Millhopper Medical Rehabilitation Specialists **2341 NW 41st Street, Suite C, Gainesville, FL 32606**
Ph: 352-375-3668 **Fax: 352-375-8416** **rehabandchiropractic.com**

Confidential Patient Information

Patient ID #:_____

First Name: _____ Middle Initial: _____ Last Name:_____

I prefer to be called: _____ Preferred pronoun:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth:_____ Age:_____ Number of Children_____

SSN:_____ -_____-_____

Spouse's Name:_____ Marital Status: Married Single Widow Divorced

Occupation:_____ Dominant Hand: ___Right ___Left ___Both

Email:_____@_____._____

Is it okay to email you? Y / N Is it okay to leave voice messages? Y / N Is it okay to send texts? Y / N

Home #: ( ) _____-_____Work#: ( )_____-_____Cell# ( )_____-_____

****Please circle your preferred contact number**

Emergency Contact: _____Contact # ( )_____-_____

Date of Injury:_____-_____-_____

Did you receive treatment anywhere? If so, where? _____

_____

Surgeries? If so when/where? _____

_____

Are you on any medications? If so, please list them: _____

_____

Insurance Provider:_____ **Number:** _____

Please provide a copy of your card and a photo ID to the front desk. Thank you.

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Patient Name:_____ DOB:_____ Date:_____

Description of Symptoms : (Check off or Circle your symptoms in the sections below.)

○ Headaches		**Left**	**Right**	**Both Sides**	**Type of Pain:**	**List ALL that**
		Front of Head				**Apply from**
		Top of Head				**List below**
		Back of Head				
○ Jaw		Left	Right	Both Sides		
○ Eye		Left	Right	Both Sides		
○ Neck		Left	Right	Both Sides		
○ Upper Back		Left	Right	Both Sides		
○ Mid Back		Left	Right	Both Sides		
○ Low Back		Left	Right	Both Sides		
○ Chest		Left	Right	Both Sides		
○ Abdomen		Left	Right	Both Sides		
○ Ribs		Left	Right	Both Sides		
○ Buttocks		Left	Right	Both Sides		
○ Shoulder		Left	Right	Both Sides		
○ Upper Arm		Left	Right	Both Sides		
○ Forearm		Left	Right	Both Sides		
○ Hand		Left	Right	Both Sides		
○ Knee		Left	Right	Both Sides		
○ Hip		Left	Right	Both Sides		
○ Leg		Left	Right	Both Sides		
○ Foot		Left	Right	Both Sides		
TYPES OF PAIN:		Dull	Sharp	Aching	Cutting	Shocking
		Throbbing	Burning	Numbing	Tingling	Cramping
		Spasm	Stinging	Shooting	Pounding	Constricting
Other types of pain:		_____	_____	_____	_____	

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Patient Name: _____ Date: _____

PATIENT'S STATEMENT OF PRIVACY RIGHTS

As a patient of this practice, you have the right to privacy of your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the Health Information Accountability and Portability Act of 1996 (HIPAA). HIPPA was enacted to give you, the patient of a health care provider and covered under a health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that health care providers and others must achieve to protect the privacy of Personal Health Information, and to hold violators accountable, with appropriate penalties for violation of a patient's right to privacy.

This notice takes effect on _____ and remains in effect until we replace it.

AS A PATIENT OFTHIS PRACTICE:

1. You are entitled to an individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice's facility. The document you are reading is this notice. PLEASE REVIEW TO CAREFULLY.
2. You are entitled to see your medical records.
3. You are entitled to receive a copy of your medical records. (Forms are available upon request.) As per allowance by HIPAA the charge will be $0.10 per page.
4. You are entitled to make an amendment to your patient health information within those records. (Forms are available upon request.)
5. While the doctor has a right to deny inclusion of amendments into a patient file, you gave the right to disagree with the doctor's refusal of such inclusion of amendment to those records. (Forms are available upon request.) If the doctor disagrees, he shall supply you with written notification of such disagreement.
6. The doctor has a right to a rebuttal to the patient's disagreement. But any time a file is sent out of the office, a copy of that rebuttal must be included in the file.
7. You have the right to specify how access to your health information is restricted and from whom.
8. You have the right to indicate the method and/or phone numbers and/or addresses to which telephonic and written communications to you shall be forwarded.
9. All covered entities under HIPAA, such as this practice or other health care providers, or business associated such as billing companies or claims administrators, as are designated by the HIPAA Privacy Rule, and with whom this practice must work on your behalf from the standpoint of effective treatment or billing of medical services and administration of such services, shall be part of a "chain of trust" under applicable with those parties. This means that those parties are bound to maintain the same privacy and security of your health information, as are we.
10. No personal health information shall be released to any person without a signed consent from patient.
11. You are entitled to this practice's best efforts to maintain the security of Personal Health Information on your behalf within and outside this office.
12. The practice shall provide Personal Health Information to require parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf) and so as to maintain the intent of HIPAA in establishing that standard.
13. You have the right to inquire of this office and gain correct and appropriate answers to any questions regarding your privacy rights at any time, consistent with those rights as covered by HIPAA.
14. You have the right to contact the Depart of Health and Human Services, Office of Civil Rights, which administrates HIPAA, with questions or to file a complaint at Toll Free: 1-877-696-6775 or Email: www.hhs.gov/ocr.

