Wellness, Science, and Beyond
5100 Thomson Terrace,
Colleyville, TX 76034
Tel: 817-428-0527
Fax: 817-428-0652

NEW PATIENT INFORMATION

Please allow our staff to photocopy all available medical documents

PLEASE PRINT.

Full Name_____ **Gender** □**M** □**F** **Birth Date**____/ ___/_____

Address_____**City**_____ **State** ____**Zip**_____

Phone _____ **E-mail** _____ **Fax/Cell:** _____ *Can we use e-mail / text messages to remind you about your appointments? Y /N*

Name of Parent/Guardian if applicable _____**Age** ____**Birth Date**___/___/_____**SS#**_____

Contact in case of an Emergency: _____ **Relationship**_____

Home phone _____**Cell Phone**_____**Work Phone**_____ *Can we use e-mail / text messages Y /N*

How did you find out about our office, or whom may we thank for referring you? _____

I hereby request and consent to the performance of physical examination, chiropractic adjustments and other chiropractic or certified complementary procedures, including various modes of physical modalities and diagnostic.

I understand that the practice of chiropractic and other complementary therapies is not an exact science, that individuals respond differently to treatment, and that there are no guarantees of the result of any treatment. I do not expect the doctor to be able to anticipate and explain all imaginable risks and/or contraindications, and I wish to rely on the doctor to exercise his judgment based on the facts known to be in my best interest during the course of my examination and treatment. I understand that the doctor is a licensed chiropractor in the state of Texas and by such is licensed to employ objective or subjective means without the use of drugs, surgery, x-ray therapy or radium therapy for the purpose of ascertaining the neuro-musculoskeletal structures of the body to correct any subluxation or impairment related to them. I understand that any complementary examinations and treatments are performed at the best knowledge of the doctor at the time of visit, at my request, and that there is no standardized, national system for credentialing all of them.

It is not expressed or implied in this Office that the treatments offered by the doctor will specifically cure any symptoms I may be experiencing in any other part of my body. I understand that any and all doctors employed by this office disclaim being able to treat me for any maladies or symptoms that I may be experiencing that may not be related to the injuries reported to the doctor.

I understand and agree to allow this Office to use this information for the purpose of treatment, payment, health care operations, and coordination of care including the submission of requested information to Health Insurance Company (or companies) provided to us by you for the purpose of payment. I understand that a written consent need only be obtained one time for all subsequent care given in this office and that I need provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

I have read and understood the above consent for examination and treatments. I understand that ultimately I am responsible for my health and that I also had the opportunity to get informed regarding this consent and my treatment plan. Further, I understand all charges incurred at this Office are my responsibility regardless of payment availability from another source. I am also aware that there is a missed appointment/cancellation policy: a variable non-refundable fee (consistent with the length of time scheduled for the visit) will be charged for each missed appointment or a cancellation that has not been received at least 24 hours prior to my appointment.

Additionally, I am here on this day and any subsequent visit, solely on my own behalf and not as an agent for federal, state, or local agencies on a mission of entrapment or investigation. I therefore authorize examination and treatment to be performed at Wellness Science and Beyond.

Patient's signature_____ **Date**_____

or

Parent's or Guardian's Signature_____ **Date**_____

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817-428-0527

HEALTH PROBLEMS AND CONCERNS: Please list your top health concerns in order of priority

1. _____
2. _____
3. _____

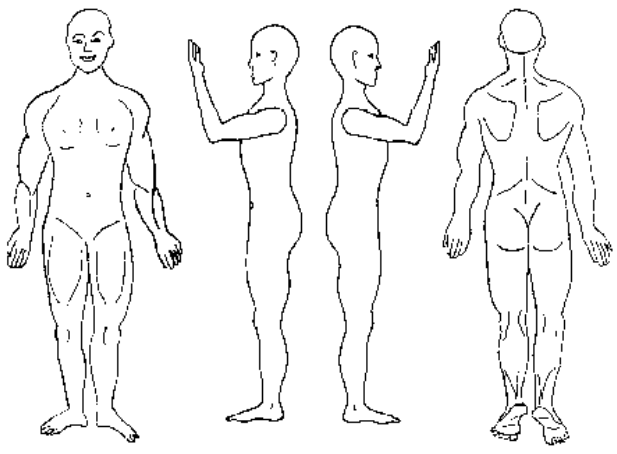
1. CHIEF COMPLAINT/PROBLEM: In relation to your primary complaint: **When** did you first noticed it? _____
How did it originally occur?_____ How did it progress? _____
If this is a recurrence, has it become worse recently? □Y □N □Same □Better □Gradually worse: _____
Treatment(s) you received: _____
Have you had any intolerance or reactions to treatments? □Y □N Describe: _____
How **frequent** is the condition? □Constant □more than ½ of the day □ Less than ½ of the day □ Less than few hours □Night only □Other: _____
Describe any associated **pain**: □Sharp □Dull □Aching □Burning □Stabbing □Numbing □Tingling □Other: _____
Is there anything that **R**ELIEVES (R), **A**GRAVATES (A), or **B**RINGS it on (B): ___Lying down ___Sitting ___Standing
___Walking, ___Bending Fw/Bk/Lt/Rt, ____Twisting Rt/Lt ____ Coughing, ____ Straining,
____ Sneezing, ____Morning/Afternoon, ____before/after meal, Other: _____
How much (1 minimal, 2 minor, 3 moderate, 4 severe) is this condition interfering with your:
__Work, __Sleep, __Daily routine, __Recreation; Other: _____

