Patient Health Consent Form

Darcy Romine, D.C. • Granbury Spine and Sport Center
1101 Waters Edge Dr., Ste. 100. • Granbury, TX 76048 • (817) 579-6400

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to ask at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI)for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, our staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractor has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature:_____

Date:_____

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Listed below is information regarding procedures of operation for Granbury Spine and Sport Center, LLC. Please keep in mind that there may be slight variances due to unforeseen circumstances.

1. Standard operation hours for the clinic are 8:30am – 5:00pm Monday, Wednesday, Thursday, and 8:00am – 12:00pm Tuesday and Friday. Any patient who is more than 10 minutes late for an appointment will be rescheduled for another date and time.
2. The staff at Granbury Spine and Sport Center, LLC understands that certain circumstances require rescheduling. However, THREE "NO SHOWS" MAY RESULT IN A PATIENT BEING DISCHARGED FROM THIS PRACTICE. A "no show" is defined as when a patient misses an appointment and has not called prior to the appointment time to reschedule, or is more than 15 minutes late.
3. For those patients who have sudden onset of illness, Granbury Spine and Sport Center, LLC provide certain times set aside during the day for "walk-ins". These times are on a first come first service basis to patients who call the clinic at 8:00am on any given day.
4. Patients whose symptoms are severe, should symptoms change dramatically while waiting or who may perhaps be infectious will be taken to a patient room as soon as possible to wait for their appointment.
5. Every effort is made to assure the patients are seen as close to their scheduled appointment time as possible. Because Granbury Spine and Sport Center, LLC wants to provide the best possible healthcare, appointments, at times, may overlap due to the condition of other patients. We appreciate your understanding at all times.

Thank you,

Granbury Spine and Sport Staff

Due to the Health Insurance Portability and Accountability Act (HIPPA) of 1996, the following information must be filled out by each patient ANNUALLY. I authorize Granbury Spine and Sport Center, LLC to release any of my medical or insurance information necessary to process my medical claims and coordinate/mange my healthcare.

In the event a family member or caregiver attends my office visits and is in the exam room at the time of my evaluation and or treatment, I give Granbury Spine and Sport Center, LLC and its providers and employees my permission to discuss freely my condition, treatment or diagnosis with that person present. _____Yes _____No

Home Phone # _____ May we leave a detailed message? Yes No

Work Phone #_____ May we leave a detailed message? Yes No

Cell Phone #_____May we leave a detailed message? Yes No

With whom may we discuss information about care, treatment or diagnosis?

_____ Relationship:_____

_____ Relationship:_____

_____ Relationship:_____

_____ _____

Signature Date

Patient Information

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Patient Information

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ Apt No: _____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Social Security No.:_____

Alternate Phone (cell / pager):_____ e-mail:_____

Date of Birth: _____ / _____ / _____ Driver's License (State and Number):_____

Employer / Name of School & Address: _____ ☐Full Time ☐Part Time

Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

If Applicable:

Spouse's Last Name:_____ First Name:_____ Middle Initial:_____

Spouse's Work Phone:_____ Spouse's Social Security No.:_____ Spouse's Date of Birth: _____ / _____ / _____

Spouse's Employer & Address: _____

Responsible Party Information (if different from above)

Last Name:_____ First Name:_____ Middle Initial:_____

Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other_____

Responsible Party's Home Phone:_____ Work Phone:_____ Social Security No.:_____

Address:_____ City:_____ State:_____ Zip:_____

Employer's Name:_____ Phone No.:_____

Address:_____ City:_____ State:_____ Zip:_____

Patient Insurance Information (Please present insurance card to receptionist)

PRIMARY Insurance Name:_____

Insurance Address:_____ City:_____ State:_____ Zip:_____

Name of Insured:_____ Relationship to Insured: ☐Self ☐Spouse ☐Parent ☐Other_____

Insurance ID No.:_____ Group No.:_____

SECONDARY Insurance Name:_____

Insurance Address:_____ City:_____ State:_____ Zip:_____

Name of Insured:_____ Relationship to Insured: ☐Self ☐Spouse ☐Parent ☐Other_____

Insurance ID No.:_____ Group No.:_____

☐Medicare Number:_____

Patient Referral Information

Referred By:_____ Other physicians who care for you:_____

Emergency Contact

Name:_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Alternate Phone No:_____

I authorize the attending physician to release my medical information for consultation, referral, or insurance processing purposes. I authorize my insurance company(ies) to pay benefits directly to the physician.

