

One Source Family Chiropractic

Confidential Patient Information

Introduction and History

Name: _____	Date: _____
Home Address: _____	
Home Phone: _____	Work Phone: _____
Social Security #: _____	Date of Birth: _____
Employer's Name and Address: _____	
Occupation: _____	E-Mail Address: _____
Marital Status: M S W D	Number of Children: _____ Pregnant? _____
Spouse/Guardian Name: _____	
Spouse's Occupation/Employer: _____	
Name of person responsible for account: _____	
Do you have Medicare Coverage? _____	
Do you have Insurance that covers Chiropractic Care? _____	
Name of Insurance Company: _____	
Have you had Chiropractic care before? If so, when and by whom? _____	
Who may we thank for referring you? _____	

Why this form is important:

Our office focuses on your ability to be healthy. Our goals are to **first** address the issues that brought you to this office, and **second**, offer the **opportunity to improve your health potential in the future**. In order to give you the best possible Chiropractic care, we will need to discover any '**stresses**' that are placed on your body. Please take the time to fill out this form completely, as each question gives us a clearer picture of your current health status.

Reason for consulting this office

Wellness / Prevention Care - *I wish to continue my Chiropractic Wellness Care. Just answer the following questions that apply.*

I have a specific health concern/pain - Please describe your current problem, including the effect it has had on your life: _____

Please describe the character of your pain (check all that apply)

- | | | | | | |
|--|-------------------------------------|---------------------------------------|--|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp/Stabbing | <input type="checkbox"/> Sharp/Dull | <input type="checkbox"/> Achy | <input type="checkbox"/> Dull | <input type="checkbox"/> Soreness | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Throbbing/Gnawing | <input type="checkbox"/> Numbness | <input type="checkbox"/> Shooting | <input type="checkbox"/> Gripping/Constricting | | |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Other: _____ | | | |

PLEASE TURN OVER →

How often are the complaints present?

- Constant Daily Weekly Monthly

When is the pain or symptoms worse?

- When you wake up During the day After work In the evening After eating
 While sleeping Same all day long

How bad is your pain or ache? Please circle a number (0= no pain, 10 = unbearable pain)

0 1 2 3 4 5 6 7 8 9 10

Since your problem began is the pain: increasing decreasing not changing

When did your problem begin: _____ (specific date, if possible)

Please draw on the diagram where you feel your symptoms: ↓

Do you sleep on your:

- Back Stomach Left Side Right Side

Physical Activity at work:

- Sitting more than 50% Light manual labor
 Heavy manual labor

General physical activity:

- No regular exercise program
 Light exercise program
 Strenuous exercise program

How would you rate your stress level:

- No Stress Minimal Stress
 Moderate Stress Greatly Stressed

Do you currently smoke? Yes No. If YES please indicate how many packs a day: _____

Number of years: _____ Have you smoked in the past? Yes No.

Who else have you seen for this condition? _____

Please describe any falls, auto accidents or major injuries (include Month/Year, Type of accident): _____

Please describe any and all past surgery: _____

Please list ANY and ALL medication (prescription and over the counter): that you are currently taking: _____

Please Circle All That Apply: PERSONAL: Aneurysm, Osteoporosis, Diabetes, Thyroid Disease, Arthritis, Cancer, Stroke, Heart Condition, Hypertension, Polio, Asthma, Psoriasis. Other: _____

Please Circle Any That Apply: FAMILY: Aneurysm, Osteoporosis, Diabetes, Thyroid Disease, Arthritis, Cancer, Stroke, Heart Condition, Hypertension, Polio, Asthma, Psoriasis. Other: _____

Please check all symptoms or areas where you have problems, even if they do not seem related to your current problem.

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Buzzing/Ringing in Ears | <input type="checkbox"/> Lungs | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Heart | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Eyes/Vision | <input type="checkbox"/> Fainting | <input type="checkbox"/> Stomach | <input type="checkbox"/> Leg Pain/Cramps |
| <input type="checkbox"/> Concentration Loss | <input type="checkbox"/> Sinus | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Bladder | <input type="checkbox"/> Numb Feeling |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Liver | <input type="checkbox"/> Feeling of Pins/Needles |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Upper Back | <input type="checkbox"/> Colon | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Loss Energy | <input type="checkbox"/> Mid Back | <input type="checkbox"/> Kidney | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Tired Mornings | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Loss of Taste/Smell | <input type="checkbox"/> Urination | <input type="checkbox"/> Fever | <input type="checkbox"/> Menstrual Problems |

