APPLICATION FOR CARE AT Comprehensive Chiropractic, Physical Therapy & Laser

Patient Information

Patient Name: _____ Occupation: _____

Address: _____ Employer: _____

City: _____ State: _____ Zip: _____ Spouse Name: _____

Cell Phone: _____ Spouse employer: _____

Email: _____ **IN CASE OF EMERGENCY**

Sex: M F Age: _____ Date of Birth _____ Name: _____

Who is your primary care provider? _____ Relationship: _____

Who may we thank for referring you: _____ Phone Number _____

How can we help you?

What brings you in today? Primary: _____ Secondary: _____

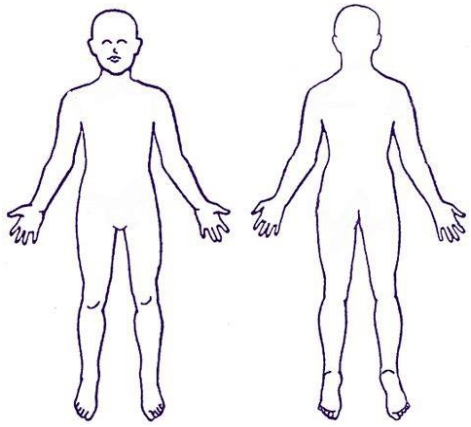
Third: _____ Fourth: _____

What symptoms, if any, are you experiencing? _____

How intense are your symptoms? **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**
No Symptoms Intense Symptoms

When did your symptoms begin? _____

Please circle, on the figure, the areas where you are experiencing your symptoms:



How did the injury occur? _____

Have you had this treated in the past? If so, by who? _____

What do your symptoms feel like?

- ☐ Numbness
- ☐ Cramping
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Sharp
- ☐ Swelling
- ☐ Burning
- ☐ Throbbing
- ☐ Other _____

Children & Pregnancy

How many children do you have? _____ Are you currently pregnant? Yes No

Children's age? _____ Number of past pregnancies? _____

Children's health concerns? _____ Pregnancy health concerns _____

Allergies, Medications, & Supplements

Allergies: _____

Medications: _____

Supplements: _____

Past Surgeries: _____

Is your problem the result of ANY type of accident? Yes No

Comprehensive Chiropractic, Physical Therapy & Laser

NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or **as dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures – open treating areas means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes – to process a claim or aid in investigation.
5. Emergency – in the event of a medical emergency we may notify a family member.
6. For public health and safety - to prevent or lessen a serious or eminent threat to the health or safety of a person or public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner, and government benefits purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders – **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership – in the event this practice is sold, the new owners would have access to you PHI.

YOUR RIGHTS:

1. The receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). X-rays are original records, and you are therefore not entitled to them. If you like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call at (210) 545-1810. If she/he is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the way this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

***Patient Initials*: _____-retaining page 1 of 2**

Comprehensive Chiropractic, Physical Therapy & Laser
NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of Comprehensive Chiropractic, Physical Therapy & Laser Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

I give this office permission to send medical records to other doctors' offices at the verbal or written request of myself or other's doctor's office.

_____ _____
Patient's Name **DOB**

_____ _____
Patient's Signature **Date**

_____ _____
Witness **Date**

I give permission to share my health information with: (spouse, next of kin, power of attorney, etc.)

_____ _____
Name **Relationship**

_____ _____
Patient Signature **Date**

Comprehensive Chiropractic, Physical Therapy & Laser

Informed Consent

REGARDING: Chiropractic Adjustments, Physical Therapy Methods, Modalities, & Therapeutic Procedures

I have been advised that Chiropractic Care, as well as Physical Therapy, like all forms of health care, hold certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, bruising/hematoma, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided by Dr. Oliver and Staff have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and/or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ ☐ ***Witness Initials***

Patient or Authorized Person's Signature **Date**

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions. Otherwise, see out receptionist for further explanation.

- ☐ **The first day of my last menstrual cycle was on ____-____-____ (Date)**
- ☐ **I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.**

By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed by understanding of the risks associated with exposure to X-rays. After careful consideration, I do hereby consent to have the diagnostic X-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ ☐ ***Witness Initials***

Patient or Authorized Person's Signature **Date**

Appointment Cancellation Policy

We strive to render excellent care to you and the rest of our patients. Your care and treatment are a priority to us. We ask that you respect our time and expertise as well.

In an attempt to be consistent with this, we have a Cancellation Policy that allows us to schedule appointments for our patients, with respect for your time, the next patient's time, and the doctor's time.

Our policy is as follows:

We request that you give a 24-hour notice in the event that you cannot make it to your scheduled appointment. If you as a patient miss an appointment without contacting our office, it is considered a "missed" or "no show" appointment and YOU WILL BE CHARGED $25. Additionally, if a patient is more than 20 minutes late for an appointment without giving us advanced notice, he/she is liable to be charged the fee at our discretion.

I have read and understand the Appointment Cancellation Policy of Comprehensive Chiropractic & Physical Therapy, and I agree to be bound by its terms. I am aware that I will be charged for any and all missed appointments.

Signature	Witness	Date

Comprehensive Chiropractic, Physical Therapy & Laser

Please note that Dr. Oliver's original office was named New Braunfels Physical Therapy, and there may be a possibility that some of your insurance paperwork will include this office name. Your treatment and billing aren't affected if this does occur on your paperwork.

By my signature below I am acknowledging that I have been made aware of the possibility that my insurance paperwork may be under New Braunfels Physical Therapy and I understand that this will in no way affect my treatment or my billing.

Signature	Witness	Date