Visit One

At Texas Family Chiropractic, our goal is your health. On your first visit with us we want to learn about you and your specific needs so that we may create a custom care plan to get you back to your busy life. We begin with your patient history and background information to lay the foundation for your care. The second step is to move on to your chiropractic exam, including range of motion of the affected region, muscle tenderness and thermogenic testing. Thru the addition of spinal X-rays Dr. Houghton is able to more accurately diagnose and treat your condition.

Once the diagnosis is established, Dr. Houghton will formulate a treatment plan that best suits your needs. This plan can include everything ranging from chiropractic adjustments, to massage therapy, physical therapy and physical conditioning.

It is our goal to see you live a lifestyle of health and wellness. We are committed to providing you with the best chiropractic care possible.

Visit Two

On your second visit to our office you can expect to have a consultation with Dr. Houghton. We refer to it as a Report of Findings. During this appointment the doctor will review your X-rays and review with you the findings, further evaluate a treatment plan and estimate the time needed to get you to the wellness stage of chiropractic. You will be treated by the doctor on this day and given a document showing your expected prognosis.

Going forward each of your treatments will be between 10-15 minutes in length, but don't think the briefness of a regular visit lessens its value! With the groundwork laid, we can quickly size up the condition of your spine and nervous system, adjust you and get you on your way.

Like a regular workout at the gym, each visit builds on the ones before. Miss a visit and you can lose the momentum necessary to make the needed changes.

We recognize your time is valuable. So we do everything possible to run on time and minimize the impact on your busy life.

Welcome

Patient Information

Date _____ \ SS# _____

Patient Name _____
Last

_____
First Name Middle Initial

Address _____

City _____ Zip _____

E-mail _____

Sex ❑ M ❑ F Age _____ Birthdate _____

❑ Married ❑ Widowed ❑ Single ❑ Minor
❑ Separated ❑ Divorced ❑ Partnered for years

Primary Ethnicity
❑ Native American/Alaska Native ❑ Hispanic ❑ Asian ❑ White
❑ Black/African American ❑ Native Hawaiian/Pacific Island ❑ Other

Occupation _____

Patient Employer/School _____

Employer/School Phone _____

Spouse's Name _____

Birthdate _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is Patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Comany(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treament plan is completed or one year from date signed below.

_____
Signature of Patient, Parent, Guardiean or Personal Representative

_____
Please print name of Patient, parent, Guardian or Personal Representative

_____
Date Relationship to Patient

Phone Numbers

Home Phone _____

Cell Phone _____ Cell Carrier _____

How would you like to receive appointment reminders?
❑ Text Message ❑ Email ❑ Both

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact # _____

Accident Information

Is condition due to an accident? ❑ Yes ❑ No

Date _____

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?
❑ Auto Insurance ❑ Employer ❑ Work Comp. ❑ Other

Attorney Name (if applicable)

_____

Patient Condition

Reason for Visit _____

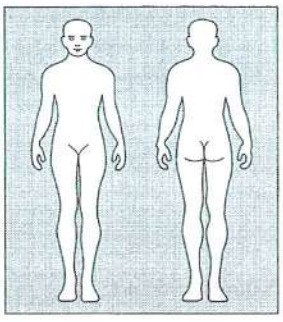
When did your symptoms appear? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other



How often do you have this pain? _____

Is it consistent or does it come and go? _____

Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

– OVER –

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Other _____		
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No						
			Measles	☐ Yes	☐ No						

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking — Packs/Day _____
☐ Alcohol — Drinks/Week _____
☐ Coffee/Caffeine Drinks — Cups/Day _____
☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy Name _____		
Pharmacy Phone (____) _____		

The Back Bournemouth Questionnaire

NAME _____ DATE _____ AGE _____

The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your back pain?

No pain										Worst pain possible
0	1	2	3	4	5	6	7	8	9	10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference										Unable to carry out activity
0	1	2	3	4	5	6	7	8	9	10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference										Unable to carry out activity
0	1	2	3	4	5	6	7	8	9	10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have your been feeling?

