

FOR OFFICE USE ONLY:

Patient Number: _____

Doctor: _____

Insurance: _____

Emp. Initials: _____

CHIRO NEW PATIENT:

PATIENT INFORMATION:

****Please give your Driver's License and insurance card to the front desk to copy for your records.****

Patient Name: Last _____ First _____ Date ____/____/____

Address: _____ City _____ State _____ Zip _____

Cell Phone: (____) ____ - ____ Home Phone (____) ____ - ____ Birth date ____/____/____ Age ____

Sex: ____M ____F Driver's License: _____ Patient Soc. Sec. # ____ - ____ - ____

Marital Status: S M D W Spouse's Name: _____ Referred by: _____

Person responsible for payment: _____ Patient Employed by: _____

Occupation: _____ Work Phone: (____) ____ - ____

Email: _____

Preferred method of contact for appointment reminders (circle one): Phone (home or cell) / text / email

Have you ever been to a Chiropractor before?: YES NO

Have you filed a legal claim at this time (circle if yes): Auto accident / Personal injury / Workman's Compensation

CHIEF COMPLAINT: Answer the questions as completely as possible. If a question does not apply, leave it blank.

Reason for today's appointment: Neck pain Upper back pain Low back pain Other: _____

Which side of your body is the complaint on? Right Left Both

How long have you had this problem?

Date: _____ or ____day(s) ____ week(s) ____ month(s) ____ year(s)

How do you think your problem began?

How often do you experience your symptoms?

Constantly (76-100% of the time) Frequently (50-75%) Occasionally (26-49%) Intermittently (0-25%)

Rate the severity of your symptoms:

Mild Moderate Severe

How does this effect your movement?

Stiffness Spasms Cramps

What makes the symptoms worse?

What makes the symptoms better?

Please add any other information about the primary complaint that may be helpful:

*****Please list any ADDITIONAL complaints that you have: (Other areas of pain, etc.)*****

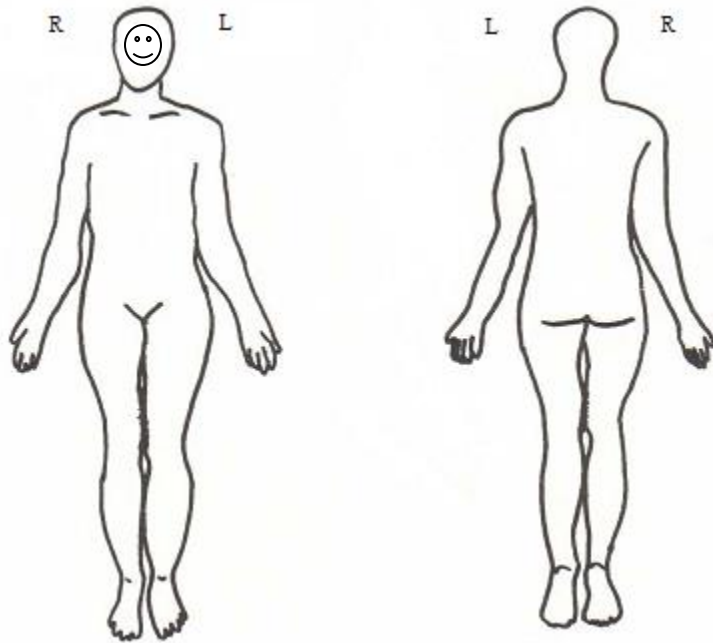
PATIENT'S INITIALS _____ DATE _____

PAIN DRAWING:

INSTRUCTIONS: *Mark the area on your body where you feel the described sensations:*

- *Use the appropriate symbol*
- *Mark the areas of spread*
- *Include all affected areas*

