Consent to use PHI & Wireless Communications

Acknowledgment 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 Georgetown Clinics and its affiliates 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.

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.

Notice of Treatment in Open or Common Areas
Describe and notify private areas available upon request

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.

GC – Wireless Communications Policy and Consent
Wireless Communication Policy and Consent: By providing Georgetown Clinics with a phone number and/or email address you, or anyone authorized to act on your behalf, are providing express consent authorizing Georgetown Clinics, as well as its agents, subsidiaries, affiliates, officers, partners, successors in interest, and any companies acting on its behalf, to contact you at any phone number or email address you provided or have provided to Georgetown Clinics at any time with information related to your account. By providing Georgetown Clinics with any phone number or email address, you are confirming you are the owner of or are authorized to use the provided phone number or email address. You also confirm that you will notify Georgetown Clinics immediately if you no longer own or are no longer authorized to use any phone number or email address you provide to Georgetown Clinics. You permit Georgetown Clinics to contact you via live operator, automatic telephone dialing systems, prerecorded and artificial voice messages, text messages (SMS or MMS), or email. Phone numbers and email addresses, you authorize Georgetown Clinics to use to contact you include any that you provide to Georgetown Clinics, and that you contact Georgetown Clinics from, and that are provided to Georgetown Clinics by someone acting on your behalf, and any that Georgetown Clinics locates from other lawful sources. You understand that you are solely responsible for payment of any message rates and data charges associated with communications you receive from or send to Georgetown Clinics By providing Georgetown Clinics with any phone number or email address, you acknowledge that you have read, fully understand, and will comply with this Wireless Communication Policy and Consent.

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

Patient or Legally Authorized Individual Signature	Date
Print the Patient's Full Name	Time
Witness Signature	Date

Georgetown Clinic
INTEGRATED INJURY CENTERS

Clinic Location:_____

Patient Information

Name: _____
First Middle Last

Mailing Address:_____ City: _____

State:____ Zip:_____Cell Phone #:_____ E-Mail: _____

Date of Birth: _____ Sex: ☐Male ☐Female SS#:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Minor

Employer:_____ Phone:_____

May we call you at work? ☐Yes ☐No Can we leave a voicemail/message? ☐Yes ☐No

Emergency contact (Name & Phone):_____

Accident Information

Is this visit due to an accident? ☐Yes ☐No If yes, what type? ☐Auto ☐Work ☐Other: _____

Date of Accident: ____/ _____/ _____ Has it been reported? ☐Yes ☐No If yes, to whom?_____

Attorney Name: _____ Contact #:_____

Financial Information

Do you have health insurance? ☐Yes ☐No Name of Carrier:_____

Do you have Automobile Med-Pay insurance? ☐Yes ☐No Name of Carrier:_____

Name of the policy holder of the insurance:_____ SS#: _____

Relationship to patient (if other than self):_____ DOB: _____ Phone:_____

ID #_____ Group #_____Phone number _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR GOVERNMENT ISSUED IDENTIFICATION

Assignment, Consent of Care and Release, HIPPA

I certify that I (or my dependent) have insurance coverage with _____ and I authorize, request and assign my and/or third-party insurance companies to pay directly to this practice the insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. Lab tests may be billed directly by laboratory. I hereby authorize the doctor/s to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me as they deem necessary.

I authorize the use of this signature on all insurance claims, including electronic submissions. If I obtain an attorney, I instruct my attorney to directly pay this clinic for services rendered to me by this clinic, its affiliate clinics and its healthcare providers, any money received from my insurance and/or a third-party insurance company for services rendered to me. I agree not to revoke this instruction before payment in full has been made. I also agree to make the same instruction to any associate or successor attorney who may represent me regarding the same.

I was given the opportunity to receive and review the office's Patient Notice of Privacy Practices policy.

