JOSHUA SPINE + HEALTH CENTER
CHIROPRACTIC • MASSAGE • WELLNESS

Confidential Patient Information

Date _____

About You

Name _____ SS #:_____
First Last

Who can we thank for referring you to us? _____

Your Address _____ City _____ State _____ Zip _____

Telephone Cell (____) _____ Home (____) _____ Work (____) _____
Is it ok to contact you at work? Yes☐ No☐Chiro

Email _____ Age ____Birth Date _____
Your email will NOT be shared with any 3rd party, and is used for general office communication.

Sex M☐ F☐ Height _____ Weight _____ Marital Status _____ Number of Children_____

Occupation: _____ Employer _____ Type of Work _____

Family Doctor _____ Clinic_____ Phone _____

Previous Chiropractic care? Yes☐ No☐ If Yes, where and when?_____

Your Family

Spouse/Partner's Name _____ Cell Phone (____) _____
First Last

Occupation: _____ Employer _____ Type of Work _____

Names and Ages of Children in your household_____

Has your family been or is your family currently under Chiropractic care? Yes☐ No☐ Name of Doctor _____

Your Condition

What is the purpose of your visit? ☐Wellness ☐Complaint ☐Injury ☐ Other

Please describe: _____

When did it start? _____ Have you had it in the past? Yes☐ No☐ When? _____

How did it happen? _____

The pain is ☐ constant ☐ comes and goes ☐getting worse Does the pain travel? Where? _____

Rate the severity of your pain (with 10 being the worst pain possible): 1 2 3 4 5 6 7 8 9 10

The pain interferes with ☐work ☐sleep ☐exercise ☐daily activities ☐other _____

The pain is aggravated by: ☐moving ☐lifting ☐bending ☐sitting ☐walking ☐lying down ☐other _____

The pain is relieved by: ☐ice ☐heat ☐rest ☐stretching ☐medi

What other professionals have you seen for this condition? _____ Results? _____

Medical History

Have you been diagnosed with any of the following conditions in the past? Cancer☐ Heart Disease☐ Stroke☐ S.T.D☐

Rheumatoid Arthritis☐ Carpal Tunnel☐ Thyroid trouble ☐ I.B.S☐ Osteoporosis☐ Gallbladder trouble☐ Diabetes☐

Fibromyalgia☐ Depression☐ Degenerative Disc Disease☐ High Cholesterol ☐ Other☐_____

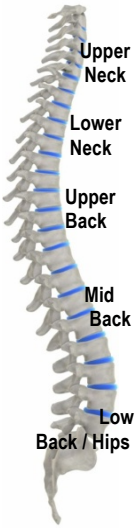
Date of last physical exam _____ Have you had x-rays taken? Yes☐ No☐ Where and What? _____

What medications (prescription and over the counter) are you taking and for what conditions? _____

-over-

Health History

Misalignments in different areas of your Spine can disturb Nerve function and create a wide variety of Symptoms.
Please check the appropriate box if you are experiencing OR have experienced in the past any of the following symptoms:
O=Occasionally F=Frequently



