LUFKIN
CLINIC OF CHIROPRACTIC

PATIENT INFORMATION

Today's Date: _____ Social Security #:_____

First Name: _____ Middle Name: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

DOB: _____ Age____ Marital Status_____ Occupation_____

Employer Name:_____ Employer Address:_____

Spouse's Name:_____ Spouse's Employer Name:_____

Emergency Contact Name: _____ Phone Number: _____

How were you referred to our office? _____

In compliance with requirements for the government Electronic Health Records program, we need the following information:

(Please Circle One In Each Column)

Smoking Status:_____ Race: _____ Ethnicity: _____

FINANCIAL INFORMATION

Do you have Medicare? □Yes □No Do you have insurance? □Yes □No

PLEASE GIVE A COPY OF ANY and ALL INSURANCE CARDS TO FRONT DESK STAFF

Policy Holder's Name:_____ Relationship to Policy Holder:_____ Policy Holder's DOB:_____

CURRENT HEALTH (please answer all questions)

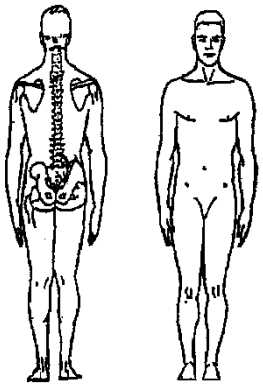
Are you pregnant? □Yes □No

What concerns bring you to our office today? (if no complaints write none)

_____

How long have you had these concerns? _____

If in pain, please mark the location of your pain on the diagram to the right.



Is your pain: □Sharp? □Dull? □Throbbing? □Constant? □Intermittent?

On a scale of 1-10, please rate the severity of your symptoms: __/10

Do you use: ☐Coffee ☐Tea ☐Artificial Sweeteners ☐Sugar
☐Alcohol ☐Cigarettes ☐Recreational Drugs ☐ None

List any drugs/medications you are currently taking: **(if you aren't taking any medications, check none)** ☐ None

Name of Medication	Reason for Use	Dosage and Frequency	Vitamins

***Note: If you have a longer list of medications, please give a copy to the front desk at your next appointment.**

Do you have any allergies? ☐Yes ☐No **(If yes, please list allergies)**
_____

_____

Do you have, or have you had, any of the following? **(If you don't not have any of the following, please check none)**
☐Pneumonia ☐Rheumatic Fever ☐Stroke ☐Diabetes
☐Pleurisy ☐Chicken Pox ☐Thyroid Disease ☐Epilepsy
☐Cancer ☐Anemia ☐Arthritis ☐ Heart Disease ☐None
If you have been diagnosed with another condition, please describe: _____
_____

Have you ever suffered from: **(Please check all that apply, if none select none)?**

☐Abnormal Blood Pressure ☐Digestive Problems ☐ Liver Problems ☐Arm/Hand Tingling
☐Dizziness ☐Loss of Sleep ☐ Prostrate Problem ☐Back Tingling
☐ Blurred Vision ☐ Lung Problems ☐Bladder Trouble ☐Excessive/ Discolored Urination
☐Low Back Pain ☐Shoulder Pain ☐Breast Pain/Lump ☐Ear Pain
☐ Migraines ☐Chest Pain ☐ Fainting ☐Nausea/Vomiting
☐Stuffy Nose ☐Confusion ☐Fatigue ☐Neck Pain
☐ Stroke ☐Cold Extremities ☐Fibromyalgia ☐ Poor Appetite
☐Dental Problems ☐Heart Problems ☐ Paralysis ☐Difficulty Breathing
☐Irregular Heartbeat ☐Difficulty Hearing ☐ Jaw Pain ☐Weight loss
☐ Painful Urination ☐Painful/Abnormal Menstruation ☐ Excessive Appetite/Thirst
☐ None

Please check any past injuries that you have had: **(Please check all that apply, if none select none)**
☐Fall/Accident ☐Head Injury ☐Sports Injury ☐Broken Bone(s) ☐Dislocation
☐Spinal Tap ☐Surgery ☐Extensive Dental Work ☐Unconscious ☐ None

Are there any other health concerns or anything else you would like us to know about? _____

By signing, I agree that the above is accurate to the best of my knowledge. I 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 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.

_____ _____
Signature Date

CHIROPRACTIC INFORMED CONSENT

You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

CHIROPRACTIC

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. Chiropractic healthcare seeks to restore health through a natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its inherent healing powers.

ANALYSIS

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation. A subluxation occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

DIAGNOSIS

The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. Due to the complexities of nature, no doctor can promise you specific results. This depends on your body's healing mechanism. If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

BENEFITS AND RISKS

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be a highly effective treatment for spinal pain, headaches, and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements above. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ ,being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____ _____

Print Name **Signature** **Date**

Consent for Use or Disclosure of Protected Health Information for Payment, Treatment and Healthcare Operations

By signing below, you hereby consent for Lufkin Clinic of Chiropractic to use or disclose information about you (or person for whom you have the authority to sign) that is protected under federal law, for the sole purpose of treatment, payment and health care operations to: INSURANCE COMPANY, ATTORNEY, OR ADJUSTER for the purpose of determining eligibility, available benefits and obtaining payment for services provided.