Not at all anxious										Extremely anxious
0	1	2	3	4	5	6	7	8	9	10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed										Extremely depressed
0	1	2	3	4	5	6	7	8	9	10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse										Have made it much worse
0	1	2	3	4	5	6	7	8	9	10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

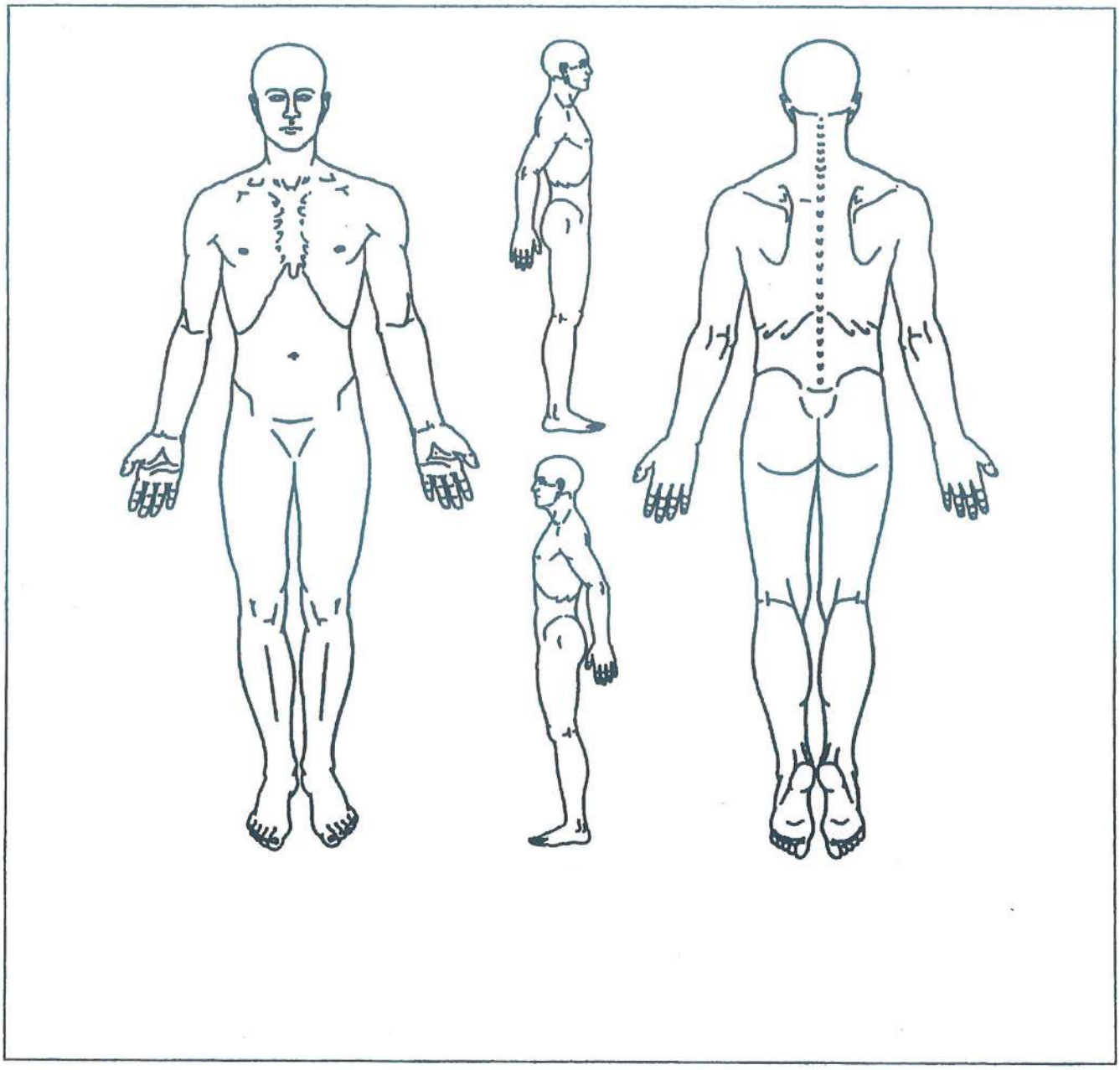
Completely control it										No control whatsoever
0	1	2	3	4	5	6	7	8	9	10

Bolton JE, Breen AC. The Bournemouth Questionnaire: a short-form comprehensive outcome measure. I. Psychometric properties in back pain patients. J Manipulative Physiol Ther 1999;22:503-10

Name _____

Date _____

A = ACHE	**B** = BURNING	**N** = NUMBNESS
P = PINS & NEEDLES	**S** = STABBING	**O** = OTHER



Cervical Spine - Bournemouth Questionnaire

Name Date Age

The following scales have been designed to find out about your *NECK* pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your Neck pain?

