First Name ______________________________ Last Name ________________________________

Gender ☐ M ☐ F DOB______/______/______ Age________

Home Address ____

City________________________________ State________ Zip code_________________

Phone ______________________________ Email_______________________________________

Preferred method of communication ☐ Phone ☐ Text ☐ Email

Employer____

Work Address ____

City________________________________ State________ Zip code_________________

Emergency Contact ______________________________ Phone__________________________

Patient Signature ______________________________________ Date____________________

Patient History

Name______________________________ Age______ DOB____/____/____ Gender ☐ M ☐ F

Height____ft____in Weight____lbs. Occupation______________________________

Previous chiropractic care? ☐ Y ☐ N If yes, how recently?____________________

Reason for today's visit:
☐ Pain ☐ Stiffness ☐ Maintenance care ☐ Recent injury ☐ Injury ☐ Other______________

When did your complaint(s) begin?____

What helps and/or worsens your condition? ____

What are your areas of complaint(s) today? Check all that apply.

☐ Headache/Migraine	☐ Neck	☐ Shoulder(s)
☐ Arm(s)	☐ Elbow(s)	☐ Wrist(s)
☐ Upper back	☐ Middle back	☐ Lower back
☐ Hip(s)	☐ Sciatica ☐ L ☐ R	☐ Knee(s)
☐ Ankle(s)	☐ Other________________	

Please place an "X" on the figures below where you are having complaints.

Front

Back

Patient/Legal Guardian Signature____________________________________Date__________

Patient history continued

Have you experienced this/these complaint(s) before? ☐ Y ☐ N

If yes, when?________________________________ Are you pregnant? ☐ Y ☐ N ☐ N/A

Are you currently experiencing any of the following: ☐ Double vision ☐ Rapid eye movement

☐ Numbness on one side of the face or body ☐ Dizziness ☐ Fainting or lightheadedness

☐ Difficulty walking ☐ Difficulty speaking ☐ Difficulty swallowing ☐ Nausea or vomiting

Current prescriptions or over-the-counter medications______________________________

____

Past history (Check all that apply)

☐ Headaches/Migraines	☐ Neck pain	☐ Arthritis
☐ Fused/fixed joints	☐ Herniated disc	☐ Shoulder pain
☐ Herniated disc	☐ Upper back pain	☐ Middle back pain
☐ Low back pain	☐ Hip pain	☐ Ankle pain
☐ Joint replacement	☐ Osteoporosis	☐ Osteopenia

Other conditions: ☐ Cancer ☐ Tumors ☐ Heart Disease ☐ Stroke ☐ AIDS/HIV ☐ Diabetes
☐ High blood pressure ☐ Pacemaker ☐ Hernia ☐ Hepatitis ☐ Tuberculosis ☐ Other__________

Previous surgeries and dates____

____

Previous hospitalizations? ☐ Y ☐ N Please describe_______________________________

Accidents/Broken Bones? ☐ Y ☐ N Please describe_______________________________

Family Health History: (check all that apply): ☐ Cancer ☐ Tumors ☐ Stroke ☐ Seizures
☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease

Patient/Legal Guardian Signature________________________________Date______________

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

____________________ ____________________ __________

Printed Name Signature Date

WITNESS:

____________________ ____________________ __________

Printed Name Signature Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Our Privacy Pledge and Duties

While we have and always will respect your privacy, a new federal law now requires us to maintain the privacy of hearing health information and other medical information (including examination, treatment and billing records) about you and to provide you with this Notice of our legal duties and privacy practices with respect to such health information.

We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change terms of our privacy notices. If we change the terms of the Notice, we will notify you during your next visit or by mail.

II. Permissible Uses and Disclosures Without Authorization

In certain situations (described in Section III below), we must obtain your written authorization in order to use and/or disclose your health information. However, here are some examples of how we might use or disclose your health information (other than highly confidential information) without first obtaining your written authorization:

A. Uses and Disclosures for Treatment, Payment or Health Care Operations

1. **Treatment**. Your hearing health care professional or staff member may use and disclose your health information to diagnose, assess and treat your health condition.
2. **Payment**. Our insurance and billing staff may disclose your health information to an insurance carrier, HMO, PPO, your employer, or other party that arranges or pays the cost of some or all of your health care, or to verify that such parties will pay for your health care.
3. **Health Care Operations**. Your hearing health care professional and members of the staff may use or disclose your health information for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.
4. **Appointment Reminders**. Your hearing health care professional and members of the staff may need to use your name, address, phone number, and other health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine or at another location that you reasonably request.
5. **Other Providers**. Your hearing health care professional and members of the staff may use or disclose your health information to another health care provider, product manufacturer, or a hospital if it is necessary to refer you to them or they are otherwise involved in your care when such information is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

B. Disclosures to Relatives, Close Friends and Other Caregivers

Your hearing health care professional and members of the staff may use or disclose your health information to one of your family members, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify your hearing health care professional.

If you are not present, you are incapacitated or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. We may also disclose your health information to notify such persons of your location or general condition.

