Welcome to Our Office!

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the term. If you need any help, please ask the receptionist.

Patient Data **Date: _____**

Name: _____ Sex: ☐ M ☐F Home Phone: _____

Personal Email: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Birthday: _____/_____/_____ Age : _____ Marital Status: M S W D No. of Children: _____

Social Security Number: _____ (or) Driver License Number: _____

Employer: _____ Position: _____ Work Phone: _____

SPOUSE: _____ Employer: _____ Work Phone: _____

IN CASE OF EMERGENCY: NAME OF NEAREST RELATIVE OR FRIEND

1. _____ Phone: _____Relation_____

How were you referred to our office? Doctor (Name/Specialty)_____

Person (name)_____ Other _____

CURRENT HEALTH CONDITIONS

Please describe your chief complaint / what brought it on? _____

_____

When did this condition begin? _____ Was it (gradual / sudden) ?_____

Have you had any treatment for this condition? If so, please tell us when, where, with whom, and what were the results ?_____

Is your pain (Improved-Worsened-Unchanged) by the following activities: (**indicate by "I"-"W"-"U")**

___Activity ___ Inactivity ___ Cough/Sneeze ___ Sitting in Chair/Car ___ Stand/Walk ___ Bending

___Twisiting ___ Kneeling ___ Lay on Back ___ Lay on Side ___ Lay on Stomach ___ Reaching

What is the nature of your pain? (circle) **Constant "Comes and Goes" Sharp Dull Burning**

Does your pain refer to other parts of your body? **Yes or No** If so, where to?_____

Grade your pain from **0(none) to 10** _____

What have you done to get relief? _____

Is your pain (**Improved / Worsened / Unchanged**)? In the __ Morning __ Afternoon __Evening __ Night

Is this condition interfering with your __ Work __Sleep __Daily Routine?

Is this condition Work related injury or auto injury? _____

Are you under a lot of stress at the present time? **YES or NO** _____

What type of bed do you sleep on? (Waterbed, soft mattress, etc.) _____

What kind of pillow do you use? (Thick foam, thin goose down, etc.) _____

Do you sleep on your _____ side _____ back _____ stomach

Do you exercise? **(work doesn't count !) YES or NO** - If so, what do you do and how often?

_____

MEDICAL HISTORY

Do you or any member of your immediate family have or had any of the following?
Please Indicate: Myself: "P" – Past "C" – Current or "F" Family

_____ HIGH BLOOD PRESSURE	_____ MUSCULAR DYSTROPHY	_____ RHEUAMTIC FEVER
_____ HEART TROUBLE	_____ MULTIPLE SCLEROSIS	_____ SCARLET FEVER
_____ DIABETES	_____ CONVULSIONS	_____ POLIO
_____ HEPATITIS	_____ EPILEPSY	_____ TUBERCULOSIS
_____ VENEREAL DISEASE	_____ CONCUSSION	_____ ANEMIA
_____ HIV	_____ CANCER	_____ OTHER: _____

The following are conditions that chiropractic may often help. Please mark an "X" if you CURRENTLY have any of the following and please mark "P" if any you have had in the PAST:

_____ DIZZINESS	_____ NUMBNESS
_____ BACKACHES	_____ ALLERGIES
_____ DIGESTIVE PROBLEMS	_____ SINUS PROBLEMS
_____ ARTHRITIS	_____ ASTHMA
_____ PAIN BETWEEN SHOUDLERS	_____ NERVOUSNESS
_____ NECK PAIN/ STIFFNESS	_____ HEADACHES

Date and purpose of last chiropractic treatment _____
Name of Last Doctor of Chiropractic : _____
Date of Last X-rays / MRI: _____ ____Where ? _____
Are you pregnant ? **YES or NO** Date of Last Menstrual Period ? _____
Have you had prior surgeries? _____
Please list any medications, vitamins, laxatives, or herbs you are taking ?

_____

Are you allergic to any medications? **YES/NO** What kind ? _____

Indicate which medications you are currently taking:
___ Nerve Pills (Anti-Depressants) ___ Pain Killers ___Insulin ___Birth Control Pills
___ Muscle Relaxants ___ Anti-inflammatory ___Anticoagulants ___ Blood Pressure Medication
___ Female Hormones ___Thyroid Medication ___Antibiotics ___ Cholesterol Medication

I understand and agree that health insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that the office 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 this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all service rendered to me are charged directly to me and that I am personally responsible for payment., I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. **I also understand that a 1.0% interest per month will be assessed on any cash balances over 30 days (ie cash account, co-payments, payment plans and personally injury/liability cases)**
NOTE Returned checks will be assessed a $25.00 fee.

