

NEW PATIENT INFORMATION

Please Print all Answers

Name _____ Age _____ Sex _____ Date _____
Address _____ City _____ Zip _____
Phone # _____ Work # _____ Cell # _____
Social Security _____ Birth date _____ E-mail _____
Referred By: _____ Nickname: _____ Family Doctor. _____
 Married Single Sep Divorced Widowed Spouse's Name _____
Employer _____ Spouse's Employer _____
Employer Address _____ Spouse's Birth date _____
Employer Phone _____ Spouse's Social Security _____
Parent's Employer If Patient Is Minor / Child _____
Parents Social Security # If Patient Is Child _____
Emergency: Who Do We Call? _____ Relationship _____
Name of Relative or Friend Not Living with You _____ Phone _____

HEALTH INSURANCE INFORMATION

Name of Insurance Company _____ Group Number _____
Name of Insured (Policy Holder) _____ Policy Number _____

ACCIDENT INSURANCE INFORMATION

Name of **YOUR** Auto Insurance Company _____
Agent Name _____ Adjuster's Name _____
Accident Claim Number _____ Phone Number _____
Name of **LIABLE** Insurance Company _____ Adjuster's Name _____
Claim Number _____ Phone Number _____
Attorney Name _____ Phone Number _____

WORK OR INJURY INSURANCE INFORMATION

Workers Comp Ins. Carrier: _____ Claim Number: _____
Contact Person _____ Phone Number _____

Please provide the receptionist with your driver's license & insurance card to be photocopied for your permanent medical record.

Welcome to our multi-specialty group practice, offering family practice & pain management medical care, chiropractic, physical therapy, rehabilitation, acupuncture, massage therapy, nutritional & psychological counseling. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice. This Notice is detailed on page -3- of this document. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff.

Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or all staff of this Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities. Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. If you must miss an appointment please notify us. **If you do not show up for your scheduled appointment you will be charged \$25.00 as a missed appointment fee that you must pay before you are seen or treated again.** We are available to immediately see new patients the same day or through our 24 hour - 7-day emergency service. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.

SYMPTOM SURVEY

What is your chief problem or symptoms? _____

What caused the problem or symptoms to occur? _____

When did the problem or symptoms begin? _____

Have you seen another doctor for this problem? No, If yes, who _____

What tests/procedures have been performed? X-Ray MRI Surgery Hospitalization _____

Have you had this problem or symptoms in the past? No, If yes, explain _____

Have you tried any other treatments for this? No, If yes, explain _____

Is the problem or symptoms getting worse? No, If yes, explain _____

Y ALL OF THE ITEMS THAT APPLY TO YOU NOW AND IN THE PAST:

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> Arthritis / Gout | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Eye Pain–Strain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Seizures | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Neck Pain / Spasms | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Swallowing Difficulty | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Chest Congestion |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Asthma/Bronchitis | <input type="checkbox"/> Mid-Back Pain |
| <input type="checkbox"/> Shoulder/Elbow Pain | <input type="checkbox"/> Wrist or Hand Pain | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Hip/Knee/Leg Pain | <input type="checkbox"/> Foot or Ankle Pain |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Groin or Rectal Pain | <input type="checkbox"/> Female Disorders | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Nausea – Vomiting | <input type="checkbox"/> Irregular Bowels |
- Other problem(s) not listed _____

PATIENT & FAMILY HISTORY

What is your occupation? _____ Full Time Part Time

What is your employment status? _____ Working Sick Leave Unemployed Retired

Do you use tobacco? No Yes Explain _____

Do you consume alcohol? No Yes Explain _____

Do you have a history of substance abuse? No Yes Explain _____

List all past surgeries _____

List all drug allergies _____

List all current and past medications / drugs

Drug Name: _____

List all physicians you have seen in the past 5 years?

Name _____	For What? _____
_____	_____
_____	_____
_____	_____

Family History

Father	<input type="checkbox"/> Living	Age: _____	<input type="checkbox"/> Deceased – Cause of Death _____
Mother	<input type="checkbox"/> Living	Age: _____	<input type="checkbox"/> Deceased – Cause of Death _____
Brother	<input type="checkbox"/> Living	Age: _____	<input type="checkbox"/> Deceased – Cause of Death _____
Brother	<input type="checkbox"/> Living	Age: _____	<input type="checkbox"/> Deceased – Cause of Death _____
Sister	<input type="checkbox"/> Living	Age: _____	<input type="checkbox"/> Deceased – Cause of Death _____
Sister	<input type="checkbox"/> Living	Age: _____	<input type="checkbox"/> Deceased – Cause of Death _____

PAIN DRAWING

Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation.