PATIENT SIGNATURE (X):_____ **DATE:**_____

SIGNATURE OF PARENT/GUARDIAN (X):_____ **DATE:**_____
NAME OF PARENT/GUARDIAN:_____

Name: _____ **Chart #:** _____

HEALTH HISTORY

Who is your primary care physician (doctor and/or practice)? _____

Please check to indicate if you are currently experiencing any of the following conditions:

For Post-Concussion Symptoms, please use: **0** = Not experienced at all | **1** = No more of a problem | **2** = A mild problem
3 = A moderate problem | **4** = A severe problem

	Neck Pain		Difficulty Breathing		Sensitivity to Light	
	Upper Back Pain		Sudden Weight Loss		Sleep Disturbance	
	Middle Back Pain		Loss of Taste or Smell		Fatigue	
	Low Back Pain		Fever		Being Irritable, Easily Angered	
	Shoulder Pain		Night Pain		Feeling Depressed or Tearful	
	Arm/Hand Pain		Cold Hands/Feet		Feeling Frustrated or Impatient	
	Leg/Knee Pain		Fainting/Seizers		Forgetfulness	
	Foot/Ankle Pain		**Post-Concussion Symptoms**		Poor Concentration	
	Jaw Pain		Headache		Taking Longer to Think	
	Rib/Chest Pain		Dizziness		Blurred Vision	
	Tingling & Numbness		Nausea/Vomiting		Double Vision	
	Allergies		Sensitivity to Noise		Restlessness	
	Other Pain(s) NOT Mentioned above? _____					

Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, please list any medications you are currently taking:

_____

Please list surgeries and/or hospitalizations you have had including type & date_____

Please list all your allergies, past and current medical conditions: _____

Please list any supplements you are currently taking (herbs, minerals, vitamins, etc.): _____

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents and siblings)

☐ Heart Disease_____ ☐ Diabetes_____

☐ Cancer_____ ☐ Arthritis_____ ☐ Other_____

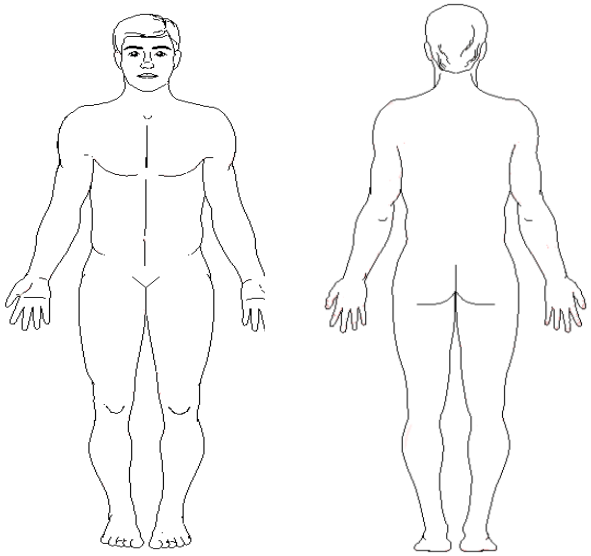
Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Please mark Pain Severity and Pain Type on the body pictures:

Pain Severity: (1) is least pain; and (10) is most pain

Pain Type:

	T = Tight		D = Dull
	A = Ache		S = Sharp
	N = Numb		B = Burning
	TG = Tingling		SH = Shooting
	TH = Throbbing		
	O = Other (please describe):		



Name: _____ **Chart #:** _____

Is the pain: ☐ Constant or ☐ Intermittent (Comes and Goes)

Is it getting progressively worse? ☐ No ☐ Yes

What makes it worse? _____

Does anything make it better? _____

Does it radiate? ☐ No ☐ Yes, If yes, ☐ Right Arm ☐ Left Arm ☐ Right Leg ☐ Left Leg

Do you experience the pain at a particular time of day? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreational Activities

What activities do you enjoy, but do poorly, or not all because of the pain? _____