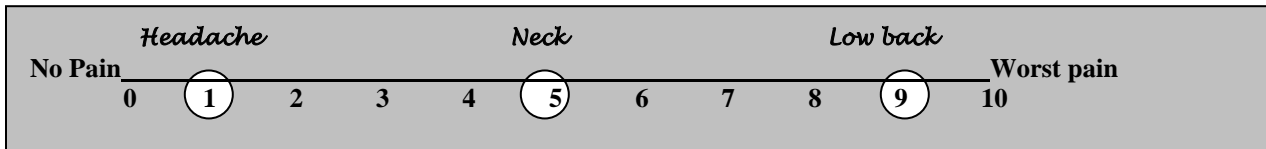
KEY:	
Numbness / Tingling	=====
Pins & Needles	oooooooo
Burning pain	xxxxxxxx
Dull / achy pain
Sharp / Stabbing pain	////////////////



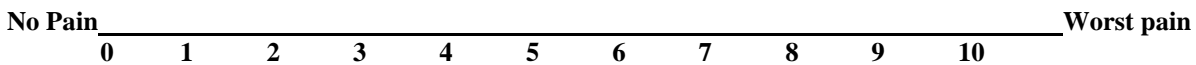
VISUAL PAIN SCALE

INSTRUCTIONS: *Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each individual complaint and indicate a score for each complaint. Please indicate your pain level right now, at its worst and at its best.*

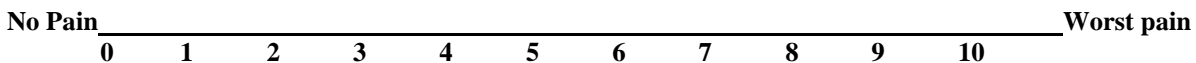
Example:



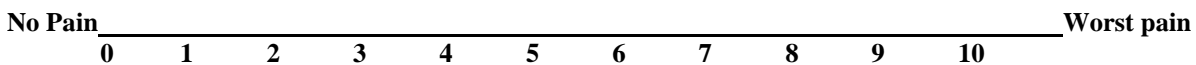
What is your pain RIGHT NOW?



What is your pain at its BEST?



What is your pain at its WORST?



PATIENT'S INITIALS _____ DATE _____

REVIEW OF SYSTEMS: Please CIRCLE any condition that you CURRENTLY HAVE. Or check NONE .

ALLERGIC/IMMUNOLOGIC: NONE Food Allergies Frequent sinus problems Hay fever Hives

CARDIOVASCULAR: NONE Ankle swelling An unusually slow pulse Blood clots Blue extremities Chest pain
Cold hands/feet Feeling light headed with standing Heart murmur Heart problems High blood pressure High cholesterol Leg pain with
walking Low blood pressure Palpitations (heart skipping beats) Poor circulation Rapid heartbeat Sores that don't heal Taking
nitroglycerine Varicose veins

CONSTITUTIONAL: NONE Chills Difficulty concentrating Difficulty sleeping Fatigue Fainting Fever Low libido
Nervousness Night Sweats Poor appetite Side effects from medications Sudden weight loss Sudden weight gain Weakness

EARS, NOSE & THROAT: NONE Bleeding gums Blisters/cold sores Chronic ear infection Dental problems/toothaches
Deviated septum Dry mouth Dysphagia Ear discharge Ear noises/ringing Ear pain Frequent colds Gum disease Halitosis Hearing loss
Loss of smell Loss of taste Loss of teeth/ have dentures Motion sickness Nose bleeds Nasal breathing problems Nasal drip Nasal polyps
Punctured ear drum Recurrent ear infections Sinus infections Sinus pain Sneezing spells Sore throat/hoarseness Sore tongue Sores or
cracks at mouth corners Sores/ulcers Tongue badly coated Tonsillitis Vertigo/dizziness

ENDOCRINE: NONE A loss of appetite Being tired most of the time Being unusually jumpy or nervous
Changes in hair growth or distribution Cold intolerance Excessive hunger Excessive thirst Extreme Thinness
Feeling drowsy after eating Feeling shaky or faint when hungry Frequent infections Heat intolerance Hoarseness Hyperthyroid
Hypothyroid Needing to eat to relieve fatigue Type I diabetes Type II diabetes Unexplained weight gain Unexplained weight loss

EYES: NONE Sensation of burning in the eyes An injury to the eyes Blurred vision Cataracts Crossed eyes Dry or gritty eyes
Far sightedness Glaucoma Itchy eyes Near sightedness Redness Swelling Tearing/crusting Vision headaches

