Just Health Center

Chiropractic and Wellness

1100 Rayford Road
Suite 300
Spring, Texas 77386
P: 346-367-7275
F: 281-367-7313
Dr. Linh Hua, DC
Dr. Nicerio De Leon, DC, NP

PATIENT INFORMATION: Title: ☐Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Pfr.

Name:_____ **Suffix:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Mobile Phone:** _____

Email: _____

Date of Birth: _____ **Age:** _____ **Gender:** ☐Male ☐Female ☐Other

Marital Status: ☐Single ☐Married ☐Widow ☐Divorce ☐Other

Employment: ☐Employed ☐Student ☐Self-employed ☐Retired **Employer:** _____

Emergency contact name: _____ **Relationship:** _____

Phone number: _____

How did you hear about our office? _____

Personal/Family Medical History (check all that apply: specify (C) Currently Have, (F) Family History, (P)Previously Had

☐ AIDS/HIV	☐ Allergies	☐ Anemia	☐ Pacemaker	☐ Asthma
☐ Bone Fracture	☐ Cancer	☐ Diabetes	☐ Scoliosis	☐ Diverticulitis
☐ Hay Fever	☐ Headaches	☐ Thyroid Problems	☐ Muscular Dystrophy	☐ Weight Changes
☐ Venereal Disease	☐ Rheumatic Fever	☐ Pins, Screws, or Plates	☐ Heart Problems	☐ High Blood Pressure
☐ Low Blood Pressure	☐ Multiple Sclerosis	☐ Arthritis	☐ Pain in Limb	☐ Stomach Ulcers
☐ Polio	☐ Prostate Problems	☐ Dislocated Joints	☐ Sleeping Issues	☐ Epilepsy
☐ Spinal Disc Problems		☐ Sinus Problems	☐ Concussion	☐ Stroke

☐ Other_____

If any options above are selected, please explain: (i.e. Cancer type, Diabetic Type, Date Diagnosed, Previous Treatment)

_____

List all surgeries:

Childhood injuries, falls, accidents, traumas, sports:

Medications (list all medications and what they are being used for):

Allergies:

Do you currently smoke tobacco? ☐ Yes: How much _____ ☐ Former: Last smoked _____ ☐ Never Smoked

Do you sleep on: ☐ Back ☐ Side ☐ Stomach **How many hours of sleep per night?** _____

Diet: ☐ Good ☐ Bad ☐ Could be better **Specific Diet (i.e Atkin's, Keto, etc):** _____

How much are you drinking: _____ gl/day or week caffeine _____ gl/day or week Alcohol_____ gl/day or week

Female Patients: Are you pregnant? ☐ Yes ☐ No Date of Last Menstrual Cycle_____ If yes: _____weeks

Prior Treatments: ☐ Chiropractic ☐ Acupuncture ☐ Massage ☐ Other

For what:_____

_____

Images: X-RAY or MRI - Where:_____ **When:**_____

CHIEF COMPLAINT:

Please describe your chief complaint/what brought you in? _____

_____

When did this condition begin?_____Was it gradual or sudden? _____

Is it getting ☐ Progressively worse ☐ Staying the same ☐ Getting better

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

_____

Does anything aggravate this condition? **YES** or **NO** _____

Does anything make this condition better? **YES** or **NO** _____

How frequent is this condition? Constant or come and go? _____

How long does it last?_____

Does your pain radiate to other parts of your body: **YES** or **NO**? If so, where to: _____

Do you have any numbness or tingling in your body: **YES** or **NO**? If so, where to: _____

Is your pain (**Improved**, **Worsened**, **Unchanged**) with: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Is this condition interfering with: ☐ Work ☐Sleep ☐Daily Routine

Is this condition a work-related injury or auto-injury?_____

Images: X-RAY or MRI - Where: _____**When:**_____

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 to assist me in making collection from the insurance company and that any amount authorized to be paid to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance to 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(i.e cash account, co-payments, payment plans and personally injury/liability cases).