Patient Signature: _____

Date:_____

Payment is due at the time services are rendered. As a courtesy we will file your insurance so that you may be reimbursed.

Patient Health Questionnaire

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Patient Name: _____

Symptoms:

If you have ever had a listed symptom in the ***past***, please check that symptom in the ***Past*** column. If you are ***presently*** troubled by a particular symptom, check that symptom in the ***Present*** column. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

Past	Present	Condition
☐	☐	Abdominal Pain
☐	☐	Abnormal Weight ☐ Gain ☐Loss
☐	☐	Angina
☐	☐	Anorexia
☐	☐	Aortic Aneurysm
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Bladder Infection
☐	☐	Blood Disorder
☐	☐	Breast ☐Soreness ☐Lumps
☐	☐	Cancer, Explain _____
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	Colitis
☐	☐	Constipation/Irregular Bowel Movements
☐	☐	Convulsions
☐	☐	Diabetes
☐	☐	Depression
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Difficulty in Swallowing
☐	☐	Dizziness
☐	☐	Emphysema (Chronic Lung Disease)
☐	☐	Endometriosis
☐	☐	Epilepsy
☐	☐	Excessive Thirst
☐	☐	Fainting
☐	☐	Frequent Urination
☐	☐	General Fatigue
☐	☐	Hand Pain ☐Right ☐Left
☐	☐	Headache
☐	☐	Heart Attack Date:_____
☐	☐	Heartburn/Indigestion
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Irregular Menstrual Flow
☐	☐	Irritable Colon
☐	☐	Jaw Pain
☐	☐	Kidney Disorders (by condition)
☐	☐	Kidney Stones
☐	☐	Liver/Gall Bladder Problems
☐	☐	Loss of Appetite

Past	Present	Condition
☐	☐	Loss of Bladder Control
☐	☐	Low Back Pain
☐	☐	Mid Back Pain
☐	☐	Muscular Incoordination
☐	☐	Neck Pain
☐	☐	Pain in Ankle/Foot ☐Right ☐Left
☐	☐	Pain in Lower Leg/Knee ☐Right ☐Left
☐	☐	Pain in Upper Arm/Elbow ☐Right ☐Left
☐	☐	Pain in Upper Leg/Hip ☐Right ☐Left
☐	☐	Painful Urination
☐	☐	PMS
☐	☐	Profuse Menstrual Flow
☐	☐	Prostate Problems
☐	☐	Rapid Heart Beat
☐	☐	Rheumatoid Arthritis
☐	☐	Scoliosis
☐	☐	Shoulder Pain ☐Right ☐Left
☐	☐	Stroke Date:_____
☐	☐	Swelling, Stiffness of Joint(s)
☐	☐	Tinnitus (ear noises)
☐	☐	Tumor, Explain _____
☐	☐	Ulcer
☐	☐	Visual Disturbances
☐	☐	Wrist Pain ☐Right ☐Left
☐	☐	Other _____

If a family member has had any of the following, please mark the appropriate box.

☐ Cancer ☐ Epilepsy
☐ Rheumatoid Arthritis ☐ Chronic Back Problems
☐ Diabetes ☐ Chronic Headaches
☐ Heart Problems ☐ Lupus
☐ Lung Problems ☐ Other _____
☐ High Blood Pressure _____

Do you have a permanent disability rating? ☐ YES ☐ NO

Location:_____

Date rating received _____/_____/_____

Rating percentage _____%

Present Weight_____ pounds Height _____ feet _____ inches

FOR WOMEN ONLY

Date of last menstrual cycle:_____ Are you taking birth control pills? ☐ YES ☐ NO
Are you pregnant? ☐ YES ☐ NO If yes, due date?_____ Do you have breast implants? ☐ YES ☐ NO
Are you nursing? ☐ YES ☐ NO

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages.

