HOUSTON SPINAL CARE, P.C.

Practice Member Information

Date_____

Name: _____ Date of Birth _____/_____/_____

Address: _____ City: _____State: _____Zip:_____

Home Phone (_____) _____-_____Work Phone (_____) _____-_____ Cell Phone (_____) _____-_____

*****Please circle the best number to reach you: HOME, WORK, CELL**

E-mail Address _____

Whom my we thank for referring you _____

Social Security: _____-_____-_____ Occupation _____ Sex _____Marital Status: M S

Insurance

If you have Chiropractic coverage in your insurance policy, we are anxious to help you receive your maximum allowable benefits. However, your insurance is a contract between you, your employer and the insurance company. We will provide you with a completed insurance form, **but you are responsible for filing it with your insurance company.** Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover.

I understand the Insurance Policy at Houston Spinal Care

_____ _____

Signature Date

Houston Spinal Care, PC Policies

Please Initial

____ **Payment for services are due at the time of service.** We accept Cash, Checks, Visa, and Master Card.

____ We make every effort to reconfirm appointments, however, should our courtesy call not be received, you are still held responsible for your appointment.

____ If you need to reschedule or cancel your appointment, a 24- hour advance notice is appreciated. Missed appointments may be assessed a $20 fee. (Emergencies excused)

____ For any returned check there will be a $20 service fee.

____ **We do not participate in any insurance filing.**

____ Please refrain from wearing heavy perfume or cologne as many patients are sensitive to chemicals.

____ Please turn your phone off before entering the adjustment or post adjustment room.

____ I also understand that if I suspend or terminate care, any fees for professional services rendered will be immediately due and payable.

____ I am responsible for costs required to enforce collection of my account, including, but not limited to collection fees, attorney fees and court costs.

I understand the Policy at Houston Spinal Care, PC

_____ _____

Signature Date

HOUSTON SPINAL CARE, P.C

Practice Member Information

Name: _____ Date _____

What is the primary reason for consulting our office?

_____

_____

**If your condition is due to an accident, and you will be filing an accident claim ask the receptionist for and "Accident Form."

If you are experiencing pain, it is

( ) Sharp ( ) Dull ( ) Comes and goes ( ) Travels ( ) Constant

Since the pain started, it is

( ) About the same ( ) Getting Better ( ) Getting Worse

What makes it worse? _____

Does it interfere with

( ) Work ( ) Sleep ( ) Walking ( ) Sitting ( ) Hobbies ( ) Leisure

Other Doctors seen for this health challenge (please list)

Chiropractor: _____

Medical Doctor: _____

Other: _____

Please check all of the following you have ever had, even if they do not seem related to you current health challenge.

□ Headaches	□ Loss of smell	□ Cold Hands
□ Pins and needles in arms	□ Buzzing in ears	□ Cold Feet
□ Pins and needles in legs	□ Ringing in ears	□ Problems Urinating
□ Dizziness	□ Depression	□ Menstrual Cycle Irregular
□ Numbness in fingers	□ Stiff neck	□ Menstrual Pain
□ Numbness in toes	□ Lights bother eyes	□ Loss of Balance
□ Fatigue	□ Neck Pain	□ Nervousness
□ Sleeping Problems	□ Fainting	□ Upset Stomach
□ Cold Sweats	□ Back pain	□ Tension
□ Diarrhea	□ Loss of taste	□ Hot Flash
□ Constipation	□ Irritability	□ Heart Burn
□ Mood Swings	□ Fever	□ Ulcers

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Name _____ **Date** _____

Your Health Profile

Why this form is Important

On a daily basis we experience physical, chemical and emotional stresses that accumulate and may result in serious loss of health. Most of the time the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stress you have faced in your lifetime, allowing us to better assess the challenges to your health.

The Beginning Years

Research is showing that many of the health challenges that occur later in life have their origins during the development years, some starting at birth. Please answer the following questions to the best of your ability.