GASTROINTESTINAL: NONE Abdominal gas Abdominal pain Acid reflux Anorexia/Bulimia Belching or burping after meals
Black or tarry stools Constipation Diarrhea Difficulty in swallowing Food sensitivities Frequent indigestion Gall bladder disease
Having one or less bowel movements Heartburn Hemorrhoids Intestinal worms Liver trouble Nausea
Pain or indigestion after eating greasy foods Pale or yellow stools Stomach ulcers Ulcer Vomiting

GENITOURINARY: NONE A discharge other than urine Bedwetting Bladder control problems
Cloudy/foul smelling urine Difficulty starting a stream Discolored urine Dribbling Erectile dysfunction Frequent urination Getting up at
night to urinate Infertility Kidney stones Kidney or bladder infections Painful urination PMS symptoms Urgency Uterine cysts
Uterine fibroids

HEMATOLOGIC/LYMPHATIC: NONE Anemia Bleeding or bruising Blood clots Hemophilia Hepatitis A Hepatitis B
Hepatitis C HIV/AIDS Jaundice Liver problems
Lymphoma Myeloma Swollen Glands

INTEGUMENTARY/SKIN: NONE Acne Boils Bruising Coarse or bumpy skin Corns Dandruff Dryness Eczema
Excessive perspiration Hair changes Hair loss Itching Nail bed changes Nail fungus Plantar warts Psoriasis Rashes Skin cancer
Sores

MUSCULOSKELETAL: NONE Arthritis Back injuries Back pain Frequent foot cramps General muscle tension Heel spurs
Hot joints Joint pain Joint stiffness Joint swelling Leg cramps during the day Leg cramps when retiring to bed or at night Muscle cramps
Muscle pain Muscle twitching Muscle Weakness Neck injuries Pain between the shoulders Painful feet Rheumatism Scoliosis
Tender ribs TMJ pain

NEUROLOGICAL: NONE Confusion Convulsions Difficulty of speech Dizziness/vertigo Double vision Epilepsy Fainting
spells Forgetfulness Hand trembling Headaches Incoordination Losing consciousness Loss of feeling Memory loss Meningitis
Muscle jerking/twitching/tics Numbness/tingling Paralysis Pins/needles Seizures Stuttering

PSYCHIATRIC: NONE Alcoholism Anxiety Being timid or shy Considerable emotional stress Crying often Depression
Drug addictions/dependency Eating when nervous Extreme worry Feeling angered or irritable Feeling miserable or blue
Frequent hyperventilation Hallucinations Insecurity Nail biting Phobias Recurrent bad dreams Sleep walking Suicidal thoughts

RESPIRATORY: NONE Apnea Asthma Chronic cough Congestion COPD Coughing up blood Difficulty breathing
Emphysema Hay fever Non-productive/dry cough Pain upon expiration Pain upon inspiration Phlegm Pneumonia Productive cough
Severe colds Shortness of breath Wheezing

PATIENT'S INITIALS _____ DATE _____

FAMILY HISTORY: Please select the conditions that pertain to your family. (If known)

Relative:	Age: (if living)	Conditions/Illnesses:	Age at death:
Mother:	_____	_____	_____
Father:	_____	_____	_____

SOCIAL HISTORY: Please answer as completely as possible.

Marital Status: _____

Number of children: ____ Number of Pregnancies: ____ Number of miscarriages: ____ Number of abortions: ____

Highest level of education: _____

Do you feel that you eat a well-balanced diet? _____

How often do you exercise? _____ What types of exercises? _____

How often do you drink alcohol? _____

If you smoke cigarettes, how often? _____ If you chew tobacco, how often? _____

Have you ever used illegal drug? (circle) YES NO

If you use illegal drugs now, which ones? _____

Have you ever been treated for substance abuse? (circle) YES NO

Are your vaccinations up to date? (circle if known) YES NO

SURGICAL HISTORY:

Please list any surgeries that you have had in the past and the date if known. Also INCLUDE RIGHT OR LEFT side of body where applicable.

