APPLICATION FOR CARE AT FAMILY WELLNESS AT TERAVISTA

Patient Demographics

Name: _____ Address: _____Apt.#_____ City: _____

State: _____ Zip: _____ Cell Ph: _____ Work Ph:_____ E-mail: _____

Birth Date: ____-____-____ □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed

SSN: _____-_____-_____

Whom may we thank for referring you? □ *Google/Website* □ *Walk-in* □ *screening/event* □ *YELP* □ *Facebook/Instagram*

□ *Teravista* □ *OTHER* □ *Other provider:* _____ □ *Family/Friend:* _____

Employment Status: □ Employed □ Student □ Stay at Home Spouse □ Retired □ Unemployed □ Disability

Occupation: _____ Employer: _____ Phone #: _____

Employer Address: _____ City: _____

Do you have Insurance: □ Yes □ No If yes: □ Major Medical □ Medicare □ Medicaid □ Auto

□ Other_____ Insurance Company: _____Policy/claim#: _____

Name of Emergency Contact: _____ Phone #: _____ Relationship: _____

Family Doctor/Dentist: _____ Phone: _____

I give Dr. Harris permission to send a brief progress report to my physician or dentist: _____ **Initial**

Female Patients Only – non- pregnancy verification for x-rays

To the best of my knowledge, I certify that I am NOT pregnant. Should I become pregnant during the course of treatment, I will provide that information to the Doctor.

_____ _____

Patient or Authorized person's Signature Date

Terms of Acceptance

When a person seeks chiropractic care and is accepted for such care, it's essential that both are seeking and working for the same goal. As a Chiropractic Rehabilitative facility, we have one main goal – to detect and correct/reduce the Vertebral Subluxation Complex (VSC) and associated effects of the nervous system. We do not offer to diagnose or treat a disease or condition other than that which relates to vertebral subluxation. However, if during the course of a chiropractic spinal exam, we encounter complaints that warrant medical attention, we will recommend that you see the services of a provider who specializes in that area. Our primary role is to identify subluxations and our primary method of correcting them is through spinal adjustments and chiropractic rehabilitative care. _____ **Initial**

Informed Consent Regarding: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between on instance per million to one per two million, have been associated with chiropractic adjustments. Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Family Wellness at Teravista have been explained to me and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to any treatment the doctor deems necessary by any means, method and/or technique at any time throughout the entire clinical course of my care.

_____ **Initial**

Insurance and Payment for Service

We will assist our patients in filing claims for reimbursement and will accept any amounts authorized by a patient to be paid directly to Family Wellness at Teravista. Fees for services are due at the time services are rendered. If during the course of care, you have a credit balance on your account, and would like a refund, it is the policy of this practice to refund patients any outstanding credit balance on their account within 30 days. I agree to a $30 charge for missed or late cancels. _____ **Initial**

_____ _____

Patient or Authorized person's Signature Date

Consent to Treat a Minor

I authorize the Doctor and whomever he may designate as assistants to examine and administer chiropractic care as deemed necessary to treat my child.

_____ _____

Parent or Guardian's Signature Date

FAMILY WELLNESS *AT TERAVISTA NOTICE REGARDING YOUR RIGHT TO PRIVACY*

I have received a copy of Family Wellness at Teravista Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ **Initial**

_____ _____

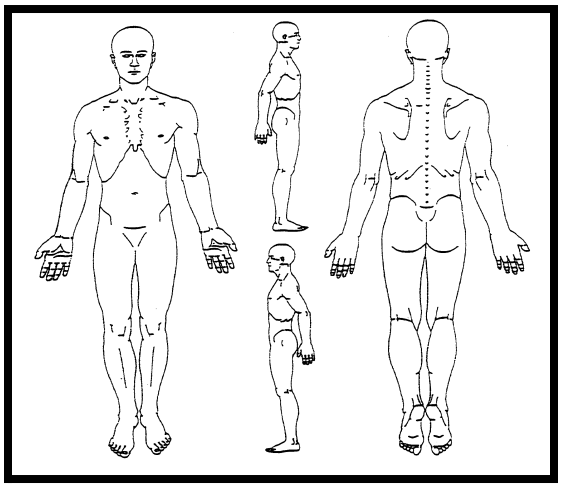
Patient's Name DOB

_____ _____

Patient's Signature Date

Please identify the condition(s) that brought you to this office: Primary: _____
Secondary: _____ Third: _____ Fourth: _____
If you are seeing us for a pain related issue, USE THE SYMBOLS to show the type of pain you feel in each location.