- Do you drink bottled or filtered water: Yes No
- Do you belong to a health club or exercises regularly: Yes No

If you remember the details, what was your birth delivery like (i.e. – breach, c section, long): _____

Have you had any or all of your childhood vaccinations? All Some: _____

Any reactions to vaccinations? _____

Please list all supplements and vitamins you take: _____

How would you rate your health:

Yuk, I've never felt worse Wow, I feel great!
1 2 3 4 5 6 7 8 9 10

How committed are you to improving your health:

Nah, not important I want to be 100% healthy!
1 2 3 4 5 6 7 8 9 10

Do you want to live to be a healthy 85 years old? Yes No

What is 'being healthy' to you (check all that apply)?

- | | |
|---|--|
| <input type="checkbox"/> Not being sick | <input type="checkbox"/> Being symptom free |
| <input type="checkbox"/> Having energy to do what I want, when I want | <input type="checkbox"/> Not needing to take time off work |
| <input type="checkbox"/> To fully enjoy all aspects of life to the fullest extent possible. | |

What is your goal or expectations with Chiropractic care: _____

Health is significant, but not necessarily serious
– we will do what we can to make each visit stress-free.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

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

The Chiropractic Office of One Source Family Chiropractic, PA

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

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.

Printed Name

Signature

Date

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

Personal Representative (Printed)

Personal Representative (Signature)

Date

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

PARTIAL ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AND TREATMENT AGREEMENT

Consideration In order to facilitate the ability of the Office to collect its charges directly from various Payers and thereby to enhance the patient-provider relationship, I, the undersigned, as consideration for the Office's services, agree to the following and direct all Payers as follows:

Partial Assignment of the Cause of Action, Assignment of Proceeds, and Contractual Lien I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to the Office, as well as any and all causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further assign my right to receive any Proceeds from any Payer to the office and further grant a contractual lien to the Office with respect to my Charges. I understand that these assignments of rights and contractual lien may effectuate, automatically or otherwise, a secured interest under the applicable Uniform Commercial Code. I intend for this Agreement to effectuate such a lien and hereby authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such lien. Except as provided herein, nothing in this agreement shall be construed as an election or waiver by the Office to a secured interest under any other statutory lien law. Consistent with these rights, I hereby direct any and all Payers to pay the proceeds directly and immediately to, and exclusively in the name of, the Office in the amount of my charges.

Other terms I understand that I remain personally responsible for my Charges. Consistent with law or contract, I agree to pay the full amount of my Charges to the Office upon its demand. Unless mutually agreed to in writing, the receipt and processing of partial payments by the Office shall not constitute a waiver of the Office's right to receive payment-in-full upon demand and shall not constitute an accord and satisfaction of my Charges, irrespective of any restrictions indicated on any payments. I understand that at anytime, I can request a copy of my total Charges. I hereby waive any statute of limitations which may apply to the collection of my charges.

In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I direct each attorney to issue an irrevocable letter of protection to the Office regarding my Charges. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office.

I authorize and direct the Office to submit my Charges to any and all Payers including, without limit, my health benefit plan. I understand, however, that in the event that my Charges are submitted to more than one Payer, I hereby authorize and direct the Office to apply any Proceeds received from one Payer to any reductions, write-offs, or discounts issued by another.

I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

This agreement shall not be modified or revoked without the mutual written consent of the Office and myself. I hereby revoke the terms of any previously signed documents to the extent those terms conflict with the terms of this Agreement.

This Agreement shall be governed under the laws of the state where the Office is located and performable in the county where the Office is located. I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Agreement 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 the Agreement shall, nevertheless, remain in full force and effect.

Definitions For the purposes of this Agreement, the following terms shall have the following meaning: "Office" shall refer to: One Source Family Chiropractic; located at 705 W. Hopkins St., Ste 100, San Marcos, Texas. "Payor" 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, tortfeasor, individual, and any other entity, which may elect or be obligated to pay or disperse Proceeds to me, either now or in the future, for any reason. "Proceeds" shall include, without limit the proceeds from any settlement, judgment, 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, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments 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, depositions, and testimony), and Collection Costs incurred by the Office, 18% interest on outstanding Charges, 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, attorneys fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charge either from me or any payer.

Patient Name (Please Print) _____

Patient Signature _____ Date _____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (Please Print) _____

Parent/Guardian Signature _____ Date _____