	O	F		O	F		O	F		O	F	
Upper Neck	☐	☐	Headaches	☐	☐	Dizziness	☐	☐	Nervousness	☐	☐	insomnia
	☐	☐	Poor Concentration	☐	☐	Upper Neck Pain	☐	☐	Ringing in Ears	☐	☐	Facial Numbness
Lower Neck	☐	☐	Pain/Numbness in fingers	☐	☐	Swollen Throat Glands	☐	☐	Tonsillitis	☐	☐	Laryngitis
	☐	☐	Shakiness in Hands	☐	☐	Lower neck Pain	☐	☐	Trouble Staying Warm	☐	☐	Arms Feeling Heavy
Upper Back	☐	☐	Chest Pain/Tightness	☐	☐	Out of Breath Easily	☐	☐	Asthma	☐	☐	Bronchitis
	☐	☐	Pneumonia	☐	☐	Upper Back Pain	☐	☐	Pain Between Ribs	☐	☐	Heartburn
	☐	☐	Sick after Eating Fats	☐	☐	Gas	☐	☐	Groggy After Meals	☐	☐	Allergic to some Foods
Mid Back	☐	☐	Indigestion	☐	☐	Craving for Sweets	☐	☐	Poor Energy	☐	☐	Stiffness in Joints
	☐	☐	Allergies	☐	☐	Swollen Ankles	☐	☐	High Blood Pressure	☐	☐	Complexion Problems
	☐	☐	Depression	☐	☐	Migraines	☐	☐	Constipation	☐	☐	Distended Abdomen
	☐	☐	Diarrhea	☐	☐	Hemorrhoids	☐	☐	Frequent urination	☐	☐	Low Back Pain
Low Back / Hips	☐	☐	Hip Pain	☐	☐	Leg Pain or Numbness	☐	☐	Cramps in Legs	☐	☐	Painful Urination
	☐	☐	Bedwetting	☐	☐	Sexual Troubles	☐	☐	Bladder Leakage	☐	☐	Irregular/Heavy Periods
	☐	☐	Cramps	☐	☐	PMS	☐	☐	Breast Tenderness	☐	☐	Hot Flashes
	☐	☐	Miscarriage	☐	☐	Can't Get Pregnant						

Lifestyle

Habits	None	Light	Moderate	Heavy		None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐	Artificial Sweeteners	☐	☐	☐	☐
Coffee	☐	☐	☐	☐	Exercise	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	Sleep	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐	Water	☐	☐	☐	☐
Fast Food	☐	☐	☐	☐	Sugars	☐	☐	☐	☐

Please list any Vitamins and/or Supplements that you are taking _____

Please list recent Emotional stressors (divorce, death, loss of job/career change, etc.) _____

Do you ☐Spend long hours in the car ☐Sleep on your stomach ☐Carry heavy purse/book bag ☐Lift/Bend repetitively

☐Stand/Sit for extensive periods of time ☐Sit on your wallet ☐wear orthotics ☐Perform repetitive movements

Do you have any hobbies or enjoy particular recreational activities? _____

Do you belong to a Health Club? Yes☐ No☐ Which One? _____

Consent to Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures. This includes examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible), which are recommended by the doctor of Chiropractic who now, or in the future, renders treatment to me, while employed by , working for , associated with, or serving as backup for the doctor of Joshua Health Center. I understand that X-rays will remain property of this office, being on file where they may be seen at any time while a patient of this office. I have had an opportunity to discuss with the doctor and/or with office personnel the nature, purpose and risks of Chiropractic adjustments and their recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo Chiropractic treatment recommended. I have also been made aware of the risks associated with refusing treatment of my condition. I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Consent to evaluate and adjust a minor child *(Sign if applicable)*

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.

Pregnancy Release for all Female Patients of child-bearing capability: *(sign if applicable)*

This is to certify that to the best of my knowledge I am NOT pregnant and the doctors at the Joshua Health Center have permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Signature _____ Date of last menstrual cycle _____

Patient affirms that all information given is true and accurate to the best of his/her knowledge.

Patient's/Guardian Signature _____ Date _____

Insurance Information

Insurance Co _____ Policy # _____ Group # _____

Subscriber's Name _____ Birth Date _____ Relation to patient _____

Additional/Secondary Insurance Co _____ Policy # _____ Group # _____

Subscriber's Name _____ Birth Date _____Relation to patient _____

Please give your insurance card to the front desk so they can verify your coverage.

Auto Injury? Yes☐ No☐ If Yes, please ask the front desk for *Automobile Accident Form*

Assignment of Benefits

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Joshua Spine and Health Center 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 Joshua Spine and Health Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Also, I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Authorization & Release

- ✓ I hereby authorize Dr. Joseph Thomas, D.C. to 1) release any information necessary to insurance carriers regarding my illness and treatments 2) to process insurance claims generated in the course of examination or treatment and 3) to allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.
- ✓ I have requested medical/chiropractic services from Dr. Joseph Thomas, D.C. on behalf of myself and/or my dependants, and understand that by making this request, I become fully responsible for any and all charges incurred in the course of the treatment authorized.
- ✓ I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. I also understand that if I suspend or terminate my care or treatment, any fees for professional services, which are rendered to me, will be immediately due and payable, unless agreed otherwise. Should my account become delinquent, I will be responsible for any interest (to accrue at 9% annually, commencing 30 days after the initial bill for services issued), for collection fees, including but not necessarily limited to attorneys fees and court costs incurred in collection attempts on my account. A photocopy of this assignment is to be considered as valid as the original.

