Plattsmouth Hometown Health, LLC

DEMOGRAPHIC INFORMATION **Date: _____**

Last Name: _____ First: _____ M.I.: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____ Cell: _____ Work: _____ (please indicate preferred number)

Email: _____

Appointment reminder via text? ☐ Yes please ☐ No

Birthdate: _____ Age: _____ Gender: ☐ M ☐ F **Social Security #:** _____

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Declined/Refused

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined/Refused

Preferred Language: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have insurance that you would like us to submit claims to? ☐yes ☐ no If yes, please provide us with a copy of your most current card. ***If you receive new cards in the mail, it is your responsibility to provide us with updated copies***.

Insured Date of Birth: _____ Relationship to patient: _____

Insured Address: _____

Insured Employer: _____

Emergency Contact Person: _____ Phone: _____

Employer: _____ Occupation: _____

Employer's Address: _____Phone: _____

Spouse's Name: _____

Spouse's Employer & Work Number: _____

How did you hear about our clinic? _____

Who may we thank for referring you? _____

Is this due to a **worker's comp** claim? ☐yes ☐no Is this due to an **automobile accident**? ☐yes ☐no

Do you have an attorney for this claim? ☐yes ☐ no

Attorney's name: _____ Phone: _____

Attorney's address: _____

If this is an **automobile accident** claim, we need to have your police report and billing insurance information for the claim.

If this is a worker's comp or automobile accident claim that will be billed to a different insurance, we must have that information prior to starting treatment.

If we do not receive the proper billing/insurance information, you will be responsible for all charges.

CONSENT TO TREAT: ***Date:***

I knowingly and willingly authorize the professionals at Plattsmouth Hometown Health, LLC to review my past medical history, current medical history, and any pertinent data relevant to my health care. Furthermore, I acknowledge that no guarantees have been made to me concerning the results of the care and treatment, and that there are risks and benefits to any form of health care. Additionally, I acknowledge that several disciplines of health care are available at this facility, and consent to all forms of therapy as advised by the provider.

Furthermore, I understand that all medical care provided at Plattsmouth Hometown Health, LLC is performed by an Advanced Practice Registered Nurse. Having this knowledge, I knowingly authorize Plattsmouth Hometown Health, LLC to proceed with my care.

Signature: _____

PRIVACY NOTICE:

The privacy notice (HIPAA) describes how medical information about you may be used and disclosed and how you can get access to that information. We are committed to maintaining the privacy of your protected health information (PHI). This includes information about your health and the treatment that you receive. A health record is created that details the care and services you receive in this office to provide you with high quality health care. This notice is to inform you how your PHI may be used and disclosed to third parties. This is also to inform you of your rights regarding your PHI.

I understand that there are independent providers within the same location as Plattsmouth Hometown Health, LLC. To provide quality care, these providers may collaborate about your health information and treatments. At no time will they identify you by name or other identifier to protect your privacy. *If you consent to the providers collaborating about your case in detail, please indicate by checking the box next to the provider's name.* Boxes left blank will indicate that you want your identity kept private during collaborative discussions.

By signing below, I acknowledge that I have received and reviewed this notice and all questions have been answered to my satisfaction in language that I can understand.

Signature: _____

I authorize Plattsmouth Hometown Health, LLC to release my PHI to the below listed individuals:

☐ Dr. Julie Howard, DC, FNP-BC

☐ Dr. Courtney Bradley, DC

☐ Other: _____ (i.e.: spouse's name, children's name, etc.)

☐ Other: _____ (i.e.: spouse's name, children's name, etc.)