No pain									Worst pain possible
0	1	2	3	4	5	6	7	8	9	10

2. Over the past week, how much has your Neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No Interference									Unable to carry out activity
0	1	2	3	4	5	6	7	8	9	10

3. Over the past week, how much has your Neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference									Unable to carry out activity
0	1	2	3	4	5	6	7	8	9	10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/ relaxing) have you been feeling?

Not at all anxious									Extremely anxious
0	1	2	3	4	5	6	7	8	9	10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed									Extremely depressed
0	1	2	3	4	5	6	7	8	9	10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your Neck pain?

Have made it no worse									Have made it much worse
0	1	2	3	4	5	6	7	8	9	10

7. Over the past week, how much have you been able to control (reduce/help) your Neck pain on your own?

Completely control it									No control whatsoever
0	1	2	3	4	5	6	7	8	9	10

_____

Signature

Home | Delete | Edit

Patient Name	Date	Date of Birth

Health Status Questionnaire (HSQ-12)

1. In general, would you say your health is:

Excellent | Very Good | Good | Fair | Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so how much?

2. Lifting or carrying groceries.

Yes, Limited a lot | Yes limited a little | No, not limited at all

3. Climbing several flights of stairs.

Yes, Limited a lot | Yes limited a little | No, not limited at all

4. Walking several blocks.

Yes, Limited a lot | Yes limited a little | No, not limited at all

5. During the past 4 weeks, how much difficulty did you have doing your homework or other regular daily activities as a result of your physical health?

None at all | A little bit | Moderately | Quite a bit | Couldn't do any work

6. During the past 4 weeks, to what extent have you accomplished less than you would like in your work or other daily activities as a result of emotional problems (such as feeling depressed or anxious)?

None at all | A little bit | Moderately | Quite a bit | Couldn't do any work

7. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

None at all | A little bit | Moderately | Quite a bit | Couldn't do any work

8. How much bodily pain have you had during the past 4 weeks?

None at all | Very Mild | Mild | Moderate | Severe | Very Severe

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks…

9. Have you felt calm and peaceful?

All of the time | Most of the time | A good bit of the time | Some of the time | Little of the time | None of the time

10. Did you have a lot of energy?

All of the time | Most of the time | A good bit of the time | Some of the time | Little of the time | None of the time

11. Have you felt downhearted and blue?

All of the time | Most of the time | A good bit of the time | Some of the time | Little of the time | None of the time

12. Have you been happy?

All of the time | Most of the time | A good bit of the time | Some of the time | Little of the time | None of the time

Please answer YES or NO for each question

13. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed?

Yes | No

14. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?

Yes | No

15. Have you felt depressed or sad much of the time in the past year?

Yes | No

TEXAS FAMILY CHIROPRACTIC

Dr. Derrick W. Houghton
16301 Yellow Sage St.
Pflugerville, TX 78660

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____Date _____

Witness Signature _____ Date_____

Texas Family Chiropractic
Dr. Derrick W. Houghton

Patient- Doctor Agreement

The purpose of this agreement is to allow us to more completely serve you and for you to get the best results in the shortest amount of time. It is our experience that ***those who follow through with these agreements get the best results.***

Signing In

When you arrive, please sign in You will be called and assigned a treatment room in the order you signed in. on each visit, puck up your card at the front desk, go to the assigned treatment room and lie face down, *rest and relax*, the doctor will be in as soon as possible.

New Patient Health Talk

We suggest that all our new patients attend our *Health Talk* as soon as possible after stating care. We meet here at the office. The Health Talk explains how the body functions, how Chiropractic works, and how results are produced, family and friends are always welcome. There is no charge for the talk. While children are welcome in the office during our regular treatment times, childcare is not available during our classes so please make other arrangements for children under the age of 12.