Signature: _____Date: _____

NOTE: Treatment may be suspended for non- payment of services rendered.

Just Health Center

1100 Rayford Road Ste 300 – Spring, TX 77386
P:281-367-7275 F:281-367-7313
Daniel Dannug, D.C. Rio De Leon, D.C.

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____ (Name), hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative Relationship
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):

Date Signed ____/____/____ Witness: _____

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Financial Policy

- Appointments/Cancellations: Please be 5 minutes early for your appointment. Each patient is scheduled an individual time slot. If you are late, or cancel without 24 hours notice this causes other patients to be late or denied an appointment when they might otherwise be seen. You will be financially responsible for all missed appointments or untimely cancellations. ***Initials***_____

- All payments are due at the time that the service is rendered. Patient visits include heat, treatment, rehabilitation (if necessary) & ice. If ancillary services are required (Ultra Sound, Electrical Muscle Stem, Laser or Decompression Therapy) during your visit, there will be an additional fee. We accept cash, checks, MasterCard, Visa, Discover and American Express.

- If you have out-of-network chiropractic benefits, we do accept most health insurance plans. Due to the numerous variations in individual coverage, all acceptances will be on a case-by-case basis. If we do not file your insurance claim, you will be provided an invoice so that you can file any insurance claims and be reimbursed directly.

- Our fees are considered usual, customary and reasonable by most insurance companies and are therefore covered up to the maximum allowance determined by each carrier. This statement does not apply to insurance companies that reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

- If your carrier has not paid a claim within **sixty- (60)** days of submission, you agree to take an active role in the recovery of your claim. If your carrier has not paid within **ninety- (90)** days of submission or denies a claim based on benefits, you accept responsibility for payment of any outstanding balance. ***Initials***_____

- Personal injury/auto claims may also be handled through your personal injury protection (PIP) insurance.

- MEDICARE/MEDICAID, We do verify that your insurance covers chiropractic, that your deductible has been met and what percentages of payment and coverage will be. You will need to pay in full for the first visit if we cannot verify your insurance.

- MANAGED CARE WAIVER: I understand that in the opinion of the doctor(s) at Just Health Center the services of items, supplies, and durable medical equipment that I have requested to be provided to me may not be covered by my commercial insurance, or my managed health care plan. If my charge(s) is (are) determined by my insurance carrier to be outside of my network or not a covered charge, I understand that I will be responsible for payment for these services because they are reasonably and medically necessary for my care. As per Medicare guidelines, any chronic conditions treated by chiropractic, run a possibility of not being paid for by Medicare. "The manipulation codes 98940, 98941, 98942 may be denied by Medicare if deemed a chronic condition". If treatment is denied, payment is your responsibility or your secondary insurance if applicable.

Patient's Name (Printed)_____ Date_____

Patient/Guardian Signature_____ Relationship to Patient_____

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Consent To Treatments

By signing this form, I am requesting and consenting to the diagnostic and therapeutic procedures which may include, but are not limited to, physical modalities, x-rays, physical examination and history and chiropractic treatment performed by the doctors of Just Health Center, L.L.P and staff. I understand that it is my right to determine the extent of my medical care, and I may, at any time, refuse treatment and withdraw my consent for the performance of any procedure or treatment.

I recognize that no guarantees have been or can be made regarding the likelihood of success of the outcome of any evaluation, treatment, test, procedure, or therapy performed by Just Health Center, L.L.P doctors of chiropractic or staff.

Verification of Pregnancy:

_____**INTIAL** By signing this form, I certify that, to the best of my knowledge, **I am not pregnant** and the above doctor(s) and/or associates have my permission to perform diagnostic X-ray examination. I have been advised that X-rays can be hazardous to an unborn child.

_____**INTIAL** By signing this form, I am affirming that **I am pregnant** and my due date is _____. I consent the above doctor(s) and/or associate to perform the necessary chiropractic manipulative therapy and/or adjunctive therapy.

NOTE: There has been a risk factor documented in the medical literature of 1:600,000 to 1:6 million (the greater risk depending in whether you are a woman that smokes and is on birth control pills) of a stroke type accident due to neck manipulation. There also might be some discomfort in areas that have never been treated chiropractically after your first adjustment. By signing this form, I understand this and will talk to the doctor(s) regarding any concerns I may have regarding this.

Authorized Signature: _____

Date: _____