Avenues of Health

Dr. Bob Shepherd **Dr. Paula Allenburg** **Dr. Jane Green**

Name _____ Date _____
(First) *(Middle Initial)* *(Last)*

Address _____ City _____

State _____ Zip Code _____ Home Phone _____

Cell Phone _____ E-mail _____

Date of Birth _____ Gender: M F

Marital Status: Married Single Divorced Widowed Separated Domestic Partner

Social Security Number _____

If under 18, please include parent/guardians name and address:

Name _____ Home Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip Code _____

Referred to this Clinic by: Friend Relative Medical Doctor Chiropractor Newspaper Yellow Pages
Insurance Directory Sign/Location

Please provide the name: _____

Employment Information

Name of Employer _____

Address _____ City _____

State _____ Zip Code _____ Telephone _____

Nature of Your Work _____

Name of Your Spouse/Partner _____

Employer _____

Address _____ City _____

State _____ Zip Code _____ Telephone _____

HIPPA PRIVACY
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this acknowledgement of Receipt of Notice of Privacy Practices (the Notice), I acknowledge and agree that I have read this copy of the Notice of Privacy Practices on the date identified below and it will kept in my records.

I understand the clinic may use and disclose necessary personal health information (for example name, address, HMO identification number, exam information, diagnosis and services provided) to another party to permit the Clinic to perform its administrative duties, provide me with chiropractic/health care services and products, process my benefit claims and communicate with me regarding services provided by the clinic (for example, making of appointment reminders or information about services/products provided by the Clinic).

I can be assured that the clinic does not sell my personal health information of any kind to a third party for any use. I authorize the Clinic to submit my chiropractic claims to my plan sponsor or health plan to receive direct reimbursement for the chiropractic services and products that I have received from the Clinic. I authorize the Clinic to release any medical information necessary to process my insurance claims(s).

This authorization will be kept on file and will remain in effect unless I notify you in writing of any changes.

_____ _____

Patient Signature Date

CONSENT FOR TREATMENT

I, the undersigned, a patient of this clinic hereby authorize Dr. Bob Shepherd, Dr. Paula Allenburg, Dr Jane Green (and whomever they designate as their assistants) to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that chiropractic care, as with any health intervention, has inherent risks. These risks, though rare, could occur ranging from a minor aggravation of current symptoms to serious conditions such as cerebral vascular accident or death. I am signing this consent being fully informed by the doctor's and or their staff of the risks and benefits of the care and the risks and benefits of not having the recommended treatment.

This authorization will be kept of file and will remain in effect unless I notify you in writing of any changes.

_____ _____

Patient Signature Date

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize Bob Shepherd, D.C., Paula Allenburg, D.C. and Jane Green, D.C. and whomever they designate as their assistant(s) to administer chiropractic care as they deem necessary to my_____
(Relationship)

_____ _____

Parent/Guardian Signature Date