KELLEY chiropractic

1503 Larson Street
Bloomer, WI 54724
715-568-4220

FINANCIAL RESPONSIBILITY:
□ COMPANY □ EMPLOYEE

HAVE YOU HAD A DOT MEDICAL EXAM HERE PREVIOUSLY?
□ YES □ NO

WHERE DID YOU HEAR ABOUT US?
□ EMPLOYER □ WORD OF MOUTH: _____ □ MAILER □ SIGN

WOULD YOU LIKE AN AUTOMATIC REMINDER TEXT BEFORE YOUR CARD EXPIRES?
□ NO □ YES - SEND TO THIS CELL NUMBER: _____

EMPLOYER INFORMATION

COMPANY NAME	CONTACT PERSON
ADDRESS	
TELEPHONE	FAX (IF KNOWN)

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- *You may request restrictions on your disclosures.*
- *You may inspect and receive copies of your records within 30 days with a request.*
- *You may request to view changes to your records.*
- *In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.*

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

I authorize the release of all information obtained in this DOT medical exam to my employer as listed above.
Failures will be automatically and immediately reported to your employer.
We are now required to report all results directly to the FMCSA.
The DOT Medical Exam does not establish a Doctor-Patient Relationship.

PRINT NAME:	
SIGNATURE:	DATE: