

**McKINLEY CHIROPRACTIC HEALTH CENTER  
DR. DON McKINLEY**

## PATIENT INFORMATION SHEET

*Welcome!* Please print clearly and read all information carefully.

Date \_\_\_\_\_

Date of Injury \_\_\_\_\_

LAST NAME	BIRTH DATE	AGE
FIRST NAME <span style="float: right;">MI</span>	SEX: <span style="margin-left: 20px;">MALE <input type="checkbox"/></span> <span style="margin-left: 20px;">FEMALE <input type="checkbox"/></span>	
ADDRESS	SSN	
CITY	MARITAL STATUS: <span style="margin-left: 10px;">SINGLE <input type="checkbox"/></span> <span style="margin-left: 10px;">MARRIED <input type="checkbox"/></span> <span style="margin-left: 10px;">DIVORCED <input type="checkbox"/></span> <span style="margin-left: 10px;">WIDOWED <input type="checkbox"/></span>	
STATE <span style="float: right;">ZIP</span>	SPOUSE NAME	
HOME PHONE	IF MINOR, GUARDIAN NAME	
CELL PHONE		
E-MAIL (will not share)	REFERRED BY:	

Please circle one:    **MAJOR MEDICAL**    **SELF- PAY**    **AUTO INJURY**    **WORK INJURY**

### EMPLOYER

### INSURANCE INFORMATION

NAME	INS. CO. NAME
OCCUPATION	Policy Holder
ADDRESS	Policy Holder SSN
CITY <span style="float: right;">STATE    ZIP</span>	Relationship to Patient
PHONE <span style="float: right;">EXT</span>	INS. ADDRESS
FAX	CITY <span style="float: right;">STATE    ZIP</span>
WEBSITE	PHONE
If AUTO/WORK Injury, Insurance Name	FAX
CLAIM#	ID #
ADJUSTER NAME	SPECIALTY CO-PAY
PHONE	PHONE
FAX	FAX

Please give our desk person your Driver's License, Medical Insurance Card or if Auto Injury, Accident Report and/or Auto Insurance Card. *Thanks!*

Is personal injury being handled by lawyer:    yes    no

If so, Lawyer's Name \_\_\_\_\_ Phone \_\_\_\_\_

Lawyer's Address \_\_\_\_\_ Fax \_\_\_\_\_

Below For Office Use Only

<input type="checkbox"/> Ins. Card	<input type="checkbox"/> Verification	DX 1	DX4
<input type="checkbox"/> TDL	Staff Initials	DX 2	DX5
	<input type="checkbox"/> Card Sent	DX3	DX6

**Office Use Only**

- 1
- 4-5
- >5

Patient #: \_\_\_\_\_

## Pain Drawing

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Examiner: \_\_\_\_\_

### TELL US WHERE YOU HURT.

***Please read carefully:***

*Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.*

Ache >>>>>

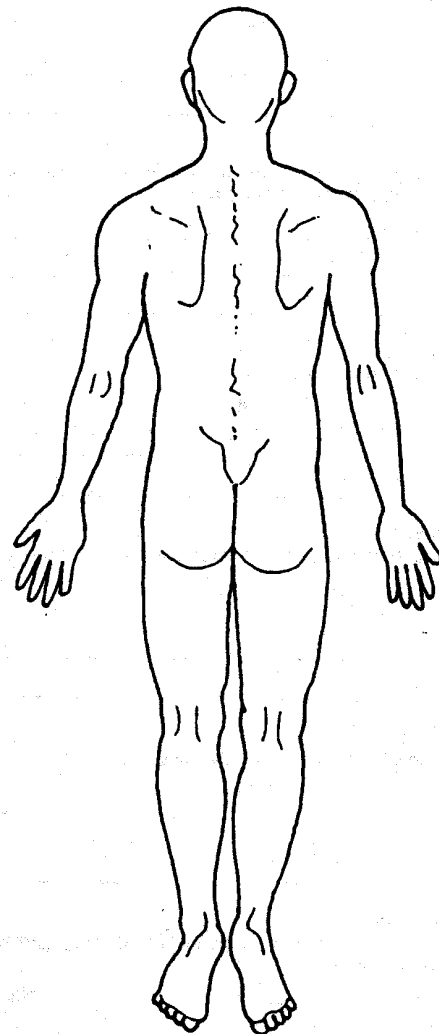
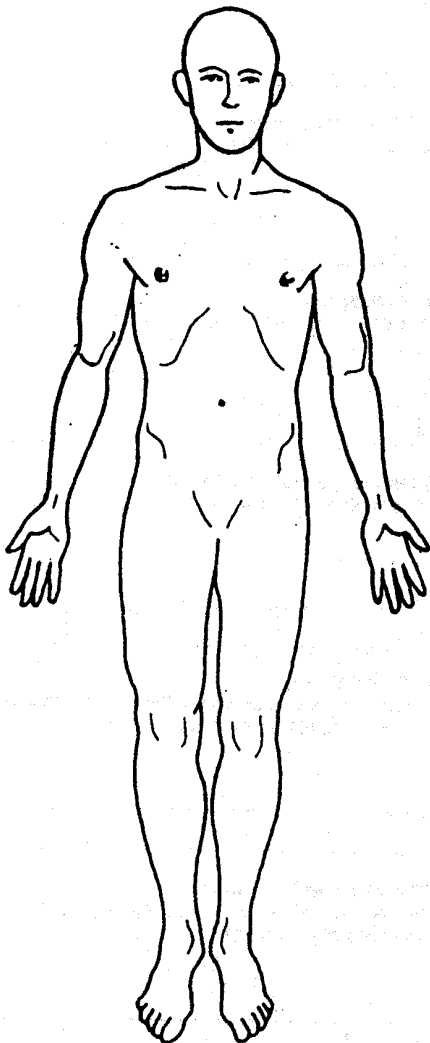
Burning x x x x

Numbness = = = = =

Stabbing // // // //

Pins & Needles o o o o

Throbbing ~ ~ ~ ~ ~



## Patient Health Information Consent Form (HIPAA)

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

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Name of Patient

Date

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Signature of Patient

Date

McKinley Chiropractic Health Center  
Dr. Donald McKinley  
4029 S. Capital of Texas Hwy., Suite 100  
Austin, TX 78704  
Phone (512) 326-1400 fax (512) 326-1463

### **Missed Appointment Policy**

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

Since our office does not charge for broken or cancelled appointments, please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

Signature

Date

PATIENT NAME:

Dr. Don McKinley, D.C., ACN  
McKinley Chiropractic Health Center  
4029 S. Capital of TX Hwy, Suite 100  
Austin, TX 78704  
(512) 326-1400

I give you permission to use my name in your patient newsletter and on any office bulletin or other notice boards for purposes of announcing births, birthdays, weddings, graduations or acknowledging my referrals.

Date

Signature

PATIENT NAME:

Print Name

