SOUTHLAKE CHIROPRACTIC

Patient Information

Southlake Chiropractic welcomes you to our office. We strive to provide the best possible chiropractic care. Dr. Devos will conduct a thorough history and physical exam to decide how to best assist you. If it is determined that your concition will not respond to chiropractic care, you will be referred to another health care provider.

Patient Identification

Name _____ Date of Birth _____

Address _____

City, State, Zip _____

I authorize Colleyville Chiropractic to contact me and leave messages at the following:

☐ Home Phone: _____

☐ Cell Phone: _____

☐ Work Phone: _____

☐ email: _____

Which phone number would you like listed as your primary contact number?

_____

Family Information

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____

Emergency Contact Person _____ Relationship _____

Phone # _____

Insurance Information

Name of Insurance Company _____

Guarantor/Carrier of Insurance Policy _____ Relationship _____

Guarantor's Employer _____ Guarantor's Date of Birth _____

ID/Member Number _____ Group Number _____

How did you hear about us? (check ALL that apply, please)

☐ Patient Referral: _____

☐ Insurance Referral: ☐ Angie's List ☐ Web Search ☐ Location/Sign

☐ Doctor Referral: _____

☐ Other: _____

Office Policies regarding late, cancelled and missed appointments. `

In an effort to reduce patient wait-time and improve appointment availability, we have enacted the following policies.

Late Appointment Arrivals

We ask that you provide our office with a courtesy call if you are running late for a scheduled appointment. Our staff will evaluate the days' schedule to determine if it will significantly impact other patient's wait time. If necessary **we may have to reschedule you for a later time.**

Late Cancellations and Missed Appointments

We ask that you provide our office with as much notice as possible when canceling an appointment. **You may incur a $25.00 fee for missing or canceling your appointment without at least 5 hours notice.** We understand that unexpected events and emergencies do occur, and we will always consider this when enforcing this policy. We also encourage you to arrive 5 minutes before your appointment time to allow for signing-in, collecting co-pays, and any other necessary paperwork or updates.

_____ _____

Patient Signature Date

Patient Health Questionnaire - PHQ

ACN Group

ACN Use Only rev 9/11/2002

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

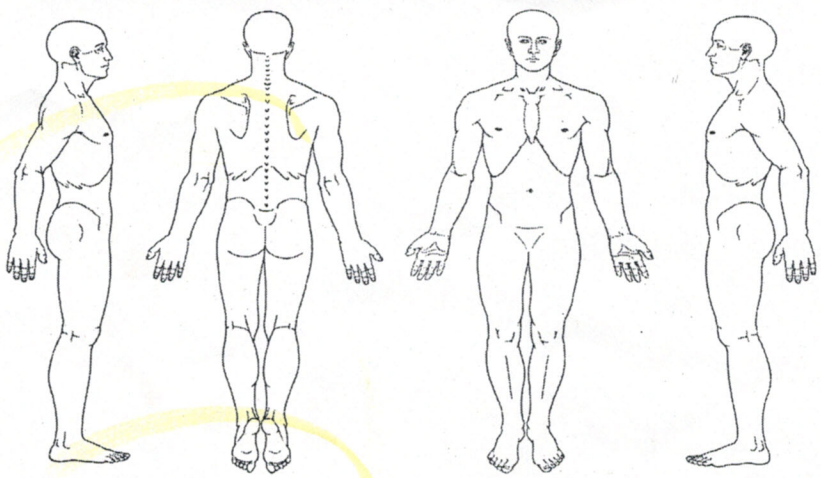
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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8. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

Health History Patient Name _____

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 _____

Have you had...

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

Exercise ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Work ☐ 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	Description	Date
Falls		
Head Injury		
Broken Bones		
Dislocations		
Surgeries		

Medications	*Allergies*	*Vitamins/Herbs/Minerals*

Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ [Name of Individual] consent to Southlake Chiropractic's use and disclosure of my Protected Health Information **for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes.** Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I hereby authorize and direct you, my insurance company, and/or attorney to pay directly to Devos Chiropractic PA, DBA Southlake Chiropractic and I give him permission to endorse his name to checks issued payable to myself and/or Dr. Devos or Southlake Chiropractic as consideration for his provision of those health care services which I received.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if Southlake Chiropractic agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

_____
Date

_____
Personal Representative's Authority

SOUTHLAKE CHIROPRACTIC

Patient _____

Date _____

Consent to Chiropractic Services

EXPLANATION OF RISKS

Manipulation is considered one of the safest methods available for the treatment of many spinal and joint disorders. Every reasonable precaution is taken to reduce the risk of adverse effects for this and any treatment. However, as with any health care procedure, there are certain complications which may arise during a manipulative adjustment. Those complications include but are not limited to: (1) Temporary aggravation of symptoms; (2) Other unlikely, but possible complications being stretch injuries to muscles, tendons and soft tissue, fracture or displacement of bones, disc injuries, injuries to nerves and occlusion of the blood vessels. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Please note the exact incidence of serious complication is described as rare or very rare.