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PATIENT'S AFFIRMATION OR RECEIPT OF
PATIENT'S STATEMENT OF PRIVACY RIGHTS

ACKNOWLEDGEMENT FORM

I have received this office's Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Affirmed,

Print Name:_____

Birth Date:_____

Signature:_____

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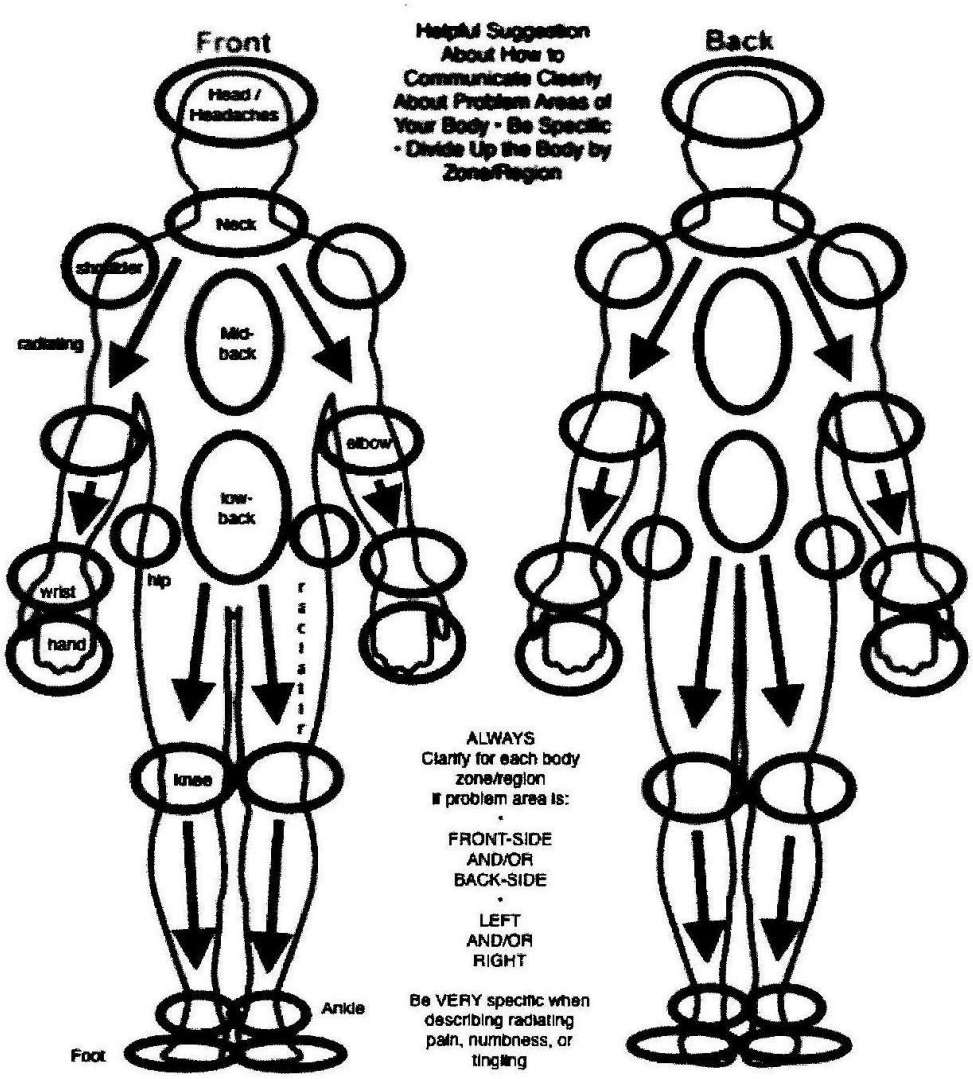
Name:_____ Date:_____

**Please list a pain scale for affected areas from 0-10 with ten being the worst pain you can imagine.



Right **Left** **Left** **Right**