2. Secondary complaint / related complaint:_____ **When** did you first noticed it? _____
When did you first noticed it? _____ **How** did it originally occur?_____
How did it progress? _____
Treatment(s) you received: _____
_____
Have you had any intolerance or reactions to treatments? □Y □N Describe: _____
If this is a recurrence, has it become worse recently? □Y □N □Same □Better □Gradually worse: _____
How **frequent** is the condition? □Constant □more than ½ of the day □ Less than ½ of the day □ Less than few hours □Night only □Other: _____
Describe any associated **pain**: □Sharp □Dull □Aching □Burning □Stabbing □Numbing □Tingling □Other: _____
Is there anything that **R**ELIEVES (R), **A**GRAVATES (A), or **B**RINGS it on (B): ___Lying down ___Sitting ___Standing
___Walking, ___Bending Fw/Bk/Lt/Rt, ____Twisting Rt/Lt ____ Coughing, ____ Straining,
____ Sneezing, ____Morning/Afternoon, ____before/after meal, Other: _____
How much (1 minimal, 2 minor, 3 moderate, 4 severe) is this condition interfering with your:
__Work, __Sleep, __Daily routine, __Recreation; Other: _____

Surgeries & Trauma - What surgeries, trauma, or stitches have you had and when? _____
_____
(tummy tuck, face lift, liposuction, etc.) _____
breast implants _____, prostheses: _____,
body piercing _____, Tattoos _____
metal/plastic in your body (pins, clamps, plates) _____

Please circle the areas where you have PAIN and rate the pain using the following scale

0- No pain at present
1-3 Aware of pain but can carry on activities of daily living
4-7 Certain motions produce pain
8-10 Constant, severe, nothing makes it better without drugs



Medication and supplements

Please check and list **all medications and supplements** that you are currently taking / have recently taken, with their **name**, the **date** you began taking them and **who recommended** them.

- ☐ Antacids_____
- ☐ Antibiotics_____
- ☐ Antidepressants_____
- ☐ Anti-Diabetics_____
- ☐ Anti-Inflammatory_____
- ☐ Blood Pressure Lowering Meds. _____
- ☐ Cholesterol Lowering Meds. _____
- ☐ Hormone Replacements (HRT) / ☐ Oral Contraceptives_____
- ☐ Other prescription or OTC _____

_____

- ☐ Vitamins and minerals _____

_____

- ☐ Other nutritional supplements _____

_____

Allergies (please list ALL allergies)

food: _____

medication: _____

seasonal / other: _____

_____

What **other health condition** have you been treated for in the past few years? Please describe _____

_____

_____

_____

Have you had any intolerance or reactions to treatments? ☐**Y** ☐**N** Describe: _____

_____

Have you ever been in the emergency room? For what reason and when?_____

_____

Have you ever been on crutches? For what reason and how long? _____

Have you been in an auto accident? ☐Past year ☐Past 5 years ☐Over 5 years ☐Never. If yes, describe: _____

Notes: (Please use additional pages if needed)

_____

_____

_____

_____

_____

Under penalty of perjury, I attest that my answers to the above questions are complete and true.

X_____

Patient / legal guardian signature

INTERRUPTIONS

Due to the nature of our office, occasionally there may be interruptions during your consultation time. We try to keep them to a minimum. We ask you to help us doing that so we can give our uninterrupted attention and energy to each patient. We apologize for any inconvenience.

FOLLOW-UP QUESTIONS

After your treatment / consultation, if you have a brief question about your program, you may fax your question to our office at 817-428-0652. Please write or print clearly' in dark ink and include your full name, your brief question, the date and your fax number. Office staff will then fax back to you a brief answer. The fax return will be attempted only twice, so be sure your fax is hooked up and has sufficient paper. There is no charge for this brief question-answer fax procedure. If you have more than a brief question, please see "Telephone Consultations".

TELEPHONE CONSULTATIONS

If you have many questions and/or would like to speak personally with your treating doctor, please call to schedule a 15-minute consultation time (or longer). The doctor will then answer your questions during the scheduled consultation time. Consultation fees are calculated at $30 per 15 minutes.