XXXXXXXXX	/ / / / / / / / / /	o o o o o o o o o	s s s s s	- - - - - - - -
DULL/ACHY	SHARP/STABBING	NUMBNESS/TINGLING	STIFF/TIGHT	BURNING



Using the pain scale below, CIRCLE the pain level you experience for each complaint:

0 = **No Pain**. No Discomfort
1 = **Minimal Discomfort**. Minor stiffness or tightness.
2 = **Discomfort**. Stiff, tight, sore. Muscle fatigue.
3 = **Minimal Pain**. More than just sore. Uncomfortable.
4 = **Mild Pain**. Noticeable pain but tolerable.
5 = **Moderate Pain**. Aggravating. Still allows movement.
6 = **Strong Pain**. Quite aggravating. Movement slightly limited.
7 = **Very Strong Pain**. Very aggravating. Movement definitely limited.
8 = **Very, Very Strong Pain**. Extremely aggravating. Movement very limited.
9 = **Severe Pain**. Brings tears. Almost impossible to move.
10 = **Excruciating Pain**. Agony. Unbearable. Cannot move. ER.

Primary or chief complaint is:	0	–	1	–	2	–	3	–	4	–	5	–	6	–	7	–	8	–	9	–	10
Second complaint is:	0	–	1	–	2	–	3	–	4	–	5	–	6	–	7	–	8	–	9	–	10
Third complaint is:	0	–	1	–	2	–	3	–	4	–	5	–	6	–	7	–	8	–	9	–	10
Fourth complaint is:	0	–	1	–	2	–	3	–	4	–	5	–	6	–	7	–	8	–	9	–	10

Is there any radiating pain into the arms or legs? _____ **Is there any numbness or tingling?** _____

How did the injury happen? _____

When did the problem(s) begin? _____ **When is the problem at its worst?** □ **AM** □ **mid-day** □ **PM**
How often do you experience your problem? (Please indicate for each of the body location if applicable)
Constant (75 – 100% of the time) _____ Frequent (50 – 75% of the time) _____

Occasional (25 – 50% of the time) _____ Intermittent (0 – 25% of the time) _____
Condition(s) ever treated by anyone in the past? □**No** □ **Yes If yes, when:** _____ **by whom?** _____

How long were you under care: _____ **What were the results?** _____

List any MD's or Chiropractors you've already seen for this problem: _____

What tests have you already had for this problem? •X-rays •MRI •C.T. Scan •Myelogram •EMG/NCV
•None •Other _____
What have you already tried for this problem? •Anti-inflammatory •Pain Meds •Muscle Relaxers
•Injections •Physical Therapy •Chiropractic •Massage •Exercise •Other _____
What makes your problem worse? •Sitting •Standing •Changing Position •Walking •Bending •Lifting •Twisting •Reaching
•Driving •Sleeping •Sneeze/Cough •Computer Work •Telephone •Going From Sit To Stand
•Other_____

PAST MEDICAL HISTORY

Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life:
_____

Please list any surgeries, hospitalizations or injuries you have had over the course of your life: _____

_____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a P for in the *Past*, C for *Currently* have or N for *Never* have had:

___ Broken Bone ___Dislocations ___ Osteopenia ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions: _____

MEDICATIONS & ALLERGIES

Are you allergic to any medications? •Yes •No **If yes, please list:** _____

List any medications, herbs or supplements you are taking and the reason for their use:

_____

FAMILY HISTORY

Please Check Box if family member suffers from any problem below:

Problem	Spouse	Child #1	Child #2	Child #3
Headaches				
Neck/Back Pain				
Allergies/Sinus				
Posture Problem				
Numbness/Tingling				
Muscle Ache/Spasm				
Scoliosis				
TMJ Problems				
Car Accident				

Check off any family history of: •Cancer •Diabetes •Heart disease •High blood pressure •Stroke •Arthritis
•Scoliosis •Thyroid disease •Osteoporosis _____

SOCIAL HISTORY

Do you have any children? •Yes •No If yes, how many? _____

Do you drink alcohol? •Yes •No If yes, how often? □ Daily □ Weekends □ Occasionally □ Never

Do you smoke? •Yes •No If yes, how often? □ Daily □ Weekends □ Occasionally □ Never

Recreation drug use? •Yes •No If yes, how often? □ Daily □ Weekends □ Occasionally □ Never

What do you do most of the day in your job postures, positions and repetitive movements:

_____

FAMILY WELLNESS AT TERAVISTA NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have a laminated copy labeled **'HIPAA'** at the front desk. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep **this** page for your records.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member and/or your emergency contact.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call our Compliance Coordinator at (512)248-9355. If she/he is unavailable, you may make an appointment with our doctor to see her /him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201