WELCOME! To **Golightley Chiropractic** 2604 West Kansas Avenue Midland, Texas 79701 Ph: 432-262-6524

PATIENT INFORMATION

Date: _____

Patient Name: _____
Last Name First Name Middle Initial

Sex: ☐ M ☐ F Birthdate: _____-_____-_____ Social Security#_____

Address: _____

_____
City State Zip Code

Phone Number: _____ E-mail: _____

Emergency Contact Name: _____Phone #_____Relationship_____

Please circle: Married Widowed Single Separated Divorced
Minor Partnered for_____years

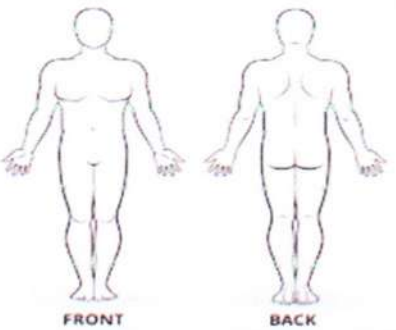
Patient Employer/School: _____Occupation: _____
Employer/School Address: _____Phone# _____

PATIENT CONDITION

Have you ever received chiropractic care? _____ If yes, when? _____
Chief compliant/Reason for visit_____
Complaint began when and how? _____
Is condition due to an accident? Circle: Yes No
If yes, when did this accident happen? _____ Type of accident: Auto Work Home
Is your condition progressively getting worse? _____
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____
Please circle the quality of the compliant/pain: Dull Aching Sharp
Shooting Burning Throbbing Deep Nagging Numbness
Tingling Stiffness Other: _____

How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with your: Work Sleep Daily Routine Recreation
Please circle activities/movements that are painful to perform: Sitting Standing
Walking Bending Lying down
Does anything aggravate this pain? _____
Does anything make your compliant better? _____
Previous interventions, treatments, medications, surgery or care you've sought for you compliant:
_____
Previous illnesses you've had in your life: _____
Previous injury or trauma: _____

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



REFERRAL SOURCE

How did you hear about us?_____

HEALTH HISTORY

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 _____

Please circle "Yes" or "No" to indicate if you have had any of the following:

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

Exercise

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ HeavyLabor

Habits

- ☐ Smoking — Packs/Day_____
- ☐ Alcohol — Drinks/Week_____
- ☐ Coffee/Caffeine Drinks — Cups/Day_____
- ☐ High Stress Level — Reason_____

Are You pregnant? ☐Yes ☐No Due Date _____ What was the date of your last menstrual period?_____

Family Health History:

Associated health problems of relatives:_____

_____

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

Social and Occupational History:

A. Level of Education:
☐ High school ☐ some college ☐ college graduate ☐ post graduate studies

B. Job Description:_____ Work Schedule:_____

C. Recreational Activities:_____

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

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

Golightley | Chiropractic

2604 W. Kansas Ave. Midland, TX 79701

Ph: (432) 262-6524 Fax: (432)262-6538

For All Your Health & Wellness Needs

Office Policy

Welcome to Golightley Chiropractic & Wellness Center. This is an appointment practice. For all appointments we ask that you call and notify the receptionist if you are running late for an appointment. **If you do not show for a scheduled appointment our office may charge a $25.00 cancellation fee. Although we rarely do charge a "No Show" fee, if a patient repeatedly cancels without notice we may require this fee. If you will be more than fifteen minutes late there is a possibility that we will have to reschedule your appointment. We do not file insurance.** Our office reserves the right to request payment for services from you. We will provide you an itemized statement upon request for you to file your insurance claim if you choose to do so.

Informed Consent

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 Dr. Golightley, D.C. and other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above. I hereby authorize Dr. Golightley to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

I understand that the doctor will not accept individuals for treatment unless he can be of assistance. It is understood and agreed that any x-ray negatives taken by Golightley Chiropractic will remain the property of this office, being on hand where they may be seen at any tine while being as patient of this office. I have had an opportunity to discuss with the doctor of chiropractic named above and/or office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and I 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 judgement 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. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

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's Signature_____ **Date**_____

Guardian/Parent Signature_____ **Date**_____

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For All Your Health & Wellness Needs

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your protected health information will be used by Golightley Chiropractic or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.
You may review the notice prior to signing consent. You may request a copy of the notice at the front desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. This office may or may not agree to restrict the use or disclosure of your protected health information.
If we agree to your request, the restriction will be binding with this office. Use or disclose of protected information of an agreed restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that's has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

'I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.'

