

# Seguro Social \_\_\_\_\_

# Licencia de Manejo \_\_\_\_\_

Fecha \_\_\_\_\_

## INFORMACIONAL CONFIDENCIAL DE PACIENTE

Nombre \_\_\_\_\_ # Tel. De Casa \_\_\_\_\_

Direccion \_\_\_\_\_ Cd. \_\_\_\_\_ # Zona \_\_\_\_\_

Edad \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_ Estatus Martial C D S V # Hijos \_\_\_\_\_

Ocupacion \_\_\_\_\_ Empleador \_\_\_\_\_

Direccion \_\_\_\_\_ # Tel Trabajo \_\_\_\_\_

Aseguransa de Trabajo \_\_\_\_\_ Nombre de Agencia \_\_\_\_\_

# de Polisa \_\_\_\_\_

Nombre de Esposo (a) \_\_\_\_\_ Ocupacion \_\_\_\_\_

Empleador \_\_\_\_\_ # Tel Trabajo \_\_\_\_\_

Familiar Cercano \_\_\_\_\_ # Tel \_\_\_\_\_

Direccion \_\_\_\_\_

Quien lo Recomendo \_\_\_\_\_

Fecha de Ultimo Examen Medico \_\_\_\_\_

A Padecido de:	SI	NO		SI	NO
1. Mareos	<input type="checkbox"/>	<input type="checkbox"/>	8. Asma	<input type="checkbox"/>	<input type="checkbox"/>
2. Dolor do Espalda	<input type="checkbox"/>	<input type="checkbox"/>	9. Neurotismo	<input type="checkbox"/>	<input type="checkbox"/>
3. Problemas de Corazon	<input type="checkbox"/>	<input type="checkbox"/>	10. Problema Digestivo	<input type="checkbox"/>	<input type="checkbox"/>
4. Deabetes	<input type="checkbox"/>	<input type="checkbox"/>	11. Problema Nervioso	<input type="checkbox"/>	<input type="checkbox"/>
5. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	12. Problema Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
6. Artritis	<input type="checkbox"/>	<input type="checkbox"/>	13. Anemia	<input type="checkbox"/>	<input type="checkbox"/>
7. Dolor de Cabeza	<input type="checkbox"/>	<input type="checkbox"/>	14. Cancer	<input type="checkbox"/>	<input type="checkbox"/>

Proposito de Cita \_\_\_\_\_

Algun otro Dr. la a tratado de este problema \_\_\_\_\_

En el ano presente, a tenido problema de salud y si a sido tratada por un doctor.  YES  NO

Describe el problema \_\_\_\_\_

Inf Adicional: \_\_\_\_\_

### Se espera pago al momeno de consulta!

Nombre de persona responsable de pago? \_\_\_\_\_

Esta usted Asegurado?  YES  NO Compania \_\_\_\_\_

Yo entindo y estoy de acuerdo que las polizas de las aseguransa que se aplican a los problemas de salud y accidents son aregladas entre las aseguradora y yo. Entiendo que el One Source Family Chiropractico se encarga de preparar los reportes y formas necesarias para asistime en colectar la suma necesaria y que sea pagada directamente a One Source Family Chiropractico. Entiendo y estoy de acuerdo que segun sean los servicios arendados hacia a mi seran cargado a mi cuenta. Yo soy responsable por pagarlos. Tambien entiendo que si suspendo mi tratamiento, cualquier servicio professional arendado hacia a mi tendra que ser pagado de inmediato.

Firma de paciente: \_\_\_\_\_ Fecha: \_\_\_\_\_

Firma de esposo (a) \_\_ o guardian: \_\_\_\_\_ Fecha: \_\_\_\_\_

## INFORMACION DE DANOS ACCIDENTAL

Fecha de Accidente \_\_\_\_\_ Hora \_\_\_\_\_ AM PM Lugar \_\_\_\_\_

Tipo de accidente  Automolístico  Relacionado con trabajo  Other \_\_\_\_\_

Por favor describa el accidente lo mas detallado posible \_\_\_\_\_

Reviso los sintomas que a tenido despues de el accidente:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Dolor de cabeza    | <input type="checkbox"/> Dearea           | <input type="checkbox"/> Sensibilidad       | <input type="checkbox"/> Mareos                   |
| <input type="checkbox"/> Dolor de cuello    | <input type="checkbox"/> Pies frios       | <input type="checkbox"/> Perdida de memoria | <input type="checkbox"/> Cabeza pesada            |
| <input type="checkbox"/> Cuello tieso       | <input type="checkbox"/> Manos frias      | <input type="checkbox"/> Sonido en oidos    | <input type="checkbox"/> Piquetes en brazos       |
| <input type="checkbox"/> Problema de dormir | <input type="checkbox"/> Estomago iritado | <input type="checkbox"/> Cara roja          | <input type="checkbox"/> Piquetes en piernas      |
| <input type="checkbox"/> Dolor de espalda   | <input type="checkbox"/> Estrenimiento    | <input type="checkbox"/> Sumbido en oidos   | <input type="checkbox"/> Dedos adormesidos        |
| <input type="checkbox"/> Nerviosismo        | <input type="checkbox"/> Escalofrios      | <input type="checkbox"/> Perdida de balance | <input type="checkbox"/> Dedos de pie adormesidos |
| <input type="checkbox"/> Tension            | <input type="checkbox"/> Fiebre           | <input type="checkbox"/> Desmayos           | <input type="checkbox"/> Falta de aire            |
| <input type="checkbox"/> Irritable          | <input type="checkbox"/> Fatigada         | <input type="checkbox"/> Perdida de olfato  | <input type="checkbox"/> _____                    |
| <input type="checkbox"/> Dolor de pecho     | <input type="checkbox"/> Depression       | <input type="checkbox"/> Perdida de sabor   | <input type="checkbox"/> _____                    |

