

Case #:

*Mats Mats Chiropractic and Wellness Clinic*

7470 Oak Bay Road  
Port Ludlow, WA 98365  
Marjorie Pederson, DC  
360-437-2596

**NEW PATIENT INFORMATION**

Welcome! Please allow our staff to photocopy your Medicare card (if applicable).

PLEASE PRINT CLEARLY

M F    Age \_\_\_\_\_    Birth Date: \_\_\_\_\_  
 Full name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 email: \_\_\_\_\_ May we contact you by email? Y N  
 Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ work phone: \_\_\_\_\_  
 Marital Status: S M D W    # of children \_\_\_\_\_    Work Status: full time part-time self-employed retired  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 May we contact you at home? Y N    May we leave a message on your phone or with a family member? Y N  
 Name of Spouse, Parent, or Guardian: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_ work phone: \_\_\_\_\_ - \_\_\_\_\_  
 In Case of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ work phone: \_\_\_\_\_  
 Do you have Medicare Insurance? Y N    Plan/Group #: \_\_\_\_\_  Medicare card copied by Staff

How did you hear about our clinic? Whom may we thank for referring you? \_\_\_\_\_

We want you to know how your Patient Health Information (PHI) will be used in this office and our rights concerning those records. Before we will begin any health care operation we must require you to read and sign this consent form stating that you understand and agree with how our records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow **Marjorie Pederson, DC** to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

**I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse's or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_