I have never had any previous surgery

PROCEDURE:	DATE:	PROCEDURE:	DATE:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES: Please list any allergies as well as your reaction to the allergen if known.

Environmental: _____
Food: _____
Medication/Drug: _____

CURRENT MEDICATIONS:

Current Medications and Vitamin Supplements: (Please use reverse side if more space is required.)

NAME:	STRENGTH:	FREQUENCY:	NAME:	STRENGTH:	FREQUENCY:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

PATIENT'S INITIALS _____ DATE _____

Neck Pain and Disability Index

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your **neck pain** has affected your ability to manage in everyday life. In each section, please fill in **ONE** box only which **most closely** describes your problem.

Section 1 Pain Intensity

- A. I have no pain at the moment.
- B. The pain is very mild at the moment.
- C. The pain is moderate at the moment.
- D. The pain is fairly severe at the moment.
- E. The pain is very severe at the moment.
- F. The pain is the worst imaginable at the moment.

Section 6 Concentration

- A. I can concentrate fully when I want with no difficulty.
- B. I can concentrate fully when I want with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want.
- D. I have a lot of difficulty in concentrating when I want.
- E. I have a great degree of difficulty in concentrating when I want.
- F. I cannot concentrate at all.

Section 2 Personal Care

- A. I can look after myself normally without causing extra pain.
- B. I can look after myself normally but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help but manage most of my personal care.
- E. I need help every day in most aspects of self care.
- F. I do not get dressed, I wash with difficulty and stay in bed.

Section 7 Work

- A. I can do as much work as I want.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I can hardly do any work at all.
- E. I cannot do my usual work.
- F. I can't do any work at all.

Section 3 Lifting

- A. I can lift heavy weight without extra pain.
- B. I can lift heavy weight but it gives extra pain.
- C. Pain prevents me from lifting heavy weights off the floor, but I can manage it they are conveniently positioned.
- D. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything at all.

Section 8 Driving

- A. I can drive my car without any neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain.
- D. I can't drive my car as long as I want because of moderate pain.
- E. I can hardly drive at all because of severe pain in my neck.
- F. I can't drive my car at all.

Section 4 Reading

- A. I can read as much as I want with no pain in my neck
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I can't read as much because of moderate pain in my neck.
- E. I can hardly read at all because of severe pain in my neck.
- F. I cannot read at all.

Section 9 Sleeping

- A. I have no trouble sleeping.
- B. My sleep is slightly disturbed (less than 1hr. sleepless).
- C. My sleep is mildly disturbed (1-2 hrs. sleepless).
- D. My sleep is moderately disturbed (2-3 hrs. sleepless).
- E. My sleep is greatly disturbed (3-5 hrs. sleepless).
- F. My sleep is completely disturbed (5-7 hrs. sleepless).

Section 5 Headaches

- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come infrequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all of the time.

Section 10 Recreation

- A. I am able to engage in all recreational activities with no neck pain.
- B. I am able to engage in all my recreational activities, with some pain in my neck.
- C. I am able to engage in most, but not all of my usual recreational activities because of my neck pain.
- D. I am able to engage in a few of my usual recreational activities because of my neck pain.
- E. I can hardly do any recreational activities because of pain.
- F. I can't do any recreational activities at all.

PATIENT'S INITIALS _____ DATE _____

Low Back Pain and Disability Index

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your **low back pain** has affected your ability to manage in everyday life. In each section, please fill in **ONE** box only which **most closely** describes your problem.