Danos o otros sintomas \_\_\_\_\_

Usted pidio ser hospitalizada en el momento de el accidente?  SI  NO Donde \_\_\_\_\_

Perdio dias de trabajo  SI  NO

#### Accidente Automovilistico

Usted era  Chofer  Pasajero  Peaton

El vehiculo fue golpea  Por atras  Por enfrente  Derecha  Izquierda

En el impacto hacia  Derecho  Izquierda  Derecha

Usaba su cinturón?  SI  NO

De quien fue la culpa?  Su vehiculo  El otro vehiculo  Los dos vehiculos

Quien recibo la multa?  Usted  Chofer de su caro  Chofer de otro caro

Su aseguranza \_\_\_\_\_ Agencia \_\_\_\_\_

Tel. \_\_\_\_\_ # de polisa o demanda \_\_\_\_\_

Tiene usted polisa de Proteccion contra Danos Personales para su auto?  SI  NO

Otra aseguranze de automoblie \_\_\_\_\_

A contratado a un abogado, para que represente su caso?  SI  NO

Nombre \_\_\_\_\_ Tel \_\_\_\_\_

#### Accidente en Trabajo

Usted reporto el accidente a su supervisor?  SI  NO

Nombre de supervisor y posicion? \_\_\_\_\_

Usted fue aconsejado de recibir cuidados con nosotros  SI  NO

Nombre de la aseguradora de Indemnizacion de Empleados \_\_\_\_\_

Usted a recibido alguna terapia fisica desde el accidente?  SI  NO

Si a recibido terapia, cada cuando y desde cuando \_\_\_\_\_

# One Source Family Chiropractic

Patient's Name \_\_\_\_\_

Guardian's Name \_\_\_\_\_

Description of the authority to act on behalf of the patient: \_\_\_\_\_

**TERMS OF ACCEPTANCE**

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective.

- An **adjustment** is the specific application of forces to facilitate the body's correction of vertebral subluxation.
- **Health** is a state of optimal physical, mental and social well being, not merely the absence of disease.
- **Subluxation** is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

Our chiropractic method of correction of subluxation(s) is by specific adjustments of the joints of the body.

I, the undersigned, hereby authorize One Source Family Chiropractic and whomever they may designate as their assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary. I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

\_\_\_\_\_  
Patient's Signature (or Guardian's Signature)

\_\_\_\_\_  
Date

**OFFICE POLICY**

- a. Insurance Patients must pay at time of service if insurance has not been confirmed and/or other arrangements have not been made. Medical insurance will almost never cover 100% of chiropractic services, therefore any patient should expect to have some out of pocket expenses.
- b. Cash patients must pay at the time of service if other arrangements have not been made.
- c. Personal Injury (i.e. auto injury) patients must have:
  - 1. Name of insurance company responsible for the injury.
  - 2. Valid claim number from insurance company.
  - 3. An adjuster's name who is handling the claim for the insurance company.All three must be provided before out of pocket expenses will be waived. If information cannot be confirmed, patient will be required to pay at the time of service. Once confirmation has been made we will return any fees paid and wait for insurance payments.
- d. Promotional offers, coupons, etc. – Patients coming in under promotions or special offers must understand that this reflects out of pocket cost whether or not you have insurance coverage. We will bill your insurance, if applicable, as this notifies your insurance company of the services we will be providing.
- e. Special Consideration – It is our policy to never turn anyone away from care based solely on financial reasons. Anyone wishing special consideration regarding fees must demonstrate three things.
  - 1. A sincere desire to regain their health,
  - 2. A willingness to offer some sort of fair exchange for care,
  - 3. *Real* financial hardship

\_\_\_\_\_  
Patient's Signature (or Guardian's Signature)

\_\_\_\_\_  
Date

**X-RAY CONSENT**

I understand that the purpose of the X-rays about to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic, or "unusual", finding when reviewing this X-ray, I will be informed. I then must determine if I should seek the services of an additional health care provider for advice, diagnosis, or treatment of the "unusual" finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

I fully understand the above and consent to chiropractic spinal x-rays, if they are found to be necessary.

\_\_\_\_\_  
Patient's Signature (or Guardian's Signature)

\_\_\_\_\_  
Date

**PREGNANCY RELEASE**

This is to certify that to the best of my knowledge I am not pregnant and One Source Family Chiropractic has my permission to perform an x-ray evaluation, if necessary. I understand that x-rays can be hazardous to an unborn child.

Date of last menstrual period: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

## Privacy Notice

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

In the course of your care as a patient at One Source Family Chiropractic, PA we may use or disclose personal and health related information about you in the following ways:

- \* Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- \* Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- \* Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not available at home and/or work to receive an appointment reminder, a message may be left for you. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- \* If we are providing health care services to you based on the orders of another health care provider.
- \* If we provide health care services to you in an emergency.
- \* If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- \* If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- \* If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, then please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to either:

Rafael A. Moreno, D.C. or Sarah J. Moreno, D.C. – 512-392-5750

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If you would like further information about our privacy policies and practices please contact:

Rafael A. Moreno, D.C. or Sarah J. Moreno, D.C. – 512-392-5750

This notice is effective as of **April 10, 2006**. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

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Printed Name

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Signature

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Date

If you are a minor, or if you are being represented by another party:

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Personal Representative (Printed)

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Personal Representative (Signature)

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Date

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Description of the authority to act on behalf of the patient.