Patient's Signature:_____

Date:_____

GRANBURY SPINE & SPORT CENTER

Patient's Present Complaints

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Patient Name: _____

Present Complaints: _____

Who is your primary care physician (PCP)? _____

Please list your symptoms in order of severity: _____

_____

How did your problem begin?_____

Date problem began:_____/_____/_____

What treatments have you undergone for this condition in the past? (surgery, medications, injections, therapy, chiropractic) _____

_____

Have you had X-rays, MRI or other tests for this condition? □ YES □ NO If yes, what tests and when?_____

_____

Is this condition the result of an auto or work accident? □ YES □ NO If yes, please explain: _____

_____

How bad is your pain?(Circle a number)	0	1	2	3	4	5	6	7	8	9	10
	No Pain										Unbearable Pain

Does your symptoms remain constant or do they come and go? _____

Describe your current pain/symptoms:
□ Sharp/Stabbing □ Throbbing □ Aches □ Dull
□ Soreness □ Weakness □ Numbness □ Shooting
□ Gripping □ Burning □ Tingling □ Other _____

Since it began, is your problem: □ Improving □ Getting Worse □ No Change

What makes the problem better? _____

What makes the problem worse? _____

Can you perform your daily home activities? □ Yes □ Yes,with help □ Not at all

Do you exercise? □ YES □ NO How often? _____

Describe your job requirements: _____

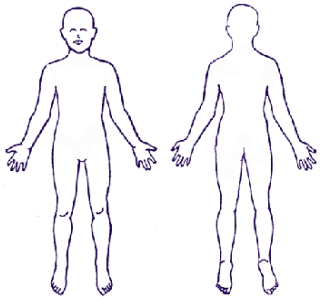
Can you perform your daily work activities? □ YES □ NO

Describe your stress level: □None to mild □Moderate □High

List all previous surgeries and hospitalizations: _____

List all medications: _____

Mark an X on the pictures where you have pain or other symptoms; include symptoms of pain, numbness or tingling.



Patient's Signature:_____ Date:_____

Financial Policy

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We are committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your care. The following is a statement of our Financial Policy that we require you to read, agree to and sign prior to any treatment.

We accept Cash, Checks, Money Orders and Visa/Mastercard.

Medicare

As participating providers, we accept assignment of benefits and will file all claims for you. You are responsible for full payment of any deductible and/or co-pay and non-covered services at the time those services are rendered.

HMO/PPO and Other Managed Care

We will file all insurance claims for you. It is your responsibility to ensure your insurance company has been informed of your PCP designation and all appointments are scheduled with your PCP, except in the event of an emergency. It is also your responsibility to present your insurance card prior to services being rendered. All co-pays and deductible are due at the time services are rendered.

Other Insurance

As a courtesy, we will file your insurance claims; however, you must provide all insurance information and a completed claim form (if required) at the time of service. Please understand that your insurance policy is a contract between you and your company. We are not a party to that contract; therefore, the balance is your responsibility whether your insurance company pays or not. Payment is due in full at the time of service. If you do not wish for us to file your claims with your insurance, please notify the front desk so your account will be set up as a self-pay.

U.C.R.(Usual and Customary Rate)

Our practice is committed to providing the best possible treatment and we charge what is usual and customary for our area. You are responsible for paying the bill regardless of the insurance company's determination of usual and customary rates. EXCEPTIONS: MEDICARE, MANAGEDCAREHMO and PPO.

Self Pay

Payment is due in full at the time of service.

Delinquent Accounts

Accounts that are not paid in full or satisfactory arrangements not made within 90 days of service rendered are considered delinquent. Delinquent accounts may be referred to a collection agency, nationwide credit bureau, or to an attorney for further action.

Change in Insurance, Patient Information

It is your responsibility to notify our office in the event of any change in your insurance, address, phone numbers, etc.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to the above Financial Policy.

_____ _____

Patient or Responsible Party Date

_____ _____

Witness Date

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize Dr. Darcy Romine and whomever she may designate as her assistants to administer treatment, physical examination, x- ray studies, laboratory procedures, chiropractic care, or any clinic services that she deems necessary in my case; and I further authorize her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to the office or to the patient or a family member or employer of the patient for all or part of the office's charge, including and not limited to, hospital or medical service company, insurance companies, worker's compensation carriers, welfare funds or the patient's employer.

Patient Signature:_____ Date: _____