Section 1 Pain Intensity <ul style="list-style-type: none"><input type="checkbox"/> A. The pain comes and goes and is very mild.<input type="checkbox"/> B. The pain is mild and does not vary much.<input type="checkbox"/> C. The pain comes and goes and is moderate.<input type="checkbox"/> D. The pain is moderate and does not vary much.<input type="checkbox"/> E. The pain comes and goes and is very severe.<input type="checkbox"/> F. The pain is very severe and doesn't vary much.	Section 6 Standing <ul style="list-style-type: none"><input type="checkbox"/> A. I can stand as long as I want without pain.<input type="checkbox"/> B. I have some pain on standing but it does not increase with time.<input type="checkbox"/> C. I cannot stand for longer than one hour without increasing pain.<input type="checkbox"/> D. I cannot stand for longer than a ½ hour without increasing pain.<input type="checkbox"/> E. I can't stand for longer than 10 minutes without increasing pain.<input type="checkbox"/> F. I avoid standing because it increases the pain straight away.
Section 2 Personal Care <ul style="list-style-type: none"><input type="checkbox"/> A. I can look after myself normally without causing extra pain.<input type="checkbox"/> B. I can look after myself normally but it causes extra pain.<input type="checkbox"/> C. It is painful to look after myself and I am slow and careful.<input type="checkbox"/> D. I need some help but manage most of my personal care.<input type="checkbox"/> E. I need help every day in most aspects of self care.<input type="checkbox"/> F. I can't dress myself. I wash with difficulty and stay in bed.	Section 7 Sleeping <ul style="list-style-type: none"><input type="checkbox"/> A. I get no pain in bed.<input type="checkbox"/> B. I get pain in bed but it doesn't prevent me from sleeping well.<input type="checkbox"/> C. Because of pain my normal night's sleep is reduced by < 1/4.<input type="checkbox"/> D. Because of pain my normal night's sleep is reduced by < 1/2.<input type="checkbox"/> E. Because of pain my normal night's sleep is reduced by < 3/4.<input type="checkbox"/> F. Pain prevents me from sleeping at all.
Section 3 Lifting <ul style="list-style-type: none"><input type="checkbox"/> A. I can lift heavy weight without extra pain.<input type="checkbox"/> B. I can lift heavy weight but it gives extra pain.<input type="checkbox"/> C. Pain prevents me from lifting heavy weights off the floor.<input type="checkbox"/> D. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.<input type="checkbox"/> E. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.<input type="checkbox"/> F. I can only lift very light weights at the most.	Section 8 Traveling <ul style="list-style-type: none"><input type="checkbox"/> A. I get no pain while traveling.<input type="checkbox"/> B. I get some pain while traveling but none of my usual forms of travel make it any worse.<input type="checkbox"/> C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.<input type="checkbox"/> D. I get extra pain while traveling which compels me to seek alternative forms of travel.<input type="checkbox"/> E. Pain restricts all forms of travel.<input type="checkbox"/> F. Pain prevents all forms of travel except that done lying down
Section 4 Walking <ul style="list-style-type: none"><input type="checkbox"/> A. I have no pain while walking.<input type="checkbox"/> B. I cannot walk more than one mile without increasing pain.<input type="checkbox"/> C. I cannot walk more than ½ mile without increasing pain.<input type="checkbox"/> D. I cannot walk more than ¼ mile without increasing pain.<input type="checkbox"/> E. I can walk with crutches.<input type="checkbox"/> F. I cannot walk at all without increasing pain.	Section 9 Social life <ul style="list-style-type: none"><input type="checkbox"/> A. My social life is normal and gives me no pain.<input type="checkbox"/> B. My social life is normal but increases the degree of pain.<input type="checkbox"/> C. Pain limits my more energetic interests, e.g. dancing, etc.<input type="checkbox"/> D. Pain has restricted my social life and I do not go out very often.<input type="checkbox"/> E. Pain has restricted my social life to my home.<input type="checkbox"/> F. I have hardly any social life because of the pain.
Section 5 Sitting <ul style="list-style-type: none"><input type="checkbox"/> A. I can sit in any chair as long as I like.<input type="checkbox"/> B. I can only sit in my favorite chair as long as I like.<input type="checkbox"/> C. Pain prevents me from sitting more than one hour.<input type="checkbox"/> D. Pain prevents me from sitting more than a half hour.<input type="checkbox"/> E. Pain prevents me from sitting more than 10 minutes.<input type="checkbox"/> F. I avoid sitting because it increases pain straight away.	Section 10 Changing Degree of Pain <ul style="list-style-type: none"><input type="checkbox"/> A. My pain is rapidly getting better.<input type="checkbox"/> B. My pain fluctuates but overall is definitely getting better.<input type="checkbox"/> C. My pain seems to be getting better but improvement is slow.<input type="checkbox"/> D. My pain is neither getting better nor worse.<input type="checkbox"/> E. My pain is gradually worsening.<input type="checkbox"/> F. My pain is rapidly worsening.

