CANADA CHIROPRACTIC, PLLC

CONFIDENTIAL PATIENT INFORMATION

Please Print

Date:______________________________

First Name:_________________________________ Last Name:________________________________ Preferred Name:___________________________

Address:____ City:________________________ State:________________ Zip:_____________

Primary Phone:_____________________________ Secondary Phone:___________________________ Cell Phone:_________________________________

Sex: ❑ M ❑ F Marital Status: ❑ M ❑ S ❑ W ❑ D Birth Date:__________________________ Age:_____________________

Social Security #:___________________________ Spouse's Name:____

Home Email Address:____ Work Email Address____

May we communicate with you by email? ❑ Yes ❑ No

Referred By: ❑ Patient:____ ❑ Physician :____

❑ Insurance Co:______________________ ❑ Crossfit Box Name_________________________ ❑ Staff ❑ Google Ad/Search ❑ Facebook

Work Status: ❑ Employed ❑ Full-Time Student ❑ Part-Time Student Other:____

Employer:____ Occupation:____________________ Phone:_________________________

Address:____ City:________________________ State:________________ Zip:____________

Were you involved in an auto accident? ❑ **Yes** ❑ **No**

Were you hurt on the job? ❑ **Yes** ❑ **No**

If you answered yes to either question, please notify us now.

Do you have Health Insurance? ❑ Yes ❑ No

POLICY HOLDER INFORMATION: Policy Holder Employer:____

Name of Insured:____ Relationship: ❑ Self ❑ Spouse ❑ Parent

Address:____ City:_____________________ State:________________ Zip:______________

Phone:____________________________ Social Security #:_______________________________ Birth Date:__________________________________

Name of Insurance Company:____

Address:____ City:_____________________ State:________________ Zip:______________

Phone:____________________________ Policy #:____ Group #:_____________________________________

Are you covered on an additional Health Insurance Policy? ❑ Yes ❑ No

Complaint #1:____

How long have you had this condition?________________________________ Most recent date of onset for this episode:__________________________

Is Condition: ❑ Constant (75-100% of time) ❑ Moderate(Marked Impairment) ❑ Slight (Moderate Impairment) ❑ Mild (Annoyance–No Impairment)

Please indicate the character of your pain below:

A. ❑ Dull or ❑ Sharp B. ❑ Deep or ❑ Surface C. ❑ Aching or ❑ Knife-like D. ❑ Burning or ❑ Pins & Needles E. ❑ Tingling or ❑ Numbness

Please indicate the onset of your condition: ❑ Immediate ❑ Gradual

Please indicate what activities aggravate or make your condition worse:

❑ Standing ❑ Sitting ❑ Coughing ❑ Sneezing ❑ Kneeling ❑ Bowel Movement ❑ Lying ❑ Twisting ❑ Bending

❑ Stooping ❑ Pushing ❑ Pulling ❑ Walking ❑ Climbing ❑ Gripping ❑ Other:____

In general, is your pain worse when you are moving about or when you are not moving?____

Complaint #1 cont.

Please indicate what helps you to relieve the pain: ❑ Lying ❑ Sitting ❑ Walking ❑ Hot Packs ❑ Standing ❑ Rest ❑ Cold Packs

❑ NOTHING ❑ Other:____________________________ ❑ Medication (Please List):____

Is your condition ***better*** in the ❑ morning or ❑ at night? Is your condition ***worse*** in the ❑ morning or ❑ at night?

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Other:____

What other doctors have you seen for this condition? Give type of treatment and dates:____

Complaint #2:____

How long have you had this condition?________________________________ Most recent date of onset for this episode:___________________________

Is Condition: ❑ Constant (75-100% of time) ❑ Moderate(Marked Impairment) ❑ Slight (Moderate Impairment) ❑ Mild (Annoyance–No Impairment)

Please indicate the character of your pain below:

A. ❑ Dull or ❑ Sharp B. ❑ Deep or ❑ Surface C. ❑ Aching or ❑ Knife-like D. ❑ Burning or ❑ Pins & Needles E. ❑ Tingling or ❑ Numbness

Please indicate what activities aggravate or make your condition worse:

❑ Standing ❑ Sitting ❑ Coughing ❑ Sneezing ❑ Kneeling ❑ Bowel Movement ❑ Lying ❑ Twisting ❑ Bending

❑ Stooping ❑ Pushing ❑ Pulling ❑ Walking ❑ Climbing ❑ Gripping ❑ Other:____

In general, is your pain worse when you are moving about or when you are not moving?____

Please indicate what helps you to relieve the pain: ❑ Lying ❑ Sitting ❑ Walking ❑ Hot Packs ❑ Standing ❑ Rest ❑ Cold Packs

❑ NOTHING ❑ Other:____________________________ ❑ Medication (Please List):____

Is your condition ***better*** in the ❑ morning or ❑ at night? Is your condition ***worse*** in the ❑ morning or ❑ at night?