The Childhood Years

	Yes	No	Unsure		Yes	No	Unsure
Did you have any childhood illnesses?				Was there any prolonged use of medicine such as antibiotics?			
Did you have any serious falls as a child?				Were you vaccinated?			
Did you play youth sports?				Did you suffer any other traumas (physical or emotional)?			
Did you take/use any drugs?				As a child, were you under regular Chiropractic care?			

Adult Years

	Yes	No	Unsure
Did/do you smoke?			
Did/do you drink alcohol?			
Have you been in any accidents?			
Women- Are you pregnant?			

On a scale of 1-10, describe your stress level
(1= none / 10= extreme)

Occupational: _____ Personal: _____

Life Style

Exercise

How often do you get cardiovascular exercise?

4+ times per week 3 times per week 2 times per week once a week never

Select all cardiovascular exercise you do.

Running Walking Stair Master Swimming Cycling Aerobic Other

How often do you work out with weights?

3 times per week 2 times per week once a week every other week never

List any contact sports you are involved in: _____

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Name _____ **Date** _____

Nutrition

How often do you eat fruits/vegetables?

Every meal two times daily once a day every other day twice a week once a week never

How often do you drink coffee or caffeinated drinks?

3+ per day two times daily once a day every other day twice a week once a week never

How much water do you drink daily?

80+ ounces 64 ounces 48 ounces 24 ounces 16 ounces 8 ounces none

Social

Select the ways you take care of yourself:

Church Synagogue Other Religious Insti. Meditation Yoga Crafts Outdoor Activities

List all surgeries and when performed

	Surgery	**Date**
1.		
2.		
3.		
4.		

List all medications you are presently taking and the condition you are taking them for:

	Medication	**Dosage**	**Condition**
1.			
2.			
3.			
4.			

List all supplements/ vitamins you are currently taking

	Supplement/Vitamin
1.	
2.	
3.	
4.	

Thank You!

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act [HIPAA] provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information [PHI]. These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov
We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the healthcare specialties of chiropractic, osteopathy and medicine. Chiropractic healthcare seeks to improve health through natural means without the use of drugs or surgery. This helps the body maximize its inherent healing ability. The success of the doctor of chiropractic's procedure often depends on underlying causes, as well as other spinal and physical conditions. It is important to understand what to expect from your chiropractic healthcare.

ADJUSTMENTS

The doctors at Houston Spinal Care utilize the NUCCA Procedure, which is a low force, non-rotary upper cervical (neck) technique. If adjustments to the lower spine are required, then the doctor will usually utilize a low force non-rotary, hand-held instrument technique. Other various forms of therapy may be necessary in your case.

INFORMED CONSENT FOR CHIROPRACTIC CARE

As a patient, you give the doctor permission and authority to care for you in accordance with the chiropractic tests and analyses. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects or pathologies may render a patient susceptible to injury. The doctor will not provide healthcare, if he is aware that such care may be contraindicated. Again, it is your responsibility to tell the doctor everything you know about your health conditions, which would otherwise not come to the attention of the doctor. The doctor of chiropractic provides a specialized, non-duplicating health service, but he is also available to work with other types of healthcare providers.

RESULTS

As a patient in this office, you are acknowledging that your doctor or his assistants have given no guarantee as to the results that may be obtained from your care. The doctor also wants it understood that although he does not utilize rotary manipulation, he is in no way indicating that his procedures are superior to his fellow chiropractors. Please understand that chiropractic care is not a treatment of disease, but a system of correcting vertebral subluxations.

AUTHORIZATION

In certain cases, it may be necessary for the doctor to discuss or send reports to other doctors, attorneys and/or insurance representatives for gaining a second opinion or help you obtain reimbursement from insurance carriers. As a patient, you are giving the doctor permission to use his best judgment for when to allow an observer in the room or when it is necessary to release the above patient information. I also give permission for the doctor to use information from my examination to help evaluate statistics for research, as long as my name is not used.

TO THE PATIENT

Please discuss any questions or problems with the doctor **before** signing this statement of policy. I have had the above explained to me and after reading it, I understand the foregoing and give my consent.

DATE _____ SIGNATURE _____