Life Force Chiropractic 202 N. Allen Drive, Suite F, Allen TX 75013 (469)777-8532

Date: _____

Name_____

Address _____

City, State, and Zip Code_____

Home Phone _____ Cell Phone _____

Email _____

Birth-date _____ Age _____

Gender: Male _____ Female _____

Marital Status: Married ____ Single ____ Divorced ____ Separated ____ Widowed _____

Social Security Number _____

Drivers License Number _____

Would you like to receive notifications through email? Yes____ No _____

Who referred you to our office? _____

Employer _____

Work Address _____

Work Phone _____

Type of Work _____

Payment Method: Cash ____ Check ____ Credit Card ____

Credit Card Number _____ Exp. Date _____
Security Code:_____

Why did you come to this office? _____

_____

_____

_____

_____

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Health History of Family Members

Condition	Self	Spouse	Father	Mother	Brother	Sister	Children
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Disc Problems							
Drinker							
Drug Addiction							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraines							
Nervousness							
Neuralgia							
Pinched Nerve							
Scoliosis							
Sinus Trouble							
Smoker							
Sports Activities							
Stomach Trouble							

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PATIENT MEDICATION RECORD

Case Number: ____________________

Patient: ____ Date: ____________________________

Dear Patient: Please indicate all over-the-counter and prescription medications you are presently taking.

Name of Medication: ____________________________
Dosage: ___________________ Date Begun: _________
Reason for taking: ______________________________
Results: ______________________________________

THIS AREA FOR EVALUATION BY DOCTOR
Actions and Uses: ______________________________
____
Reactions and Risks: ____________________________
____
Contraindications: ______________________________
____

Name of Medication: ____________________________
Dosage: ___________________ Date Begun: _________
Reason for taking: ______________________________
Results: ______________________________________

THIS AREA FOR EVALUATION BY DOCTOR
Actions and Uses: ______________________________
____
Reactions and Risks: ____________________________
____
Contraindications: ______________________________
____

Name of Medication: ____________________________
Dosage: ___________________ Date Begun: _________
Reason for taking: ______________________________
Results: ______________________________________

THIS AREA FOR EVALUATION BY DOCTOR
Actions and Uses: ______________________________
____
Reactions and Risks: ____________________________
____
Contraindications: ______________________________
____

Name of Medication: ____________________________
Dosage: ___________________ Date Begun: _________
Reason for taking: ______________________________
Results: ______________________________________

THIS AREA FOR EVALUATION BY DOCTOR
Actions and Uses: ______________________________
____
Reactions and Risks: ____________________________
____
Contraindications: ______________________________
____

Name of Medication: ____________________________
Dosage: ___________________ Date Begun: _________
Reason for taking: ______________________________
Results: ______________________________________

THIS AREA FOR EVALUATION BY DOCTOR
Actions and Uses: ______________________________
____
Reactions and Risks: ____________________________
____
Contraindications: ______________________________
____

Name of Medication: ____________________________
Dosage: ___________________ Date Begun: _________
Reason for taking: ______________________________
Results: ______________________________________

THIS AREA FOR EVALUATION BY DOCTOR
Actions and Uses: ______________________________
____
Reactions and Risks: ____________________________
____
Contraindications: ______________________________
____

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Terms of Acceptance

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and method that will be used to obtain such goal.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our Chiropractic method of correction is to provide specific adjustments to the spine.

HEALTH: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a Chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment of those findings, we will recommend that you seek the services of another health provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference of the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statement.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

(Signature) (Date)

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____, being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care in this office.

_____ _____

(Signature) (Date)

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FINANCIAL POLICY

We no longer accept insurance assignment. It is the policy of this office to collect all fees at the time that services are rendered

Upon request we will supply you with a detailed statement on each visit you can submit to your insurance carrier dependent upon the financial plan you have selected. We will respond in a timely manner to any requests for information from an insurance company which may be needed to process you claims.

We strive to make available to everyone and keep our charges affordable

_____ _____

Patient's Signature Date

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to the spine, as he deems appropriate.I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due or payable.

Ownership of X-ray films

It is understood and agreed upon that payment to the Doctor for x-ray procedures is for the review and examination of said x-rays. The x-ray negatives, and/or CD's will remain the property of this Chiropractic office. The x-ray films are to be kept on file where they may be seen upon request while I am a patient of this office. If, I the patient require or request a copy of my x-rays films, I understand that copies must be obtained from the imaging center at which the x-rays were initially taken for a fee determined by the imaging center.

Patients Signature_____

Date_____

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Dan K. Fleishman, D.C.

Consent for Purpose of Treatment, Payment and Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient,
and "Chiropractor" refers to Dan K. Fleishman, D.C.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of my by Chiropractor may be conditioned upon my consent as evidence by my signature below.

I understand I have the right to request a restriction as to how my protected heath information is used or disclosed to carryout treatment, payment or heath care operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time. except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another heath care provider, a health plan, my employer or health care clearinghouse. This protected heath information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected heath information that will occur in my treatment. payment of my bills to in the performance of heath care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 202 N. Allen Drive, Suite F, Allen, TX 75013. This Notice of Privacy Practice also describes my rights and duties of the Chiropractor with respect to my protected heath information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative's Authority