered on the same business day. We will make an effort to read and respond to email as soon as possible, but we cannot guarantee that any email message will be answered within any set period of time.

Never use email in an urgent situation or in an emergency.

Conditions for the Use of Email

If you agree to the use of email, you agree to the following rules:

- Your message should be short. If you feel your message is too long for an email, you may wish to call our office or schedule an appointment.
- Please write the topic of your email in the subject line.
- Please write your name and patient identification number, if known, in the message.
- It is the policy of Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic to make all email messages sent or received that are about medical treatment a part of your

medical record. We will treat such email messages with the same amount of confidentiality as other portions of the medical record.

- We will make every effort to protect the privacy of email information. All of our employees must use password-protected screen savers whether they are working in the office, hospital or their home office. However, due to the possibility of technical problems, we cannot guarantee the security of all emails. **Your use of email is an acknowledgement of this insecurity and your acceptance of the risk.**

- Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic may forward email messages as needed for diagnosis, treatment, and reimbursement. Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic will not pass on the email to others without your prior consent.

- Because some medical information is sensitive and the privacy of email is not guaranteed, **you should not use email for communications about sensitive information.** Some examples are protected diagnoses (such as mental health conditions or substance abuse problems), information about HIV/AIDS, and workers' compensation injuries.

- To prevent identity theft, we require that you come into the office to change your address or other contact information maintained in our records. You cannot do this by email.

- Do not send financial information, credit card numbers, checking account numbers, or any similar information to Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic by email. **We will not ask you for this information by email. Any email supposedly from Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic asking for credit card or checking account information is fraudulent.** Please let us know if you receive such an email.

- It is your duty to protect your password or other means of access to email sent or received from Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic. Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic is not responsible for breaches of confidentiality caused by the patient.

- You may withdraw consent to the use of email at any time by email or written communication with Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic.

Your signature below allows Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic to send email to this address:

_____	_____
Email Address (please print)	Full Name (please print)
_____	_____
Signature of Patient or Responsible Party	Date and Time

1605 Rock Prairie Road Ste. 315, College Station, Texas 77845. Tel 979-694-2026 / 979-695-1976 Fax 979-694-6403
1100 Rayford Road Ste. 300, Spring, Texas 77386 Tel 281-367-7275 Fax 281-367-7313

Authorization for Release of Medical Information

Medical Record Number _____

I hereby authorize the release of information from the medical record of:

Patient Name:_____ Date of Birth:_____

Social Security #_____(optional) Daytime Phone #:_____

Information Released

TO: _____ FROM: _____

_____ _____

_____ _____

Please release the following:

- **0** Problem List
  Progress Notes
- **0** History/Physical Exam
- **0** Lab Reports
- **0** Immunizations
- **0** X-ray reports
  X-ray films
- **0** EKG reports
- **0** Other diagnostic reports (specify) _____
- **0** Other (specify) _____

Including information (if applicable) pertaining to:

0 Mental Health **0** Drug/Alcohol **0** HIV/AIDS **0** Communicable Treatment

Purpose or Need for Disclosure:

- **0** Continued Patient Care
- **0** Attorney/Legal
- **0** Disability Determination
- **0** Personal Use
- **0** Insurance Claim/Application
- **0** Other (specify) _____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

X _____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO THE PATIENT:

I understand that my medical record may contain reports; test results, and notes that *only a licensed healthcare professional can interpret.* I understand and have been advised that I should contact a *licensed healthcare professional* regarding the entries made in my medical record and my misunderstanding of the information contained in these entries.

I will not hold Cashion and De Leon, L.L.P dba NP Clinic and/or BCS Chiropractic liable for any misinterpretation of the information in my medical record as a result of not consulting my *licensed healthcare professional* the correct interpretation.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient Witness

Date request completed _____ # of pages _____ Reviewed only _____

Charges $ _____ Cash _____ Check _____ Initials _____