Painful movements: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

What have you done to treat the pain before today? _____

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

1. Do you suffer from neck, shoulders, arms or hands pain? No Yes
   Comment: _____

2. Do you have weakness, numbness or burning in your shoulders, arms or hands? No Yes
   Comment: _____

3. Do you suffer from a loss of handgrip strength? No Yes
   Comment: _____

4. Do you suffer from back, buttocks, legs, knees or feet pain? No Yes
   Comment: _____

5. Do you have weakness, numbness or burning in your buttocks, legs or feet? No Yes
   Comment: _____

6. Do you have reduced feeling (sensation) or swelling in your legs, feet? No Yes
   Comment: _____

7. Do you suffer from cold hands or feet? No Yes
   Comment: _____

8. Do you suffer from headaches, dizziness, memory loss or ringing in the ears? No Yes
   Comment: _____

9. Do you have difficulty maintaining your balance, have vertigo? No Yes
   Comment: _____

10. Do you have difficulty sleeping, lifting or interacting with others since your injuries? No Yes
    Comment: _____

Name: _____ **Chart #:** _____

INFORMED CONSENT TO PROCEDURES & TREATMENTS

Providers: _____

Providers: _____

I hereby request and consent to the performance of joint manipulations/ mobilizations, injections, prescribed medications, natural herbs & supplements, homeopathic remedies and other procedures including various modes of physiotherapy, exercise rehab and diagnostic testing on me (or on the patient named for whom I am legally responsible) by the doctor/s named above and/or other doctor/s who now or in the future while employed by, working or associated with serving as back up for the doctor/s or with the doctor/s named above, including those working at the clinic or office listed above. I have had an opportunity to discuss with the doctor/s named above and /or with other office or clinic personnel the nature and purpose of such and understand that results are not guaranteed. I understand and am informed that as in the practice of medicine, chiropractic, physiotherapy and other health care disciplines, there are some risks to the treatments including but not limited to reactions to medications, infections, fractures and strains. I do not expect the doctor/s to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/s to exercise judgement during the course of the procedures which the doctor/s feels at the time, based on facts then known, are in my best interests. I also understand such practice disciplines and procedures involve touching some parts of my body; therefore, I authorize such touching by the doctor/s or their associates or back up providers, for now and future. I have read or have had read to me above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above-mentioned. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

A patient coming to the doctor gives their permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problems. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor will not provide specific healthcare, if they are made aware of such problems prior to treatment. It is the responsibility of the patient to make them known to the doctor.

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Georgetown Clinic, its affiliate clinics and healthcare providers, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as “Healthcare Providers”) the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Providers/clinics for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that have been or will be rendered or provided; as well as designating and appointing Healthcare Providers as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Providers all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing and agreed by Georgetown Clinic and its affiliates. *It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Providers.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 _____

PATIENT/PARENT SIGNATURE (X): _____

PATIENT NAME PRINTED: _____

GUARDIAN SIGNATURE (if applicable) (X): _____

Name: _____ **Chart #:** _____

MEDICAL RECORDS REQUEST RELEASE AUTHORIZATION FORM

Patient Name: _____ Account: _____

D.O.B: _____ SSN: _____

Home Phone: _____ Work: _____

I hereby authorize _____

(Name of: Hospital, Urgent Care &/or Other Doctor's Office Other than Georgetown Clinics)

to release my records to Georgetown Clinics any of the following information:

Dates From: _____ to _____

OFFICE USE ONLY

___ History & Physical

___ Operation Report(s)

___ Discharge Summary

___ Complete Medical Records

___ Other, Specify _____

___ Radiology Reports (s)

___ Laboratory Report(s)

___ Pathology Report(s)

I want this information released in writing, verbally, via fax, audiovisual format to:

_____

_____

Street Address City State Zip Code

for the purpose of _____

I understand and acknowledge that the records I have requested to be released pursuant to this authorization may contain psychiatric, drug, alcohol abuse and/or infectious disease information, which is protected under the laws of the State of Georgia and Federal Regulation (42 CFR part 2). I hereby release _____ (facility or physician) from all legal liability that may arise from the release of any information from my medical record pursuant to the Authorization, including, but limited to the release of psychiatric, psychological, alcohol, drug abuse or infectious disease (HIV or AIDS) information protected under state and federal laws. This authorization, except for action already taken, may be revoked by any time. This authorization is valid for 90 days unless otherwise specified.

_____ _____

Patient/Representative's Signature Date

_____ _____

Relationship to Patient Date

_____ _____

Witness's Signature Date