I hereby consent to the performance of chiropractic procedures and diagnostics that the doctor of chiropractic may consider necessary or advisable in the course of my health care. I have read and understand the explanation of risks, and I acknowledge that no guarantees have been made to me concerning the result of treatment.

Patient Signature: _____

Consent to Treatment of a Minor Child

I authorize the licensed chiropractor, and whomever he may designate as assistants to perform diagnostic tests if needed, and administer treatment to my _____ (relationship), _____(name).

Parent (Guardian) Signature: _____ **Date:** _____

Southlake Chiropractic

Doctor – Patient Policy

Welcome to Southlake Chiropractic

The purpose of this policy is to allow us to serve you more completely and to get the best results in the shortest amount of time. It is our experience that those patients who adhere to the following policy get the best results.

Signing In

When you arrive at our office, please sign in. For legal and bookkeeping purposes, we need your name printed legibly on the Daily Sign-In Sheet every time you visit our office. One family member can sign for the rest of the family, but each name needs to be separate. Patients are not seen on a first come first serve basis. Scheduled appointments are always honored first. If you come late of early for a scheduled appointment, you may have to wait, and you will be promptly informed of what the estimated waiting time will be.

Treatment or Therapy Preparation

A staff member will take you to the appropriate treatment/therapy area or room. Comfortable and loose clothing is always ideal. Please remove necklaces, large earrings, barrettes, belts and loose fitted shoes. Empty your pockets of loosed change and bulky items that will be uncomfortable while lying down. There are small baskets provided in each room. Normally you will be asked to lie face down on the treatment table and breathe deeply before treatment to allow your body to relax. If lying face down is uncomfortable, please tell us.

Financial Agreements

Payment is expected before services are rendered. We accept Cash, Checks, Debit Cards, Visa, Mastercard, Discover and American Express Credit. Financial agreements you make with our office are expected to be honored. If you find that you cannot fulfill the agreement you have made with us, advise our staff immediately so that new arrangements can be made. Insurance billing is a complimentary service. Any insurance checks and explanation of benefits "EOB" sent to you home should be brought to our office within three days. There is a $35 service fee for any returned checks.

Missing or Changing Appointments

We have set up a specific course of treatment for you. Dr. Devos will prescribe a certain number of treatments required to get the results you both desire. Our office hours are:

Monday, Wednesday
7:30am – 12:00pm and 2:30pm – 6:00pm
Closed Tuesday
Thursday
2:30pm – 6:00pm
Friday
7:30am – 12:00pm
Saturday – 8:30am – 12:00pm

It is **VERY** important that you keep your scheduled appointment. This will aid in achieving optimum function and health. A 24 hour notice of any changes to your appointment is required, allowing us to continue to provide excellent service to everyone.

Please communicate with the doctor or appropriate staff member about any concerns you may have. We are here to help you and your family members enjoy a healthy and productive life!

Patient Name: _____

Patient /Guardian Signature: _____ Date: _____

SOUTHLAKE
CHIROPRACTIC

Our Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our ***Financial Policy.*** We require you to read and sign this form prior to any treatment.

All patients must complete our information and Insurance from before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, DEBIT CARDS, VISA, MASTERCARD, AM EX AND DISCOVER.

REGARDING INSURANCE

We may accept assignment of Insurance benefits at the time of your first visit. The balance is your responsibility **whether your Insurance company pays or not.** We cannot bill your Insurance Company unless you give us your Insurance Information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days of treatment, the balance becomes your responsibility and may be paid with the options listed above. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Regarding Insurance Plans where we are a participating provider. All co-pays and deductibles are a due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating provider, refer to the above paragraph.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS

Adult Patients are responsible for full payments at the time of service.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment, refer to the above paragraphs.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. Your signature is required following this statement. "I have read and understand the Financial Policy."

Patient Name_____ Date_____

Patient/Guardian Signature _____

Southlake Chiropractic 1959 W. Southlake Blvd Suite 140 Southlake, TX 76092
Phone (817)488-8837 Fax (817)488-8927

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, [patient's name] acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Southlake Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ _____

Date Signature

_____

Print Name

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____, [patient's name] , authorize Southlake Chiropractic to release my Protected Health Information to the following individuals: (Please include any family members or friends that you would like your medical records, tests, reports or other health related information to be released to.)

_____ _____

Name of Recipient relationship

_____ _____

Name of Recipient relationship

_____ _____

Name of Recipient relationship

_____ _____

Date Signature

_____

Print Name

EXPIRATION DATE: This Authorization is valid until: Two years from the date above.

FOR OFFICE USE ONLY
IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____ [patient's name]'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

elbaliavanU tneitaP ڤ elbanU yllacisyhP tneitaP ڤ gnilliwnU tneitaP ڤ

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply) **:**

yllanosreP ڤ liaM ڤ pU wolloF enohP ڤ :rehtO ڤ_____

_____ _____

Date Signature

Wim Devos DC
Devos Chiropractic PA DBA Southlake Chiropractic