C. Other Permitted Uses and Disclosures Without Your Authorization

Under federal law, we are also permitted or required to use or disclose your health information without your authorization in these following circumstances:

1. **Public Health Activities**. We may disclose your health information for certain public health activities such as (i) reporting health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (ii) reporting child abuse and neglect to authorities authorized by law to receive such reports; (iii) reporting information about products or services under the jurisdiction of the U.S. Food & Drug Administration; (iv) alerting a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading a disease or condition; and (v) reporting information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.
2. **Victim of Abuse, Neglect or Domestic Violence.** If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose health information to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect or domestic violence.
3. **Health Oversight Activities.** We may disclose your health information to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health care programs such as Medicare or Medicaid.
4. **Judicial and Administrative Proceedings.** We may disclose your health information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.
5. **Law Enforcement Officials.** We may disclose your health information to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.
6. **Decedents.** We may disclose your health information to a coroner or medical examiner as authorized by law.
7. **Organ and Tissue Procurement.** We may disclose your health information to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.
8. **Research.** We may use or disclose your health information if an Institutional Review Board approves a waiver of authorization for use or disclosure.
9. **Health or Safety.** We may use or disclose your health information to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.
10. **Specialized Government Functions.** We may use or disclose your health information to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law.
11. **Workers' Compensation.** We may disclose your health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.
12. **As Required by Law.** We may use or disclose your health information when required to do so by any other law not already referred to in the preceding categories.

III. Uses and Disclosures Requiring Your Authorization

1. **Uses or Disclosure With Your Authorization.** Other than the circumstances described above, any other use or disclosure of your health information will only be made with your written authorization. Additionally, you have the right to refuse to give us authorization to use or disclose your health information for purposes other than those described above. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.
2. **Your Right to Revoke Your Authorization.** You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have taken an action in reliance upon such authorization before we receive your request to revoke your authorization.
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at the address given in Section VII below.

3. **Marketing.** We must also obtain your written authorization prior to using your health information to make you aware of products or services that you may have an interest in purchasing from time to time. We can, however, provide you with marketing materials in a face-to-face encounter without obtaining your authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without first obtaining your authorization. Additionally, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings.
4. **Uses and Disclosures of Your Highly Confidential Information.** In addition, federal and state law requires special privacy protections for certain highly confidential information about you. In order for us to disclose your highly confidential information for a purpose other than permitted by law, we must obtain your written authorization.
5. **Right to Refuse Authorization.** You have the right to refuse to give us an authorization to use or disclose your health information or otherwise contact you for purposes other than those set forth in Section II above. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

IV. Your Individual Rights

1. **Your Right to Receive Confidential Communication Regarding Your Health Information.** We normally provide information about your health in person, at the time you receive hearing care services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide by an alternative means of communication or at an alternative location. To help us respond to your needs, please make any requests in writing.
2. **Right to Request Additional Restrictions.** You may request restrictions on our use and disclosure of your health information (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your general location and general condition. All requests for such restrictions must be made in writing. While we consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction.
3. **Your Right to Inspect and Copy Your Health Information.** You may request access to your health information maintained by us in order to inspect and/or copy your health information. We require your request to inspect an/or copy your health information to be in writing. If you request copies, we will charge you [may charge no more than $25 for the first 20 pages, and 50 cents for each page thereafter. Thus, you may charge a maximum of $27.50 for a 25-page paper chart]. We will also charge you for our postage costs, if you request that we mail the copies to you.
4. **Your Right to Amend Your Health Information.** You have the right to request that we amend your health information maintained by us. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.
5. **Your Right to Receive an Accounting of the Disclosures We Have Made of Your Records.** You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request, provided such request does not apply to disclosures that occurred prior to June 16,2020. The accounting will include all disclosures except those disclosures:

- required to carry out treatment, payment and health care operations to you.
- that are incident to a permitted use or disclosure.
- made pursuant to an authorization.
- required to maintain a directory of the individuals in our facility or to individuals involved with your care.
- required for national security or intelligence purposes.
- to correctional institutions or law enforcement officers.
- made as part of a limited data set.
- made prior to June 16,2020.

If you request an accounting more than once during a twelve (12) month period, we will charge [per Texas state law] per page of the accounting statement.

V. Re-Disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by federal law.

VII. Your Right to Obtain Further Information; Complaints

If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about providing you access to your health information, please contact us. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, we will provide you with the address for the Director. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint or request information at any time, written comments should be addressed to:

[NAME OF HEARING HEALTH PRACTITIONER]

Scott Jones, DC

2100 Roosevelt Dr, Suite D

Dalworthington Gardens, TX 76013

VIII. Your Right to Receive a Paper Copy of this Notice

Upon written request, you may obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically.

IX. Effective Date. This Notice is effective as of June 16th, 2020

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of Simply Chiropractic's Notice of Privacy Practices. I have read and understand the Notice and I have had an opportunity to ask questions about the use and disclosure of my health information, and other concerns regarding my health information.

____

Signature of Patient (or Personal Representative) & Date

____

Printed Name of Patient

____

Printed Name of Personal Representative (if applicable)