Terms of Acceptance

When a patient seeks chiropractic 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: To restore the health potential of the body by removing spinal nerve impingements (called subluxations) which may be contributing or causing certain health condition(s). To remove the vertebral subluxations, a specific process us used which is called a chiropractic adjustment. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Although chiropractic has clinically been associated with the reduction of many symptoms and health conditions, we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advice you. Regardless of what the disease is called, we do not offer to treat it.

When pressure is removed off a nerve, the nerve will begin to heal and that will increase the function of the muscles, joints and organ systems the nerve supplies. Please feel free to ask for additional information.

Signature: _____ Date: _____

Printed Name of Patient or Legal Representative _____

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 carefully.*

Joshua Spine & Health Center, PC uses health information about you for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of *Joshua Spine & Health Center, PC.*

How May We Use or Disclose Your Health Information

For Treatment: We may use your health information to provide you with the best health care possible. For example, information obtained by a health care provider, such as physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions. *Joshua Spine & Health Center, PC* may use your health information when referring you to other health care professionals and facilities.

For Payment: We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you, your insurance policy holder, or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations: *Joshua Spine & Health Center, PC* may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- ✓ Evaluate the performance of our staff;
- ✓ Assess the quality of care and outcomes in your case and similar cases;
- ✓ Learn how to improve our facilities and services; and
- ✓ Determine how to continually improve the quality and effectiveness of the health care we provide.

Required by Law: We may use and disclose information about you as required by law. For example, we disclose information for the following purposes:

- ✓ For judicial and administrative proceedings pursuant to legal authority;
- ✓ To report information related to victims of abuse, neglect or domestic violence; and
- ✓ To assist law enforcement officials in their law enforcement duties.

Appointment Reminders and Treatment Calls: *Joshua Spine & Health Center, PC* or his assistants may contact you to provide appointment reminders or information about treatment plans, medication or test results, other health-related benefits and services that may be of interest to you. When contacts are made via telephone, messages will be left on answering machines with limited information.

Communication with Family: *Joshua Spine & Health Center, PC* and staff members, exercising their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Miscellaneous Communications: *Joshua Spine & Health Center, PC* may occasionally use your information to send you greeting cards, notices or other written communications. We may also use your information to identify candidates for focus groups to improve the quality of service for our patients.

Business Associates: In some cases, *Joshua Spine & Health Center, PC* contracts with business associates to provide services on its behalf. An example includes arrangements with business associates and *Joshua Spine & Health Center, PC* to provide collection or research services. *Joshua Spine Health Center* may disclose your health information to such a business associate so that they can perform their respective job functions.

To protect your health information, however, *Joshua Spine & Health Center, PC* requires the business associate to safeguard your information.

Public Health and Government Functions: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities. Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Decedents. Health Information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Research: *Joshua Spine & Health Center, PC* may use your health information for research studies when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research. *Joshua Spine & Health Center, PC* may use information to identify qualified candidates for research. *Joshua Spine and Health Center, PC* may use information to make contact with you to determine your interest in the research study/clinical trials.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Workers Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.
Other Uses: Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent *Joshua Spine and Health Center, PC* has taken action in reliance on such.

Your Health Information Rights

You have the right to:

- ✓ Request a restriction on certain uses and disclosures or your information. Our office will make every effort to honor reasonable restriction preferences from our patients.
    - o Obtain a paper copy of the notice of privacy practices upon request;
- ✓ Inspect and obtain a copy of your health record;
- ✓ Request that your health record be amended;
- ✓ Request communications of your health information by alternative means or at alternative locations; and receive an accounting of disclosures made of your health information.