Name of Patient (PRINT)

Signature of Patient Date

Signature of Patient Representative Date

Relationship of Patient Representative to Patient

Office Representative Date

Others we may release your PHI to:

Golightley Chiropractic

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For All Your Health & Wellness Needs

Partial Assignment of the Causes of Action, Assignment of Proceeds Contractual Lien & Authorization

Purpose: The purpose of this Assignment is to improve the ability of the office to collect my charges directly from various payers. Accordingly, I agree to the following and direct all payers as follows.

Definitions: In this assignment, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to Golightley Chiropractic, 2604 W. Kansas Avenue, Midland Tx 79701: "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 be disburse proceeds to me, either now or in the future, for any reason; "proceeds" shall include without limit, the proceeds from any settlement, judgement, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payment benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; "charges" shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony) and Collection costs incurred by the Office, interest (and penalties on delinquent charges) to the extent permitted by law, and any other charges incurred by me at the Office: "Collection costs" shall include, without limit, any pre and post judgment court costs, filing 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 from any payer.

Partial Assignment of the cause of action, assignment of proceeds, and contractual Lien. I hereby assign to the office in so far as permitted by law, but only to the extent of my charges, all of my rights, remedies, and benefits relating to any payer, including without limit my right to receive proceeds from any payer now or in the future, and any and all causes of action that I might have against any payer now or in the future, the right to prosecute such cause of action either in my name or in the offices name, and the right to settle or otherwise resolve such causes of actions as the office seems fit, I further grant a contractual lien to the office with respect of my charges. I further intend for this agreement to create a secured interest under the applicable Uniform Commercial Code and hereby direct the office to file the form(s) normally filed with the secretary of state or other government agency in order to perfect such lien. Consistent with these provisions, I hereby direct and all payers, to pay the proceeds directly to, immediately to and exclusively in the name od the office to the extent of my charges.

Specific direction to any attorneys I retain, such as in accident cases. In the event that I retain one or more attorneys to assist me in collection of any proceeds, I hereby direct (and the office hereby requests) each attorney to provide immediate notice to the office regarding proceeds received by the attorney, to promptly pay the office in full out of said proceeds, and to provide a full accounting of them to the office, I agree that the purpose of any proceeds received by the attorneys is to pay my charges.

Other disclosure authorization. I hereby direct all payers to release to the office and pertinent information regarding any coverage I may have including without limit the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize and direct the office to release any information regarding my treatment or pertinent to my case, including without limit a copy of my charges and a copy of this assignment, to all payers in order to facilitate collection of my charges.

Miscellaneous provisions. Except as provide in this paragraph, this assignment shall not be modified or revoked without the expressed, written consent of the office. I hereby revoke, with the offices consent, the terms of any previously signed documents, but only to the extent those terms conflict with terms of this assignment. I agree that each and every provision of this assignment is reasonably necessary for the protection of the rights and interests of this office and myself. However, should any provision 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 assignment shall nevertheless, remain in full force and effect. This action based upon this assignment, I hereby consent to a personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-convenience as such term is defined by law, I further waive and statue of limitations which may apply in any action based upon this assignment.

I have read, understood, and agree to the terms of this assignment.

Patient name (print):

_____

Patient signature:

_____ **Date** _____

Name of custodial parent or legal guardian, on behalf of patient (print):

_____

Parent/Guardian signature:

_____ **Date** _____

HIPAA AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient:

Name of Patient (Previous Name) _____ Birth Date/ Medical Record Number _____

Street Address _____ City, State, Zip Code _____

Authorizes: Release of Protected Health Information To:

Golightley Chiropractic
Name of Health Care Provider/Plan/Other _____ Name of Health Care Provider/Plan/Other

2604 West Kansas Avenue
Street Address _____ Street Address

Midland, Texas 79701
City, State, Zip Code _____ City, State, Zip Code

Information to Be Released:

___Medical History, Examination, Reports ___Surgical Reports ___Immunizations ___X-Ray Reports
___Treatment/TestsAllergy Records ___Consultations ___Laboratory Reports ___Prescriptions
___Hospital Records Including Reports __X__Entire Record ___Other (Specify)

Purpose for Need of Disclosure: (Check all applicable categories)

__X__Further Medical Care ___Legal Investigation or Action ___Insurance Eligibility/ Benefits
___Changing Physicians ___Other (Specify) ___Personal

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining authorization.

Your Rights with Respect to this Authorization:

Right to inspect or copy the health information to be used or disclosed. I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting _____ Privacy Officer.
Right to receive copy of this Authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
Right to Refuse to Sign this Authorization: I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
Right to Withdraw this Authorization. I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact _____ Privacy Officer. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s)_____or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient or Legal Representative:_____ Date:_____
(If signed by other than patient, state relationship/authority to do so)

Witness:_____