CRAIG RANCH CHIROPRACTIC

PATIENT INFORMATION / INTAKE

Patient Name: _____ **Today's Date:** ___/___/___

Gender: Male Female **DOB:** ___/___/___ Last 4 digits of SSN _____ Single / Married / Divorced / Widowed

Race: Decline White/Caucasian Hispanic American Indian/Alaska Native Asian

Black/African American Native Hawaiian/Pacific Islander Other

Smoker / Tobacco User: Never Former Current/Everyday Current/ Some days

Heavy Tobacco User Light Tobacco User

Address: _____

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

Home Phone (_____) _____ **Cell Phone** (_____) _____

Patient's E-mail address: _____

Medications: _____

_____

Medication Allergies: _____

If your visit is the result of an injury, please describe: _____

_____ **Date of Injury:** _____

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

Headaches	Tingling in Legs/Feet	Digestive Problems
Migraine / Tension Headache	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 Across Shoulders	Allergies	Asthma
Leg/Foot Pain	Depression	Several Flu/Cold

Who should we contact in the event of an emergency? _____

Relationship of emergency contact to patient:_____ Phone (_____)_____

QUADRUPLE VISUAL ANALOGUE SCALE

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 average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

EXAMPLE:

			headache		neck					low back		
no pain	0	1	(2)	3	(4)	5	6	7	8	(9)	10	**worst possible pain**

##

1. What is your pain RIGHT NOW?

no pain	0	1	2	3	4	5	6	7	8	9	10	**worst possible pain**

2. What is your TYPICAL or AVERAGE pain?

no pain	0	1	2	3	4	5	6	7	8	9	10	**worst possible pain**

3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

no pain	0	1	2	3	4	5	6	7	8	9	10	**worst possible pain**

What percentage of your awake hours is your pain at its best? ________%

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

no pain	0	1	2	3	4	5	6	7	8	9	10	**worst possible pain**

What percentage of your awake hours is your pain at its worst? ________%

NAME ______________________________ **AGE**_______ **DATE**__________ **SCORE**______

SCORE: #1 ______ + #2 ______ + #4 ______ = ______ / 3 x 10 = ________ (Low intensity = <50; High intensity = >50)

********** INSURANCE AND FINANCIAL AGREEMENT **********

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and me -- NOT between my insurance company and this office. **I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing.** I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/_____

PLEASE COMPLETE THIS SECTION AND GIVE INSURANCE CARD TO FRONT DESK

Policy holder (circle): self spouse parent other

Policy Holder Name: _____

Policy Holder Address: _____

Policy Holder's Date of Birth ___/___/_____ Policy holder gender: Male Female

Does the policy holder have the insurance through employer? □ YES □ NO

Employer? _____

********** FOR OFFICE USE ONLY **********

Insurance Company: _____

ID: _____ Group number:_____

Deductible: _____ Co-Pay: _____

Co-insurance: _____ Visit Limit: _____

Referral Required: Yes No ACN Required: Yes No

Notes: _____

_____

_____

_____

CRAIG RANCH CHIROPRACTIC
Dr. Troy Allam D.C. & Dr. Camhy Hall, D.C.
Physical: 8880 SH 121, Ste 152 | McKinney, TX 75070

LEONARD FAMILY CHIROPRACTIC
Dr. Troy Allam, D.C.
Physical: 113 Connett | Leonard, TX 75452

Mailing: 2300 McDermott #200-296 | Plano, TX 75025
Phone: 214.644.0810 | Fax 214.644.0813 | admin@craigranchchiro.com

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

As of October 15, 2020

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 your Doctor know at the beginning of your appointment. Massage therapy and Wellness Counseling 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.

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.

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 Craig Ranch Chiropractic for the performance of chiropractic procedures, various modes of physical therapy and wellness counseling, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above 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 _____