

Allie Chiropractic Clinic
1654 Rice Street • St Paul, MN 55117

PATIENT INFORMATION SHEET

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please print. All information will be confidential.

Date _____ Patient Name _____ Patient # _____
 Male Female (Last) (First) (MI)
SSN _____ Birth date _____ Home phone (_____) _____

Cell phone (_____) _____ Email address _____

Address _____ City _____ State _____ Zip _____

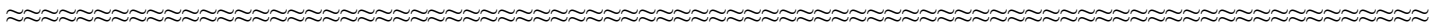
Check appropriate box: Minor Single Married Divorced Widowed Separated

If Minor-parent's name _____ Birth date _____

Patient's or Parent's Employer _____ Work phone (_____) _____

Person to contact in case of emergency _____ Phone (_____) _____

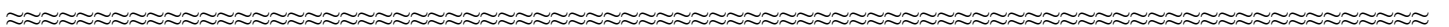
Whom may we thank for referring you? _____



We ask you to make every effort to be here for your scheduled appointments because these appointments are important for your continued improvement.

If you are satisfied with the care you receive we ask that you try to refer a friend or relative so that they may also benefit from improved health and well being.

If you are not satisfied with the care you receive we ask that you please give us suggestions about how we can improve.



A service charge of 1.5% per month 18% APR will be added to all overdue accounts. Also you will be liable for all legal and collection fees. **ALL COPAYS ARE DUE AT THE TIME OF YOUR VISIT.**

X _____
Signature of patient or parent if minor

Date

Allie Chiropractic Clinic & Primary Care & Rehabilitation

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NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for announcements and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Printed Name

Authorized Provider Representative

Signature

Date

Date

