

**INFORMATION/APPLICATION FOR CARE**

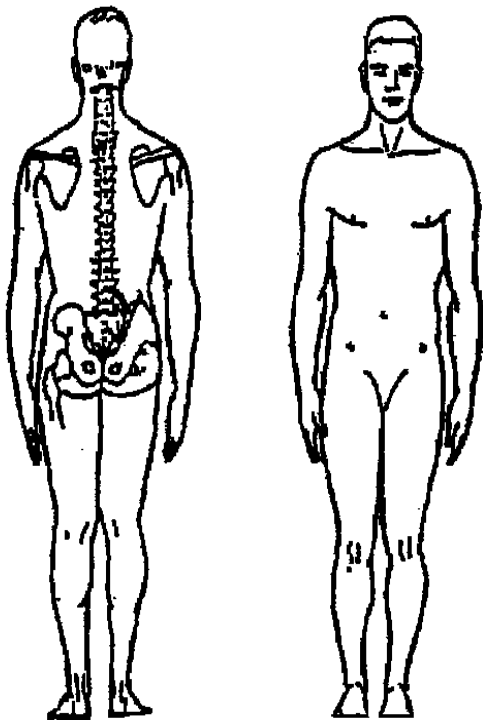
The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. (PLEASE PRINT.)

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Age \_\_\_\_\_ Birth date \_\_\_\_\_ Marital Status: S M W D Number of Children \_\_\_\_\_

Please circle one payment type: Cash Check Master Card/Visa American Express  
 Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years On Job \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Your Social Security # \_\_\_\_\_  
 Do you have Medicare? Yes \_\_\_ No \_\_\_ Do you have Medicaid? Yes \_\_\_ No \_\_\_  
 Name of Spouse or Parent \_\_\_\_\_ Their Birthdate \_\_\_\_\_  
 Spouse Employed By \_\_\_\_\_ Occupation \_\_\_\_\_ Years On Job \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Office Phone # \_\_\_\_\_ Spouse's SS# \_\_\_\_\_ Driver's License # \_\_\_\_\_  
 Does your spouse have health insurance at work? Yes \_\_\_ No \_\_\_

**COMPLETE THESE DIAGRAMS**

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc.....



**MAJOR COMPLAINTS**

(Please list any condition you are being treated for or are experiencing.)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Referred to our office by: \_\_\_\_\_

How payment will be made: \_\_\_\_\_ Type of Insurance: \_\_\_\_\_

\_\_\_\_\_ Cash \_\_\_\_\_ Worker's Comp. \_\_\_\_\_ Health Insurance  
 \_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_ Automobile Insurance Policy

Is your condition due to an accident? Yes \_\_\_ No \_\_\_ Date of accident? \_\_\_\_\_  
 Type of accident? Auto \_\_\_ Work/On Job \_\_\_ At Home \_\_\_ Other \_\_\_\_\_  
 Have you ever been in an auto accident? Past Year \_\_\_ Past 5 Years \_\_\_ Over 5 Years \_\_\_ Never \_\_\_

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also

understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

# Confidential Patient Case History

*Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.*

Name \_\_\_\_\_ Date \_\_\_\_\_

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

**O – OCCASIONAL**  
**F – FREQUENT**  
**C – CONSTANT**

**O F C**

**GENERAL**

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Neuralgia
- Numbness
- Sweats
- Tremors

**MUSCLE & JOINT**

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain or stiffness
- Pain between shoulders
- Pain or numbness in:
  - Shoulders
  - Arms
  - Elbows
  - Hands
  - Hips
  - Legs
  - Knees
  - Feet
  - Painful tail bone
  - Poor posture
  - Sciatica
  - Spinal Curvature
  - Swollen joints

**O F C**

**GASTRO-INTESTINAL**

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distension of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

**EYES, EARS, NOSE & THROAT**

- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental Decay
- Earache
- Ear discharge
- Ear noises
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Far sightedness
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nosebleeds
- Sinus infection
- Sore throat
- Tonsillitis

**O F C**

**CARDIO-VASCULAR**

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

**RESPIRATORY**

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

**SKIN**

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

**GENITO-URINARY**

- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine

**FOR WOMEN ONLY**

- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge
- Yes  No Are you pregnant?

**CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:**

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Cold sores     | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Scarlet fever    |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Gout          | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Diphtheria     | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Influenza     | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Typhoid fever    |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Lumbago       | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Malaria       | <input type="checkbox"/> Polio              | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chorea           | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Measles       | <input type="checkbox"/> Rheumatic fever    | <input type="checkbox"/> Whooping cough   |

**PLEASE PRINT**

What's your major complaint? \_\_\_\_\_

List surgical operation and years: \_\_\_\_\_

Drugs you now take:  Nerve pills  Pain killers  Muscle relaxers  
 "Pep" pills  Tranquilizers  Birth control pills

Others: \_\_\_\_\_

Age of mattress: \_\_\_\_\_  Comfortable  Uncomfortable  Do you use a bed board? \_\_\_\_\_

Are you wearing:  Heal lifts  Sole lifts  Inner soles  Arch supports

Have you been in an auto accident:  Past year  Past five years  Over five years  Never

Describe: \_\_\_\_\_

Have you ever had any mental or emotional disorders?  Yes  No When? \_\_\_\_\_

Have others in your family had such disorders?  Yes  No When? \_\_\_\_\_

**HAVE YOU EVER:**

Yes No

**DESCRIBE BRIEFLY**

- |  |                          |                          |       |
|--|--------------------------|--------------------------|-------|
| Been knocked unconscious?                          | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Used a cane, crutch, or other support?             | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Been treated for a spine or nerve disorder?        | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Had a fractured bone?                              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Been hospitalized for anything other than surgery? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

**DO YOU:**

- |  |                          |                          |       |
|--|--------------------------|--------------------------|-------|
| Now take vitamins or minerals?           | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Think you may need vitamins or minerals? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have an allergy to any drug?             | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

**DATE OF LAST:**

Less than 6 months

6-18 months

Over 18 months

Never

- |                      |                          |                          |                          |                          |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Spinal examination   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical examination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood test           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest X- ray         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spinal X-ray         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental X-ray         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Urine test           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**HABITS**

Heavy

Moderate

Light

None

- |          |                          |                          |                          |                          |
|----------|--------------------------|--------------------------|--------------------------|--------------------------|
| Alcohol  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coffee   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tobacco  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Drugs    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Appetite | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

NAME \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

**AUTHORIZATION, ASSIGNMENT & RELEASE FORM**  
**AUTHORIZATION AND ASSIGNMENT**

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges you incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Indiana.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continual effort until revoked by both parties.

\_\_\_\_\_

\_\_\_\_\_

Date

Patient/Insured Signature

**RECORDS RELEASE**

To \_\_\_\_\_, I hereby authorize you to release to \_\_\_\_\_ any information including the diagnosis and records of treatment or examination rendered to me or all care during the period from \_\_\_\_\_ to \_\_\_\_\_.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date

Patient/Insured Signature

Date

Staff Signature

**RELEASE FROM CARE**

I, \_\_\_\_\_ hereby understand that Dr. Porterfield is releasing me from care, for my accident dated \_\_\_\_\_, and that I have reached [ ] pre-accident status or [ ] maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Staff Signature \_\_\_\_\_

# OFFICE FINANCIAL POLICY

## CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

## INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.
3. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any overpayment exists after all insurance billing has been done, we will issue you an overpayment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.
5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.
6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full expected immediately; regardless of any claims submitted.
8. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

# NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

**This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.**

## PLEASE REVIEW THIS NOTICE CAREFULLY

### **A. OUR COMMITMENT TO YOUR PRIVACY**

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

### **B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**

**Porterfield Family Chiropractic**  
**Ryan Porterfield, D.C.**  
**503 Silhavy Rd., Ste. A104**  
**Valparaiso, IN 46383**  
**office@porterfieldfamilychiropractic.com**  
**(219) 850-1031**

### **C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS**

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to – may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or



to conduct cost-management and business planning activities for our practice.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

#### **D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

**1. Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

**2. Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

**3. Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

**4. Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

**5. Deceased Patients.** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

**6. Organs and Tissue Donation.** Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation in you are an organ donor.

**7. Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except

when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

**8. Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

**9. Military.** Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

**10. National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

**11. Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

**12. Workers' Compensation.** Our practice may release your IIHI for worker's compensation and similar programs.

## PRIVACY PRACTICES ~ PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (4 pages) for Porterfield Family Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application For Care) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

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Patient Signature

---

Date

---

Print the Patient Name

**CONSENT FOR TREATMENT  
AND AUTHORIZATION TO  
PERFORM X-RAYS**

Date \_\_\_\_\_ Time \_\_\_\_\_ AM / PM

I have been informed by Dr. Porterfield that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness).

I authorize Dr. Porterfield to perform such radiographic examination necessary to diagnose, and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

Signed: \_\_\_\_\_

Witness: \_\_\_\_\_

To the best of my knowledge I am NOT pregnant and the above named Doctor has my permission to x-ray me for diagnostic interpretation.

Signed: \_\_\_\_\_