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Other:____

What other doctors have you seen for this condition? Give type of treatment and dates:____

____

Past Medical History

*Please list any conditions you have been treated for prior to this occurrence. List the **dates,** the type of **treatment** received along with **who performed the treatment**, and any **residual effects** you are still experiencing.*

Surgeries ❑ ____
Fractures ❑ ____
Serious Injuries ❑ ____
Work Injuries ❑ ____
Personal Injuries or Motor Vehicle Injuries ❑ ____

Please list any medications including **dosage and frequency**, if known____
____
____

List any allergies that you have to any medication____
____

Briefly list your activities at work____
Briefly list your leisure activities____
Please list any other symptoms you are experiencing ____

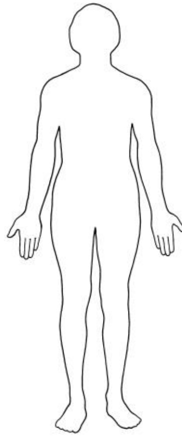
Family Health History

Relation (father, mother, sibling, child, etc) Past & Present Health Conditions

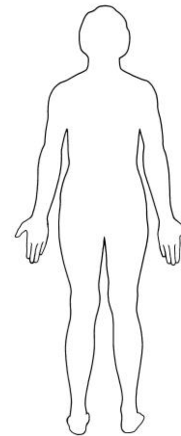
________________________________ / ____
________________________________ / ____
________________________________ / ____
________________________________ / ____

On the diagrams below, please indicate where you are experiencing pain right now. Please mark the exact location of your pain on the diagrams using the following abbreviations:

PAIN = P **TINGLING = T** **NUMBNESS = N** **BURNING = B** **STIFFNESS = S**



FRONT



BACK

Do you sleep on your ❑ Stomach ❑ Side ❑ Back ❑ Toss & Turn Age of Mattress ________________________ ❑ Comfortable ❑ Uncomfortable
Do you use a bed board? ❑ Yes ❑ No

HAVE YOU EVER	*YES*	*NO*	*DESCRIBE BRIEFLY*
Been knocked unconscious?	❑	❑	
Been treated for a spine or nerve disorder?	❑	❑	
Been hospitalized for other than surgery?	❑	❑	
Taken vitamins or minerals?	❑	❑	________________
Had an allergy to any medication?	❑	❑	________________
Have you seen a chiropractor in the past?	❑	❑	DC Name: ________________

Reason for treatment: Date of Treatment:

DATE OF LAST:	*Less than 6 months*	*6-18 months*	*Over 18 months*	*Never*
Spinal Examination	❑	❑	❑	❑
Physical Examination	❑	❑	❑	❑
Blood test	❑	❑	❑	❑
Chest X-Ray	❑	❑	❑	❑
Spinal X-Ray	❑	❑	❑	❑

Have you had an X-ray or CT scan or MRI of your <u>low back spine</u> in the past 28 days? ❑Yes ❑No

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care. Please check the appropriate box if you have been diagnosed with the following:

❑ Hepatitis
❑ Appendicitis
❑ Scarlet Fever
❑ Diphtheria
❑ Typhoid Fever
❑ Pneumonia
❑ Rheumatic Fever
❑ Polio
❑ Tuberculosis
❑ Anemia
❑ Measles
❑ Mumps
❑ Small Pox
❑ Chicken Pox
❑ Eczema
❑ Cancer
❑ Heart Disease
❑ Goiter
❑ Pleurisy
❑ Alcoholism
❑ Venereal Disease/Infection
❑ Arthritis
❑ Epilepsy
❑ Mental Disorder
❑ Lumbago
❑ Whooping Cough
❑ Influenza

Please check any conditions you are currently diagnosed with or have been diagnosed with in the past:

MUSCULO-SKELETAL
❑ Low Back Pain
❑ Pain between Shoulders
❑ Neck Pain
❑ Arm Pain
❑ Joint Pain/Stiffness
❑ Walking Problems
❑ Difficulty chewing/ Clicking jaw

C-V-R
❑ Chest Pain
❑ Shortness of Breath
❑ Irregular Heartbeat
❑ Heart Problems
❑ Lung Problems/Congestion
❑ Varicose Veins
❑ Ankle Swelling

GASTRO-INTESTINAL
❑ Poor or Excessive Appetite
❑ Excessive Thirst
❑ Frequent Nausea
❑ Vomiting
❑ Diarrhea
❑ Constipation
❑ Hemorrhoids
❑ Liver Problems
❑ Gall Bladder Problems
❑ Weight Problems
❑ Abdominal Cramps
❑ Gas or Bloating after meals
❑ Heartburn
❑ Black/Bloody Stool
❑ Colitis

NERVOUS SYSTEM
❑ Numbness
❑ Paralysis
❑ Dizziness
❑ Forgetfulness
❑ Confusion
❑ Depression
❑ Fainting
❑ Convulsions
❑ Cold/Tingling in Extremities
❑ Changes in Handwriting
❑ Irritability
❑ Changes in Personality

GENITO-URINARY
- ❑ Bladder Problems
- ❑ Painful/Excessive Urination
- ❑ Discolored Urine

EENT
- ❑ Vision Problems
- ❑ Dental Problems
- ❑ Sore Throat
- ❑ Earaches
- ❑ Hearing Difficulty/Impairment
- ❑ Stuffed Nose

GENERAL
- ❑ Allergies
- ❑ Loss of Sleep
- ❑ Fever
- ❑ HIV Positive

Would you like us to send a report of your findings to your physician? ❑ YES ❑ NO If Yes, please complete the information listed below:

Physician Name:____ Practice Name:____

Address:____ City/State/Zip:____

Phone:____

THE PURPOSE OF OUR CLINIC IS TO SUPPORT EACH INDIVIDUAL IN ACHIEVING THEIR OPTIMUM HEALTH AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND A MULTIDISIPLINED APPROACH TO HEALTH AND IN TURN, EDUCATE OTHERS.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due.

