

CRAIG RANCH } CHIROPRACTIC

NEW PATIENT INFORMATION - PLEASE FILL OUT ENTIRE FORM, SIGN, & DATE ALL PAGES

Name: _____ Jr. Sr. II III

Gender: Male/Female DOB: _____ Single/Married/Divorced/Widowed

Race: Declines White/Caucasian Hispanic American Indian/Alaska Native Asian
Black/African American Native Hawaiian/Pacific Islander Other Race

Smoking Status: Never Former Smoker Unknown If Ever Smoked
Current Everyday Current Some Days Heavy Tobacco User Light Tobacco User

Address: _____

City: _____ State: _____ Zip: _____

Home#: _____ Cell #: _____ Height: _____ Weight: _____

Email Address: _____

Medications & Dosage: _____

Medication Allergies: _____

Date of Injury: _____ Describe Injury & Why You Are Here: _____

*****CIRCLE ANY OF THE FOLLOWING SYMPTOMS THAT YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS*****

- | | | |
|----------------------------|-----------------------|---------------------|
| Headaches | Tingling in Legs/Feet | Digestive Problems |
| Migraine/Tension Headaches | Knee Pain | Weight Trouble |
| Shoulder Pain | Mid-Back Pain | ringing in Ears |
| Arm/Hand Pain | Low Back Pain | Nervousness |
| Tingling Arms/Hands | Fibromyalgia | Fatigued/Tired |
| High Blood Pressure | Muscle Spasms | Difficulty Sleeping |
| Jaw Pain (TMJ) | Irritability | Difficulty Bending |
| Neck Pain | Dizziness | Physical Weakness |
| Tension | Allergies | Asthma |
| Leg/Foot Pain | Depression | Several Flu's/Colds |

Quadruple Visual Analog Scale

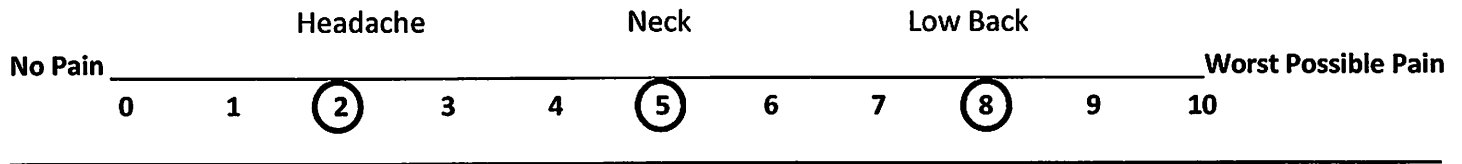
Patient Name: _____ Date: _____

Please read carefully:

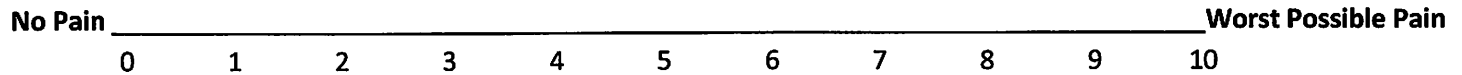
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

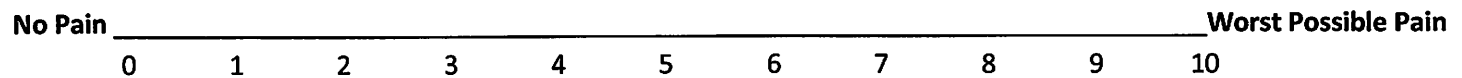
Example:



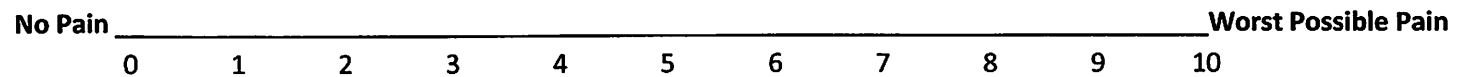
1: What is your pain RIGHT NOW?



2: What is your TYPICAL or AVERAGE pain?



3: What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

*****Please hand INSURANCE CARD to front desk*****

(This Is The Main Person Who Carries the Insurance, Not Necessarily The Patient)

Policy Holder: **Self** **Spouse** **Parent** **Other**

Policy Holder Name: _____

Policy Holder Address: _____

City: _____ **State:** _____ **Zip:** _____

Policy Holders Birthdate: _____ **Policy Holder Gender:** **Male/Female**

Policy Holders Phone #: _____

Name of Employer: _____

*****Office Use Only*****

Insurance Company: _____

ID #: _____ **Group #:** _____

Deductible: _____ **CoPay:** _____

Percentage: _____ **Visit Limit:** _____

Referral Required: **Yes/No** **ACN Required:** **Yes/No**

Notes:

CRAIG RANCH CHIROPRACTIC

Physical: 8880 SH 121, Ste 152, McKinney, TX 75070

Mailing: 2300 McDermott #200-296, Plano, TX 75025

214-644-0810

LEONARD FAMILY CHIROPRACTIC

Physical: 113 Connett, Leonard, TX 75452

Mailing: 2300 McDermott #200-296, Plano, TX 75025

903-587-2496

CONSENT TO USE PHI

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 Craig Ranch Chiropractic and/or Leonard Family Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, to evaluate the quality of care you receive, or to support the day-to-day health care operations of this office. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, email, fax or other methods. If you sign an authorization to disclose information, you can later revoke it to stop any further disclosures.

Use and Disclosure of your Contact Information

We use your phone numbers, address and email in order to contact you regarding your appointments, to communicate office events and information, for insurance information and any referrals to doctors for additional testing and/or treatment. We DO NOT sell your contact information to third party marketers.

Notice of Treatment in Open or Common Areas

Generally, adjustments and therapies will occur in a comment treatment area. If you would like to discuss your healthcare concerns in a more private setting, please let Dr. Allam know at the beginning of your appointment. Massage therapy will be in a private room.

Our Legal Duty

We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time. The Notice of Patient Privacy Policy will be displayed in the office. You can request a copy at any time or print a copy from our website (www.chiropractorsmckinney.com).

To release any of your health information family members, you will need to complete and sign an authorization form which you can receive in the office. If you request copies of your health information, we may charge you a cost-based fee.

Privacy Complaints

If you are concerned that we have violated your rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact our privacy officer, Stephanie Fleming Allam. You may send a written complaint to the US Department of Health and Human Services. Our privacy officer can provide you with the forms and appropriate address upon request.

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.

I have read and received the Notice of Patient Privacy Policy. _____ Patient Initials

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 disclosure of protected information in violation of an agreed upon 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 has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information to healthcare providers.

_____	_____
Patient or Legally Authorized Individual Signature	Date
_____	_____
Print Patient's Full Name	Time

INFORMED CONSENT

I hereby request, authorize and give consent to Dr. Troy Allam, for the performance of 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 the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and 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 judgment 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.

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 or Legally Authorized Individual Signature	Date
_____	_____
Print Patient's Full Name	Time

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my Insurance companies.
- I understand that I am responsible for my bill and all charges for services rendered.
- I authorize my doctor to act as my agent in helping me obtain payment from all my insurance companies.
- I authorize payment direct to my doctor.
- I permit a copy of these authorizations to be used in place of the original.

_____	_____
Patient or Legally Authorized Individual Signature	Date
_____	_____
Print Patient's Full Name	Time