Complaints

You may complain to *Joshua Spine and Health Center, PC* and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of *Joshua Spine & Health Center, PC are* required by law to:

- ✓ Maintain the privacy of protected health information;
- ✓ Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- ✓ Abide by the terms of this notice;
- ✓ Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- ✓ Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.

Joshua Spine & Health Center, PC reserves the right to change its privacy practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you upon your request at your next visit to our practice.

I acknowledge that I received and/or have been given the opportunity to review this Chiropractic Office's Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name of Patient or Legal Representative Relationship to Patient

JOSHUA SPINE + HEALTH CENTER
CHIROPRACTIC • MASSAGE • WELLNESS

Patient Account #_____ This does not authorize release of copies of medical records without a signed Authorization to Release Medical Records by patient or guardian
Patient Information

Name Last, First, MI	Date of Birth:

Information to be disclosed: verbal communication only regarding patient's cares-no copies of medical records provided.
Please Provide your current telephone numbers:

Home Phone	Cell Phone
Work Phone	Other Phone

We normally contact our patients between 8 a.m. and 6 p.m. Monday through Friday. Please check below where you would prefer to be contacted during these hours.

Home Phone_____ Cell Phone_____ Work Phone_____

Other Phone_____

If we need to reach you after hours, please ***check below*** where you prefer to be called:

Home Phone_____ Cell Phone_____ Work Phone_____

Other Phone_____

Your Protected Health Information Designees:
If you are not available at the time that we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information (e.g. lab or test results, prescription information). This person (designee) will also be able to call the office on your behalf. Please print the name and relationship to you/patient of each designee below:

Designee Name:	Relationship to Patient:
Designee Name:	Relationship to Patient:
Designee Name:	Relationship to Patient:

_____ Check here if you ***do not want*** your health care information discussed with anyone other than yourself.

Confidential Voice Mail:
Please ***check below*** where we have your permission to leave a confidential voice mail (e.g. lab or test results, prescription information). Leave the space(s) blank if you do not wish to receive voice mails.

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Other Phone: _____

Email Address:

Your signature below confirms your approval of these updated HIPPA communication preferences. You may change your selections at any time, but must do so in writing by completing an updated form.

_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

_____
DATE SIGNED

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

Joshua Spine and Health Center, honor a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Sending Authorizations to Joshua Spine and Health Center: If mailing an authorization, please mail to:

Joshua Spine and Health Center
332 N. Broadway
Joshua, TX 76058

Verbal Communication Only. This authorization allows for verbal communication (both in person and on the telephone between Joshua Spine and Health Center and the designated person(s) on this form. It does not allow for copies of medical records to be released.

Voice Mail Messages. Joshua Spine and Health Center Providers and their staff recognize confidentiality as a very important part of your relationship with them. To protect your confidentiality, they will not routinely leave messages on your personal messaging system (voice mail or answering machine or with your spouse, family members or any other individual) unless you specifically give your permission to do so. This authorization may be used to share this information in the manner that you specify.

No Obligation to Sign. You are under no obligation to sign this form, and you may refuse to do so for either all or part of it. Except as permitted under applicable law, Joshua Spine and Health Center Providers may not refuse to provide you treatment or other healthcare services if you refuse to sign.

Revocation. You have the right to revoke this authorization, in writing at any time. However, your written revocation will ***not*** affect any disclosures of your medical information that the person(s) listed on the release form have already made, in reliance on this authorization, before the time that you revoke it.

Joshua Spine and Health Center, Dr. Joseph J. Thomas, D.C

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy and/or have been given the opportunity to review this office's Notice of Privacy Practices.
As required by the Privacy Regulations, I am aware that this practice reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

- ○ I wish to file a "Request for Restriction" of my Protected Health information.
- ○ I wish to fil a "Request for Alternative Communications" of my Protected Information.
- ○ I wish to object to the following in the "Notice of Privacy Practices":

_____
_____

I understand that this office may change their Notice of Privacy Practices and is not required to honor the terms of the original/previous version(s).

Printed Name:_____

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communication barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (Please specify)

_____
_____