



Body + Balance Center

1306 Johnson Ave. San Luis Obispo, CA 93401 phone (805) 541-8005 Fax (805) 541-8010

CONSENT FOR THE USE OR DISCLOSURE FOR PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996, *Body and Balance Center* may use your personal health information for the purpose of treatment, payment, or health care operations. The specific uses and disclosures that we intend to make are described in our **Notice of Privacy Practices**. You have a right to review the **Notice of Privacy Practices** prior to signing this consent form. You may request restrictions on the uses and disclosures described in the **Notice of Privacy Practices** by describing the requested restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section of your copy of the form and returning it to this office.

CONSENT SECTION

I, _____ (print patient name) hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read *Body and Balance Center's* Notice of Information Practices and to have any questions answered before signing.

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section of this form (given upon request). I further understand that *Body and Balance Center* is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form (given upon request) and returning it to 1306 Johnson Ave., San Luis Obispo, CA 93401. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

Signature of Patient or Guardian

Date



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PATIENT INFORMATION

Date ___/___/___ Social Security # _____ Drivers License _____

Name _____ DOB ___/___/___

Home Phone (___) _____ Cell (___) _____ Email _____

Address _____
Street City State Zip

Marital Status: Single Married Divorced Widowed Sex: Male Female

Referring Physician _____ Date of next appointment ___/___/___

Primary Care Physician _____

Employer _____ (___)
Name City Phone #

Occupation / Student _____ Emergency Contact _____
Phone# (___) _____

Name of spouse / responsible party _____

Employer _____
Name City State Zip

Primary Insurance Company _____ Name on card _____

Co-pay amount \$ _____ DOB ___/___/___

Secondary Insurance Company _____ Name on card _____

Co-pay amount \$ _____ DOB ___/___/___

Was the injury work related? yes no Was the injury car accident related? yes no

Date of Injury ___/___/___

Attorney (if any) _____
Name Street City State Zip

ASSIGNMENT OF INSURANCE AND PATIENT AGREEMENT

- I certify that I and / or my dependant(s) have insurance coverage with _____ and assign directly to *Body and Balance Center* all insurance benefits, if any, otherwise payable to me for services rendered.
- I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of of my signature on all insurance submissions. I understand it is my responsibility to understand my insurance policy and coverage.
- I the undersigned will be responsible for all collection and legal fees accrued on delinquent accounts.

CONSENT FOR SERVICES AND RELEASE OF INFORMATION

I voluntarily consent to services provided at *Body and Balance Center*. I authorize *Body and Balance Center* to release any information it may have on my medical condition to my physician, insurance company or attorney as indicated above.

CANCELLATIONS / NO SHOWS

If during the course of treatment I must cancel a scheduled appointment, I will notify *Body and Balance Center* no less than 4 hours before the time of appointment. If I fail to give notice of cancellation,

I UNDERSTAND THAT A \$25 FEE WILL BE ASSESSED AND I AM RESPONSIBLE FOR PAYMENT OF THAT FEE, NOT MY INSURANCE COMPANY.

Signature/Guardian signature (if minor)

Date



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MEDICAL INFORMATION

Name _____ Date ____/____/____

Have you ever had any of the following?

- | | | | |
|----------------------------------|--|-----------------------------------|--|
| 1. Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Recurrent! Frequent Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Ulcer! Stomach Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Hospitalization in past year | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Parkensons Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Smoker | <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Chemical Dependency/Alcohol | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | 22. Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | 23. Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Pregnant | <input type="checkbox"/> Yes <input type="checkbox"/> No | 24. HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Respiratory Problems! Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | 25. Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | 26. Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | 27. Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |

List any medications you arecurrently taking, prescribed or over the counter. _____

Since the onset of the current symptoms, have your experienced any of the following:

- | | |
|--|--|
| Dizziness or fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty with bowel/bladder function | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Numbness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Weakness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Problems with hearing or vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Unexplained weight change | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fever or chills | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please describe any regular exercise activities _____

Level of stress High Medium Low