Patient Signature:____ **Date**:_______________________________

Guardian or Spouse's
Signature Authorizing Care:____ Date:_______________________________

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home)

Name:____

Address:____ Phone:_______________________________

PATIENT CONSENT FOR TREATMENT

CONSENT FOR TREATMENT (All Patients):

I voluntarily consent to the rendering of care, including chiropractic, physical therapy and physician treatment, and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and/or physical therapist and it is the responsibility of the staff to carry out the instructions of such clinician(s).

____

PRINT PATIENT NAME

____

PATIENT SIGNATURE

____

IF YOU ARE NOT THE PATIENT, PRINT YOUR NAME AND STATE YOUR RELATIONSHIP TO PATIENT

NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and the methods you can use to request access to this information. Please review this notice carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, personal research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on disclosure on this information. By law, we are not required to grant your request. However, if we decide to grant your request, we are bound by our agreement.

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Canada Chiropractic, PLLC to use and disclose your protected health information for the purposes of treatment, payment and healthcare operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. By your signature on this consent you are acknowledging your receipt of the Notice of Patient Privacy Policy..

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at (832) 409-9940. You have a right to request a restriction on how we use and disclose your private health information for the purposes of treatment, payment or health care operations. By law, we are not required to grant your request. However, if we decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent that we have already used or disclosed your protected health information in reliance on your consent.

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or any other related Medicare or Medicaid claim.

- √ Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.
- √ You may inspect and receive copies of you records within 30 days of your request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation of your medical records.
- √ You may request changes to your records. Our practice has the right to accept or deny your request.
- √ We maintain a history of protected health information disclosures that is accessible to you.
- √ In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.
- √ Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.
- √ For your convenience, you may obtain an Authorization for Release of Records form by calling (832) 409-9940.
- √ You may file a complaint to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. To file a complaint you may go to: http://www.hhs.gov/ocr/privacy/hipaacomplaints/hipcomplaintform.pdf or our office can provide you with a written form in which to file your complaint. You may also file a complaint with us by notifying our Privacy Officer of your complaint. We ill not retaliate against you for filing a complaint. Our Privacy Officer is Susanna Perez, she can be reached at (832)409-9940 or by email frontdesk@canadachiropractictx.com

____

PATIENT SIGNATURE **DATE**

OFFICE FINANCIAL POLICY

Our policy is to extend you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expenses and allows you to place your family under our care.

1. If You Do Not Have Insurance: All payments are due at the time of service or by an authorized payment plan. For bookkeeping purposes, we suggest that you prepay for your scheduled appointments with the doctor. This will greatly reduce your time at the front desk and help us minimize our bookkeeping expenses.

2. If You Have Insurance: All deductibles and co-payments are due at the time of service or by an authorized payment plan.

Please be advised that a quote of eligibility and benefits is not a guarantee of payment from your insurance carrier. All benefits are subject to eligibility, medical necessity and the terms, conditions, limitations and exclusions of your health benefit plan at the time the services are rendered. You, the patient, are responsible for any balances your insurance carrier deems as patient responsibility.

√ You are considered a cash patient until you bring in your completed insurance forms and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but we will be happy to provide you with a claim for your secondary carrier.

√ Our fees are considered usual, customary and reasonable by most insurance companies and are therefore covered up to the maximum allowance determined by each carrier. This statement does not apply to insurance companies that reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

√ If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active role in the recovery of your claim. If your carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

√ When your treatment plan is once per month or less in frequency, you insurance carrier may deem your treatment as maintenance and not cover the visit. Charges for services rendered will be due as they are performed or by an authorized payment plan. We will happily provide you with an insurance claim form for these visits.

√ If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claims already submitted.

Cancelation Policy: Our schedule is strategically timed to accommodate each patient in need. Since Dr. Canada is a solo practitioner, we request at least 24 hours notice if you have to change an appointment so we can accommodate other patients who require our services. Failure to do so will result in a cancelation fee.

Patient's Printed Name:____

Signature:______________________________________ Date:________________

For your convenience, you may retain your credit card number on file with us.

Credit Card #:____________________________ Type of Card:__________ Exp Date:________________

Your name as it appears on the card:____Sec Code:__________

CANADA CHIROPRACTIC, PLLC
8830 Long Point Road Ste 504
Houston, TX 77055

832-409-9940

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 Canada Chiropractic, PLLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

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 received a copy of 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.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

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.

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