

## Patient Registration Information

*Welcome To Our Office*

*Date*

Patient's Name (Please Print)		Marital Status S M W D Sep	Sex M F	Birth Date	Age  S.S.#	Religion (Optional)
Street Address Permanent Temporary		City and State		Zip Code	E-Mail Address  Home Phone #	
Patient's or Parent's employer		Occupation(indicate if student)	How Long employed		Bus. Phone # Ext. #	
Employer's Street Address		City		State and Zip Code		
Emergency Contact Person(s)			Phone: (H)		(w)	

**Insurance Information (If Patient is Primary Insured)**

Insurance Company	Effective Date	Policy #
Secondary Insurance Company	Effective Date	Policy #

**If Insurance belongs to spouse or parent please fill out next section**

Spouse or Parent's Name		S.S. #	Birth Date	
Spouse or Parent's Employer		Occupation(Indicate if student)	How long employed	Bus. Phone #
Employer's Street Address		City and State		Zip Code
Spouse St. Address, if Divorced or Separated		City and State		Zip Code Home Phone #

**If a Medicare or Medicaid Patient Please fill out next section**

Medicare (Please give number)		Medex #			
Medicaid	Effective Date	Program #	County #	Case #	Account #

**Work or Auto Insurance**

Industrial	Were you injured on the job? Yes No	Date of Injury	Industrial Claim #
Accident	Was an Automobile involved? Yes No	Date of Accident	Name of Attorney and Phone Number:

**Other Information**

Were X-Rays taken? Yes No	If yes, Where were x-rays taken	Date X-Rays were taken
Has any member of your immediate family been treated by our Physician(s) before? Include name of Physician and family member.		
Referred by	Street Address, City, State	Zip code

\*I understand that my signature authorizes Baystate Health Services, James W. Morgan, D.C. and/or Timothy R. Morgan, D.C. to release my medical records to my Insurance Company, HMO or any other party so that payment may be made directly to them on my behalf. I agree that any amount not paid by my Insurance Company or HMO is my personal responsibility, and is payable at the time of service or immediately upon denial of such benefits from my Insurance Company or HMO.

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





**NORFOLK COUNTY CHIROPRACTIC**  
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU AND YOUR FAMILY MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

- 1.) Our Practice is dedicated to maintaining the privacy of your individually identifiable information. In conducting our business, we are committed to maintaining the confidentiality of your personal health information, including the means by which we may use and disclose your personal health information, your privacy rights to this information, and our obligations concerning the use and disclosure of your personal health information. We are required by law to abide by these privacy regulations.
- 2.) According to the rules of the Health Insurance Portability and Accountability Act (HIPAA) we may use and disclose your individually identifiable health information (IIHI) in the following ways:
  - Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example would be providing information to a consultant or your PCP.
  - Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review.
  - Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal chart review.
  - Certain Special Circumstances:
    - Public Health Risks
    - Health Oversight Activities
    - Medicolegal Correspondence
    - Law Enforcement/Social Services
- 3.) Your Rights Regarding Your Personal Information:
  - You have the right to confidential communication of your personal health information.
  - You have the right to request in writing that our practice communicate with you at a particular location, or in a particular manner. For example you may request that we contact you at home instead of work. Our practice will accommodate reasonable requests. You do not need to give a reason for such requests.
  - You have the right to request restrictions to the use and disclosure of your individually identifiable health information. We are not required to agree to such restrictions; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
  - You have the right to inspect and retain a copy of your individually identifiable health information.
  - You have the right to ask for an amendment to your health information if you believe it is incorrect or incomplete.
  - You have the right to receive an accounting of certain disclosures of protected health information for purposes other than for treatment, payment, or operations thus not otherwise allowed by HIPAA.
  - You have the right to file a complaint with our privacy officer or with the secretary of the Department of Health and Human Services if you feel that your privacy rights have been violated. You will not be penalized for filing a complaint.
- 4.) Our practice may contact you either by mail, email or telephone to remind you about an upcoming appointment or need for follow-up. We may contact you to discuss lab, x-ray, or other medical reports. We may contact you about billing or financial information. You have the right to change the way we contact you about these such issues.
- 5.) Any other uses and disclosures (those not allowed by HIPAA, as above) will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor that request, except to the extent that we have already taken actions relying on your authorizations. Examples of such disclosures may include, information regarding health and wellness newsletters, NCC's participation in upcoming charitable events or information related to other NCC sponsored community activities.
- 6.) Any of our patients who are considered by state law to be emancipated minors will have the same rights with respect to the privacy of their protected health information. They will be entitled to their own copy of our privacy policies, and will be asked to sign an acknowledgement that they received such a copy. An example of an emancipated minor would include patients under eighteen years of age who are serving in a branch of the military.
- 7.) We reserve the right to revise or amend this notice of Privacy Practices.
- 8.) If you have questions or need to address any of these policies please contact our practice's Privacy Officer, Dr. James Morgan at (508) 359-5200 or [JMorgan@NCCsportsmed.com](mailto:JMorgan@NCCsportsmed.com).

# NORFOLK COUNTY CHIROPRACTIC & SPORTS MEDICINE

## Notice of Privacy Practices for Protected Health Information

I acknowledge that I have received a copy of the Norfolk County Chiropractic's *Notice of Privacy Practices for Protected Health Information*. I acknowledge that I understand and agree to the terms stated therein. Furthermore I agree that NCC and/or its staff may contact me for informational purposes as indicated in paragraph 5.

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Authorized Provider Rep.

\_\_\_\_\_  
Personal Representative Printed

\_\_\_\_\_  
Personal Rep. Signature