_____

AUTHORIZATION TO RELEASE MEDICAL/FINANCIAL INFORMATION (VERBAL AND COPIES)

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, in order for the doctors or staff of Lufkin Clinic Chiropractic to give copies of and/or discuss your condition/exam/procedures/x-rays or finances with members of your family or other individuals, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

X-ray Consent & Policy Form: **The New Patient Special** includes consultation, exam and x-ray, at $99.00. The normal value of the new patient special is $400. By signing this consent form, if any patient needs a copy of their x-ray and reports. The patient is fully responsible for the full amount of $400

Initial: _____

I authorize Lufkin Clinic of Chiropractic to release all information (including verbal information, copies of x-rays and medical paperwork, and/or financial information) concerning to the following individuals:

_____ _____ _____ _____

Name (please print) Relationship Name (please print) Relationship

_____ I DO NOT authorize Lufkin Clinic of Chiropractic to release any information concerning my care to any individual.

____ I authorize Lufkin Clinic of Chiropractic to leave a message at the numbers listed in my patient information regarding appointment times.

____ I authorize Lufkin Clinic of Chiropractic to send correspondence to me at the address listed in my patient information.

____ I understand that I need not supply address or phone numbers provided I do not wish to be contacted. In such case, I agree to pay for all charges incurred at the time of service.

____I hereby give my permission to publish my name and picture(s) in whole or part in any of the publications of Lufkin Clinic of Chiropractic.

____ I understand that I can refuse for my picture to be on file with the office if I do not wish for my picture to be published by Lufkin Clinic of Chiropractic.

____ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care. If you would like a copy of this, please initial here _____.

By signing below, I have read and understand this form and acknowledge receipt of the Notice of Privacy Practices. My signature represents agreement with these practices.

_____ _____

Patient/Legal Guardian Signature Date

You have the right to revoke this authorization in writing at any time. However, your written request is not effective to the extent that we have already provided services or taken actions based on your prior authorization. Revocation is not effective until it is received by the privacy official. If I refuse to sign this authorization, Lufkin Clinic of Chiropractic will not refuse treatment, however, it will not be possible for Lufkin Clinic of Chiropractic to file third

party billing on my behalf, and I will be responsible for payment at the time services are provided to me and scheduling my own appointments. Any collection activity as permitted by law is not waived by refusal to sign the authorization.

OFFICE POLICIES

MISSED APPOINTMENTS:

1. We strive to deliver the highest care possible to our patients. To meet this goal, we reserve appointment times for each patient and try to keep our patients from waiting. An appointment is a mutual agreement that we will be here to serve you and that you will be present for the appointment. It is important to be present for your scheduled appointments so that the doctor can treat you according to his/her prescribed plan. If you are unable to keep your appointment for any reason, we request that you call us immediately to reschedule. Please be aware that there may be a $60 broken appointment fee charged to your account for any scheduled appointments missed or not canceled within 24 hours. Initials: ____

2. We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait until the next available appointment.

3. Should more than a 6-month period elapse between office visits, a re-evaluation is necessary prior to reinstating treatment.

FINANCIAL:

4. Payment is due at the time of service unless a prior arrangement has been made. Patients with an outstanding balance 60 days or more overdue will be charged a 1.8% late fee (18% annually) on their balance each month and must make arrangements for payment prior to scheduling appointments. Any balance over 90 days will be forwarded to a collection agency. 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 payable in full immediately, regardless of any previous arrangements or discounts.

INSURANCE:

5. Many insurance companies cover our care; however, we do not accept assignments for Major Medical, Medicare, or Personal Injury. Please give us your insurance cards and we will happily submit your claims to your primary insurance company **ONE TIME** as a courtesy to you. Initial: _____

6. Your first visit will not be submitted to insurance if you are using a promotional gift to assist in the cost.

7. ***We do not submit claims for secondary insurance companies. We will provide you with a super bill that lists all the codes, charges, and numbers required for billing that you can send to your secondary insurance once the primary has paid you.***

I have read and understand the Office Policies. I agree to assign insurance benefits to Lufkin Clinic of Chiropractic whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

If you have any questions concerning this or any other matter, please speak with the receptionist prior to seeing the doctor.

Acknowledgment – Notice of Privacy Practices (on back)

I hereby acknowledge receipt of Lufkin Clinic of Chiropractic's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information. I understand that Lufkin Clinic of Chiropractic has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided or made available to me.

Signature _____ Date _____

NOTICE OF OUR PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed, as required the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

PLEASE REVIEW THIS NOTICE CAREFULLY

We are required by law to abide by the terms of this Notice and to provide you with a copy of this notice. We may change the terms of our notice at any time. The new notice will be effective for all protected information that we maintain at that time.

The following categories describe the different ways in which we may use and disclose your information:

1. **Treatment:** We will use and disclose your information to provide, coordinate or manage your chiropractic care and any related services. Any of the people who work for our practice – including, but not limited to, our staff and any provider we refer you to – may use or disclose your information in order to treat you, or to assist others in your treatment.

2. **Payment.** Our practice may use and disclose your information 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 information 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 information to bill you directly for services and items.

3. **Health Care Operations.** Our practice may use and disclose your information to operate our business. These activities include, but are not limited to: quality assessment activities, employee review activities, training of staff/students, substitute or observing chiropractors and marketing.

   In addition, we may use a sign in sheet at the registration desk. We may also call you by name in the waiting or adjusting room. Your name or picture may be used in our office on bulletin boards, in newsletters, or on our website or social marketing sites unless you have specifically requested for us not to do so.

4. **Appointment Reminders.** Our practice may use and disclose your information to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment. We may mail appointment reminders, announcements or greeting cards to your home.

5. **Treatment Options.** Our practice may use and disclose your information to inform you of potential treatment options or alternatives.

6. **Release of Information to Family/Friends.** Our practice may release your information 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.

7. **Disclosures Required by Law.** Our practice will use and disclose your information when we are required to do so by federal, state, or local law. We may disclose your information to public health authorities authorized by law to collect information for the purpose of public health risks, lawsuits, etc.