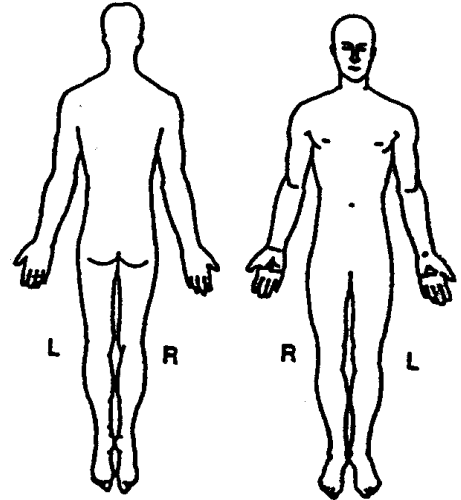
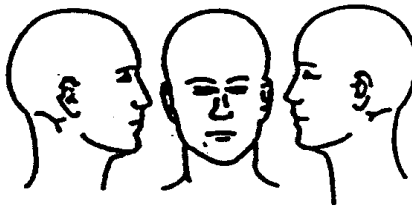
Describe your pain (check all that apply):

- Constant
- Intermittent
- Recurring
- Stabbing
- Dull Ache
- Sharp
- Deep Ache
- Throbbing
- Tingling
- While Resting
- Daily
- During Exercise
- Nightly
- _____

Pain	∴ ∴ ∴ ∴ ∴ ∴ ∴ ∴
Numbness	+++++
Burning	////////
Ache	XXXXXXXX

Onset of Pain:

- Sudden
- Gradual



On a scale of 1 to 10 how would you rate your pain level? _____ (1 = Mild, 10 = Intense)

What if anything gives you relief? _____

IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN ACCIDENT OR INJURY PLEASE COMPLETE BELOW

{ **AUTO ACCIDENT** Date _____ Time ____ [am] [pm] Location _____

- | | | |
|----------------|--|--|
| Were You | <input type="checkbox"/> Driver
<input type="checkbox"/> Unconscious
<input type="checkbox"/> Wearing a Seat Belt
<input type="checkbox"/> Transported by Ambulance | <input type="checkbox"/> Passenger
<input type="checkbox"/> Treated in E.R.
<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| Vehicle Damage | <input type="checkbox"/> Minimal – Moderate
Was the vehicle towed away? | <input type="checkbox"/> Severe - Totaled
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| Police Report | <input type="checkbox"/> None | <input type="checkbox"/> Yes with Police Dept _____ |
| Activities | <input type="checkbox"/> No restrictions
<input type="checkbox"/> I felt fine before the accident | <input type="checkbox"/> Missed ____ days of work or school |

{ **Work Related** Date _____ Time ____ [am] [pm] Location _____

or Other Injury Describe injury and how it happened:

Accident Reported to _____ on _____ (date)
 No restrictions Missed ____ days of work or school I felt fine before the injury

HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT – ASSIGNMENT OF BENEFITS – AUTHORIZATION & LIEN

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to Texas Health Centers.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility.

Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility.

Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility.

I understand that this Facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur.

I further understand that in the practice of medicine, chiropractic, psychological counseling, massage therapy & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions & reactions and/or other injuries or side effects which cannot be pre-determined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility.

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers mis-quote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing medical report charges, which you are responsible to pay.
2. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. All account balances, including automobile claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
5. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy.
6. A service charge is computed by a 'periodic rate' of 1½ % per month – 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee's. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a \$30.00 charge.
7. For your convenience we accept most major credit & debit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Name of Patient _____

Claim # (if applicable) _____

Signature (if minor, parent must sign) _____

Date _____

ACCIDENT & INJURY QUESTIONNAIRE

Please complete this form only if you were in an accident or had a work injury.

Name _____	Account _____	Date _____
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Automobile Accident

Date & Time of Accident _____

Describe how accident occurred and what happened to your body motion at the time of the accident.

How did you feel 24 hours before the accident?

FINE — NO PAIN _____

- | | | |
|--------------------------|----------------------------------|-------------------------------------|
| Were you | <input type="checkbox"/> Driver | <input type="checkbox"/> Passenger |
| Others in car | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Were they hurt | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Wearing seat belt | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Wearing eye glasses | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Where were you hit | <input type="checkbox"/> Behind | <input type="checkbox"/> Front/Side |
| Damage to vehicle | <input type="checkbox"/> Minimal | <input type="checkbox"/> Moderate |
| Was car totaled | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Did seat back break | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Did glass break | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Police report made | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Did you go to E.R. | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| If yes, which one: _____ | | |
| Had accident before | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Missed any work | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

For insurance purposes please complete:

Your auto insurance co _____
 Your auto agent _____
 His/her phone number _____
 This claim number _____
 Adjusters name _____
 Adjusters phone no. _____
 Person who hit you _____
 Their phone number _____
 Their auto ins co. _____
 Your attorney _____
 Telephone number _____
 Address (if known) _____

Other Insurance Information

Work Related Injury

Date & Time of Accident _____

Describe how injury occurred in your own words. Be Specific in details & accurate in pains & injuries.

How did you feel 24 hours before this injury?

FINE — NO PAIN _____

- Was injury report made _____
 Report to supervisor _____
 Missed any work _____
 Had any work injury before _____
 Seen company doctor yet _____
 Were you authorized to see us _____

List your routine job duties in detail

For insurance purposes please complete:

Employer/Company _____
 Your supervisor _____
 Company phone no. _____
 Company doctor name _____
 Doctors phone number _____
 Your med insurance _____
 Your policy number _____

Your attorney _____
 Telephone number _____
 Address (if known) _____

Other Insurance Information