CANCELLATION POLICY

The nature of our practice is to spend individual time with our patients and if you are late or you cancel we cannot fill your time slot without 24 hours notice.

If you miss any appointment, without a minimum of 24 hours notice, you will be charged for the time that you were scheduled (generally, $100 for a 30 min appointment). This amount must be paid before you will be treated again.

If you arrive more than 15 minutes late without calling you will need to reschedule and you will be charged for a miss appointment, or you may wait and be worked in as time permits.

Thank you for your cooperation.

Signature Date

Notices of Privacy Practices

(Effective April, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, ALSO HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding your health record

A record is made each time you are treated at our Clinic. Your injuries, evaluation, test results, diagnosis, treatment, and a plan of care are recorded. This information is most often referred to as your "health or medical record", and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure it's accuracy, and enable you to relate to who, what, when, where and why others may be allowed access to you health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others.

Understanding your health information rights

You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. This Clinic is not required to accept your requests and you cannot request restrictions on uses or disclosures otherwise required by law. Your rights include being able to review or obtain a paper copy of your health information, and are given an account of all disclosures. You may also request communication of your health information be made by alternative means or to alternative locations in a confidential manner. This Clinic is required by law to accommodate reasonable request to receive communications of health information by alternative means or to alternative locations if you clearly state that disclosures of all or part of the information that could endanger you. This Clinic may require you to submit a written request for any of the documents or actions that you have a right to under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Our responsibilities

This Clinic is required by law to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with the respect to the information we collect and maintain about you. This Clinic is required to abide by the terms of this notice, as currently in effect, and to notify you if we are unable to grant your requested restrictions or locations. This Clinic reserves the right to change its practices and effect the new provisions with respect to all health information that it maintains (including such information that this Clinic had prior implementation of the new provisions).

Use and disclosure of your Health Information without your authorization

This Clinic may use and disclose your health information in order to provide 'Treatment", obtain "Payment" and perform our "Health Care Operations", as well as other specific reasons detailed below:

- **Treatment** — information obtained by your provider in this Clinic will be recorded in your medical record and used to determine the course of treatment. This consists of you provider recording his/her own expectations and those of others involved in providing your care. The sharing of your health information may progress to others involved in your care, such as physicians.
- **Payment** — Your health care information will be used in order to receive payment for services rendered by this Clinic. A bill may be sent to either you or a third party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used.
- **Health Care Operations** — The medical staff in this Clinic will use your health information to assess the care you received and the outcome of your cases compared to others like it. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.
- **Business Associates** — Some or all of your health information may be subject to disclosure through contracts for services to assist this Clinic in proving health care. To protect your health information, we require these Business Associates to follow the same standards held by this Clinic through the terms detailed in a written agreement.
- **Notification** — Your health record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance your well-being or your whereabouts.
- **Communications with Family** — Using best judgment, a family member, or close personal friend, identified by you, may be given health information relevant to your care and/or recovery.

- **Worker's Compensation** — This Clinic will release information to the extent authorized by law in matters of worker's compensation.

- **Public Health** — This clinic is required by law to disclose your health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This Clinic is further required by law to report communicable diseases, injury, or disability.
- **Law Enforcement** — This Clinic may disclose your health information to the police or other law enforcement officials as required or permitted under state law or in response to a valid court, grand jury, or administrative subpoena.
- **Health Oversight Activities** — This Clinic may disclose your health information to a health oversight agency that overseas the health care system and is charged with responsibility for ensuring compliance with rules of government health programs, such as Medicare and Medicaid.
- **Victims of Abuse, Neglect, or Domestic Violence** — If this Clinic reasonably believes that you are a victim of abuse, neglect, or domestic violence, it may disclose your health information to the appropriate governmental authority, authorized by law to receive reports such as abuse, neglect, or domestic violence.
- **Judicial and Administrative Proceedings** — This Clinic may disclose your health information in the course of a judicial proceeding in response to a legal order or other lawful purpose.
- **As required by Law** — This clinic may use and disclose your health information when required to do so by any other law not already referred to in the proceeding categories.

Use or disclosure of your health information with written authorization
Any other use or disclosure of your health information, other than those listed above, will only be made with your written authorization. You may revoke your authorization at any time, except to the extent this Clinic used or disclosed your health information in reliance of your authorization.

To receive additional information or report a problem
For further explanation of this notice or any complaints about your Privacy rights, or how Chiropractic Health and Fitness has handled your health information please contact us at 817-640-0282. If nobody is available to answer your concerns please feel free to make an appointment for a personal conference in person or by phone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue. S.W.
Room 509F HHH Building
Washington. DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.
By way of my signature, I provide my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____ _____
Patient's Name (print) Parent's / Legal Guardian's Name (print)

_____ _____
Patient's / Legal Guardian's Signature Date

_____ _____
Authorized Facility Signature Date

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