NOTE: returned checks will be assessed a $25.00 fee.

Signature _____ Date _____

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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, acupuncture treatment or massage therapy performed by the doctors of ust Health Center and anyone working in the clinic authorized by the above referenced doctors of chiropractic. 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 doctors of chiropractic or staff

_____INITIAL I understand that there are risks associated with any treatment. Chiropractic and acupuncture are very low risk procures. Potential risks include slight pain, discomfort or soreness in the area treated. Associated risk factors for acupuncture include but are not limited to the following::bruising, blistering, bleeding, redness around the site where the needle was inserted, weakness, fainting, nausea, temporary discoloration of the skin, possible aggravation of the symptoms existing prior to treatment, skin infection or broken needle.

**Patients with bleeding disorders, pacemakers, seizure disorders, local infections, Hepatitis, HIV positive or have AIDS, on any anticoagulant medications or pregnant must disclose this information to the doctor.*

Women Only

Verification of Pregnancy: 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.

_____**INITIALS**

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.

_____**INITIALS**

NOTE: There has been a risk factor documented in the medical literature of 11:600,000 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.

With this knowledge, I voluntarily consent to the procedures realizing that no guarantees have been given to me by any doctor or staff member at Just Health Center regarding cure or improvement of my condition. I herby release the doctors and staff from Just Health Center from any and all liability which may occur in connection with the procedures, except failure to preform the procedures with appropriate care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

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

_____
Signature of Individual

_____
Relationship to Patient

_____
Date

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Financial Policy

Initials

Appointments/Cancellations: Please be 10-15 minutes early for your appointments. Each patient is scheduled an individual time slot. If you are late, or cancel without 24hours 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.

All payments are due at the time that the service is rendered. If ancillary services are required (ultra sound, electrical muscle stem, laser or decompression therapy) during your visit, there will be an additional fee.

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

Medicare- If I am a Medicare patient, I understand that I need to provide the office both my Medicare Insurance card and my secondary Insurance card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement. *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.*

_____ _____
Printed Patient name and Guardian Name if applicable — Patient or Guardian Signature

_____ _____
Relationship to Patient — Date

I give permission to communicate my Private Healthcare Information to:

_____ _____
Name — Relationship

_____ _____
Name — Relationship

_____ _____
Name — Relationship

Our office does not make the rules. They are determined by your specific medical insurance.

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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 would 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 I can understand.

Signature_____ Date_____

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Patient Provider Email Agreement

Name: _____

Email offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has the advantages over office visits or telephone calls. But remember, there are also important differences. Email is not the same as calling our office, there is no person at the other end of the call - just a computer. You can't tell for certain when your messages will be read, or even if your doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication that email affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us via email.

- Email is never, ever, appropriate for urgent or emergency problems. Please use the telephone or go to the Emergency Department for emergencies.
- Email is great for asking those little questions that don't require a lot of discussion. Appropriate uses of email also include referral letters, excuse notes needed for work/school after an appointment, and billing/insurance questions.
- Emails should not be used to communicate sensitive information, such as information regarding sexually transmitted diseases, AIDS, HIV, mental health, developmental disability, or substance abuse.
- Email is not confidential. It is like sending a postcard through the mail. Our staff may read your emails to handle routine, non-emergency matters. You should also know that if sending emails from work, your employer has a legal right to read your email if they choose.
- Email may become a part of the medical record when we use it, a copy may be printed and put in your chart.
- Email is not a substitute to seeing a doctor at Just Health Center. If you think that you may need to be seen, please call and schedule an appointment.
- Emails may be forwarded to our staff for handling, if appropriate.

Finally, Just Health Center reserves the right to revoke permission of the email system at any time.

☐ **I DO** want to communicate with my doctor electronically. I have read the above information and understand the limitations of security of information transmitted. I understand that my doctor may not be able to communicate with me electronically about my specific condition if I live outside of the state of which my doctor is licensed.

PATIENT:

Patient Name: _____

Patient Signature: _____

Email Address: _____

Date: _____