PATIENT'S INITIALS _____ DATE _____

HIPAA Acknowledgement and Consent

I, the undersigned, acknowledge that I have had access to a copy of the **NOTICE OF PRIVACY PRACTICES**. I consent to your disclosure, which you deem necessary in connection with my or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

Patient signature _____ Date _____

Authorization and Assignment

AUTHORIZATION TO BILL INSURANCE: I understand my insurance will be billed for services rendered at Total Health Systems, PC.

AUTHORIZATION TO RELEASE INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you of any consequence thereof.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any moneys due him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charges and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

MEDICARE ASSIGNMENT (if applicable): I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

ACKNOWLEDGMENT AND UNDERSTANDING: I hereby acknowledge; That if there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor; or if a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then payment of services rendered by Total Health Systems PC, will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last statement, whichever comes first.

SPECIAL CONSIDERATION: I understand that should I have a financial hardship and am unable to completely satisfy my deductible/copy/or coinsurance I will notify Total Health Systems, PC and a separate written contract will be created and signed.

Patient signature _____ Date _____

Consent to Treat

THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL, PHYSICAL THERAPY, AND/OR CHIROPRACTIC CARE. I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Total Health Systems, P.C. I understand, and am informed that, while extremely rare, there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, and strains. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Patient signature _____ Date _____

Parent/Legal guardian name (please print) _____

Guardian Signature _____ Date _____

PATIENT'S INITIALS _____ DATE _____

TOTAL HEALTH SYSTEMS

Multi-Specialty Clinic

Chiropractic • Medical • Physical Therapy • Massage Therapy • Nutrition

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Total Health Systems, P.C. or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature

Date

Print Patient's Full Name

Time

Witness Signature

Date

26672 Van Dyke • Centerline • Michigan 48015 • (586) 756-7670
43740 Garfield • Clinton Township • Michigan 48038 • (586) 228-0270
28098 23 Mile Rd • Chesterfield Township • Michigan 48051 • (586) 949-0123
30045 Harper Ave • St Clair Shores • Michigan 48082 • (586) 772-8560
57911 Van Dyke Rd • Washington Township • Michigan 48094 • (586) 781-0800
Fax (586) 228-9019

www.totalhealthsystems.com

PATIENT'S INITIALS _____ DATE _____

TOTAL X HEALTH SYSTEMS

Multi-Specialty Clinic

Chiropractic • Medical • Physical Therapy • Massage • Nutrition • Fitness

Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

- X-Rays History Diagnosis Treatment Reports
 Other: _____

Purpose of Release

- For the purpose of treatment at the above health care facility.
 Other: _____

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Name of Person Organization

Name of Person Organization

Expiration Date of Authorization

This authorization is effective through _____ unless revoked or terminated by the patient or patient's personal representative.

Patient Rights

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contacting the Privacy Officer.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure. **If you understand and agree with all of the above policies, please sign your name below.**

Patient or Legally Authorized Individual Signature

Date & Time

Print Patient's Full Name

Date of Birth (XX/XX/XXXX)

Witness Signature

Date

26672 Van Dyke • Centerline • Michigan 48015 • (586) 756-7670
43740 Garfield • Clinton Township Michigan 48038 • (586) 228-0270
28098 23 Mile Rd • Chesterfield Township • Michigan 48051 • (586) 949-0123
30045 Harper Ave • St Clair Shores • Michigan 48082 • (586) 772-8560
57911 Van Dyke Rd • Washington Township • Michigan 48094 • (586) 781-0800
Fax (586) 228-9019

www.totalhealthsystems.com

PATIENT'S INITIALS _____ DATE _____