CHAMPION TOTAL HEALTH
PATIENT INFORMATION

WELCOME! Please allow our staff to photocopy all of your insurance cards.

Full Name _____ Gender M F Age _____ Birth Date ____/____/____

Address _____ City _____ State _____ Zip _____

Email Address_____

Marital Status (circle one) S M W D Sep No. of Children _____ Home Phone (_____) _____

SS# _____ Employer _____ Occupation _____

Work Phone (_____) _____ Extension _____ Cell Phone (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Physician _____ Name of Spouse, Parent or Guardian _____

Spouse's Employer _____ Work Phone (____) _____

In case of an Emergency Contact _____ Relationship _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (____) _____

How did you find out about our office, or whom may we thank for referring you? _____

I understand payment is required in full at the time of service unless other arrangements have been made prior to my appointment. I agree to be financially responsible for any and all services.
I further understand and agree I will be charged for missed appointments without 24 hours notice.

I hereby give permission to Dr. James Buckley to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my condition.

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. I understand and agree to allow Champion Total Health to use my Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, I agree to allow Champion Total Health to submit requested PHI to my Health Insurance Company (or companies) 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. I have the right to examine and obtain a copy of my health record at any time and request corrections. I may request to know what disclosures have been made and submit in writing any further restrictions on the use of my PHI. Our office is not obligated to agree to those restrictions.
3. My written consent need only be obtained one time for all subsequent care received in this office.
4. I may provide a written request to revoke consent at any time during care. This would not affect 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. You have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If you refuse to sign this consent for the purpose of treatment, payment and health care operations, Dr. James Buckley 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.

Patient's Signature _____ Date _____

Guardian's Signature ____ Date __________________________