Missing or Changing Appointments

The doctor will set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required to get the results we both desire. Thus, if you need to change the time of your appointment, plan to come another time the same day, or if the same day is not possible, it is important that you make up the missed appointment within one week. *Schedule your life around your health, not your health around your life.*

Appointment Times

We will set up a specific time for your adjustment. Try to be prompt as the doctor has set this time aside for adjustments and during this time, this is all he will do. If you come at another time, you may have to a few minutes, as the doctor also sets aside a specific time to see new patients and conduct extended consultations. *We value your time* and do not want you to wait needlessly. If you wish to sit down with the doctor to discuss your care, a specific Doctor/Patients Conference can be arranged at no additional charge.

Re-Examinations

During your treatment series, re-examinations and progress reports will be done on a regular basis

Communication

Please communicate directly to the doctor any upsetting matter such as waiting too long, rudeness by any staff member, failure to understand treatment, need for extended consultation, etc. *We are here to serve you.* You constructive criticism will help us to help you as well as others.

Financial Policy

We will expect you to honor the financial agreement you make with our office. For cash patients we request that 100% of that first visit be paid at the time of the first visit. We are happy to accept your check, MasterCard, Visa, Discover, American Express or cash. All of your payment options will be discussed with you on your second visits. ***We can help you understand your benefits.*** If you have suspended or terminated your care without the doctor's approval, payment for services rendered is due immediately. For questions regarding ***Major medical/Group Insurance, Auto Accident/Personal Injury, Worker's Compensation, or Medicare***, please ask.

I _____, understand the above policy and agree to abide by it.

(Print Name)

_____ _____

Signature Date

Texas Family Chiorpractic

Health Insurance Election

(Accident and Non-Accident Cases)

How would you like for us to handle your health insurance? Please choose one:

☐ **Option 1 -- I Do Not Have Health Insurance / I Don't Want You to File My Health Insurance**

I want the services we discuss, but either I don't have health insurance or I don't want you to bill or submit paperwork to my health insurance. You may keep any health insurance which I may have and that I provide to you on file, but only for the purposes set forth in, and as consistent with, your Financial Policy. I understand that if my claims or forms are not submitted to my health insurance in a timely manner, my payer may decline to pay on my claims and I may not be able to appeal this decision.

☐ **Option 2 -- I Want You to File My Health Insurance and Also to Help Me Verify My Benefits. To Help You Get Paid, I'll Make Partial Payments and/or Sign an Assignment & Financial Policy**

I want the services we discuss, but I also want you to bill my health insurance for an official decision on payment. Please help me verify any Terms of Non-Coverage. If I have any questions, I will verify my coverage on my own. You may ask to be paid now for estimated co-pays, co-insurance, deductibles and other Non-Covered amounts. I understand that these are just estimates. In the event that my health insurance delays or Denies Payment, I will be responsible for payment as described in your Financial Policy, but I understand that I will be able to appeal to my health insurance following its directions.

☐ **Option 3 -- I Want You to File My Health Insurance, But I'll Pay in-Full at the Time of Service or Pre-Pay. If Insurance Pays, You'll Give Me a Refund**

I want the services we discuss, but I also want you to bill my health insurance for an official decision on payment. However, you may ask to be paid now. If my health insurance does pay, you will refund any payments I made to you, less co-pays, co-insurance, and deductibles, and also discounts (Mandatory Fee Reductions) as described in your Financial Policy. In the event that my health insurance Denies Payment, I can appeal to my health insurance following its directions.

Important: I understand that in certain circumstances, the Office may have a policy of not filing health insurance or law may actually control or regulate the filing of insurance. This election will remain in effect until a new election is signed with the Office's consent. This election supersedes any prior health insurance election.

Patient Signature: _____ Date: ___/___/___

Patient Name: _____

PARTIAL ASIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AND TREATMENT AGREEMENT

Consideration: In order to facilitate the ability of Texas Family Chiropractic to collect its Charges directly from various Payers and thereby to enhance the patient-provider relationship, I, the undersigned, as consideration for the Office's services, agree to the following and direct all Payers as follows:

Partial Assignment of the Cause of Action, Assignment of Proceeds, and Contractual Lien: I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Texas Family Chiropractic., as well as any and all causes of action that I might have now or in the future against any Payer to the extent of my Charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as Texas Family Chiropractic sees fit. I further assign my right to receive any proceeds from any Payer to Texas Family Chiropractic and further grant a contractual lien to Texas Family Chiropractic with respect to my charges. I understand that this assignment of rights and contractual lien may effectuate, automatically or otherwise, a secure interest under the applicable Uniform Commercial Code. I intend for this Agreement to effectuate such a lien and hereby authorize Texas Family Chiropractic to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such lien. Except as provided herein, nothing in this agreement shall be constructed as an election or waiver by Texas Family Chiropractic to a secured interest under any other statutory lien law. I consistent with these rights, and hereby direct any and all Payers, to pay the Proceeds directly and immediately to, and exclusively in the name of Texas Family Chiropractic in the amount of my charges.

Other Terms: I understand that I remain personally responsible fro my charges. Consistent with law or contract, I agree to pay the full amount of my charges to Texas Family Chiropractic upon demand. Unless mutually agreed to in writing, the receipt and processing of partial payments by the office shall not constitute a waiver of the Office's right to receive payment-in-full upon demand and shall not constitute an accord and satisfaction of my charges, irrespective of any restrictions indicated on any payments. I understand that at any time, I can request a copy of my total Charges. I hereby waive any statute of limitations which may apply to the collections of my charges.

In the event that I retain one or more attorneys to assist me in collecting any proceeds, I direct each attorney to issue an irrevocable letter of protection to the Office regarding my Charges. I further direct (and the office hereby requests) each attorney to provide immediate notice to the office regarding any proceeds received by the attorney, to promptly pay the Office in full out such proceeds, and to provide a full accounting of such Proceeds to the Office .

I authorize and direct the Office to submit my charges to any and all payers including, without limit, my health benefit plan. I understand, however, that in the event that my Charges are submitted to more than one Payer, I hereby authorize and direct Texas Family Chiropractic to apply any Proceeds received from one Payer to any reduction, write offs, or discounts, issued by another.

I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse, or my dependents. I further authorize the office to apply any credit balances on my Charges to any other outstanding Charges still owed by me , my spouse, or my dependents, regardless of whether these other charges are related to my condition.

This agreement shall not be modified or revoked without the mutual written consent of the office and myself. I hereby revoke the terms of any previously signed documents to the extent of those terms conflict with the terms of this Agreement.

This agreement shall be governed under the laws of the state where the Office is located and performable in the country where the Office is located. I hereby consent to personal jurisdiction and venue of any court in said country and waive all objections based on improper jurisdiction, venue, or forum non-convenes.

I agree that each and every provisions of this Agreement is reasonably necessary for the protection of the rights and interest of the office and myself. However, should any provisions of this Agreement be found-to-be "invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless; remain in full force and effect.

Definitions: For the purpose of this Agreement, the following terms shall have the following meaning: "Office" shall refer to: Texas Family Chiropractic located at 15803 Windermere Dr. suite # 420, Pflugerville, TX 78660. "Payer" shall refer to , without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for my reason; "Proceeds" shall include, without limit the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits. Plans, coverage: individual and group health benefits. Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; "Charges" shall include, without limit, the full fees for the "Offices" services (including., without limit, treatment, medical equipment, supplies., supplements, narrative reports, depositions, and testimony), any Collection Costs incurred by the Office, 18% interest on outstanding Charges, and any other charges incurred by me at the Office; "Collections Costs" shall include, without limit any pre-and post judgment court costs, filling fees, service of process charges, attorney fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or any payer.

Patient Name (please print):_____

Patient Signature_____Date:_____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print)_____

Patient/Guardian Signature: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on 2/28/14 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, _Dr. Derrick Houghton_. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $1.00 (max of $25.00 total) for each page and the staff time charged will be $25 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 (max of $25.00 total) for each page and the staff time charged will be $25 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: Texas Family Chiropractic Privacy Officer: Dr. Derrick Houghton

Telephone: 512-252-9444 Fax: 512-252-9341

Email: dwhdcm3@sbcglobal.net

Address: 16301 Yellow Sage St Pflugerville Texas 78660

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

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Employee signature *Date*