

**BestHealth Chiropractic Clinic**  
**New Patient Information**

PATIENT INFORMATION					
Patient Name		DOB		o M o F	
Address		SSN			
City		State		Zip	
Home Phone		Pager			
Work Phone		Cell			
Driver Lic. #		State			
Emergency Contact		Phone			
<b>H</b> ow did you hear about this office?					
EMPLOYER INFORMATION					
Company					
Address					
City		State		Zip	
Medical Rep		Phone			
Job Descrip.		Fax			
RESPONSIBLE PARTY					
Insured		DOB		o M o F	
Home Phone		SSN			
INJURY INFORMATION					
Date of Injury		Injured Areas			
Reported to Supervisor? Date Reported	<input type="radio"/> Yes <input type="radio"/> No	Supervisor's Name			
INSURANCE INFORMATION					
Company		ID #			
Address		Group #			
City		State		ZIP	
Adjuster		Phone			
		Fax			
ATTORNEY INFORMATION					
Name		Phone			
Address		Fax			
City				Zip	
Do you have an accident report?		<input type="radio"/> Yes <input type="radio"/> No			

**Signature:**

**Date:**

# BestHealth Chiropractic Clinic

## General Health / Social History

Are you taking any medications for *any* reason? Y / N Please list: \_\_\_\_\_

Please list any medications to which you are *allergic*: \_\_\_\_\_

Is there any possibility you could be pregnant? Y / N Date of last menstrual period: \_\_\_\_\_

Cigarettes/tobacco Y / N Quantity per day \_\_\_\_\_

Alcohol Y / N Quantity per day \_\_\_\_\_

Coffee Y / N Quantity per day \_\_\_\_\_

Do you take vitamins? Y / N Please list \_\_\_\_\_

Do you exercise regularly / participate in sports? Y / N What kind / type? \_\_\_\_\_

Hobbies: \_\_\_\_\_

## Review of Symptoms

Below is a list of conditions. Circle conditions you have now and underline conditions you have had previously.

### Diseases:

**NONE**

- Pneumonia
- Asthma
- Heart Disease

- High Cholesterol
- High Blood Pressure
- Diabetes
- Cancer/Tumors
- Thyroid Problems

- Prostate Problems
- Arthritis
- Epilepsy/Seizures
- Mental Disorders
- Eczema/Rashes

- Migraines/HA
- Hepatitis
- Anxiety/Depression
- Other: \_\_\_\_\_

### General Health:

- NONE**
- Allergies
- Loss of sleep
- Fever
- Chills/Night sweats
- Weight loss/gain without trying
- Fatigue
- Infections
- Dizziness

- Unusual bleeding
- Ear aches
- Ringing in the ears
- Dental problems
- Difficulty swallowing
- Persistent cough
- Coughing blood
- Blurred vision
- Specs of light

- Chest pain
- Shortness of breath
- Palpitations (heart)
- Swelling in hands/feet
- Cold hands/feet
- Nausea/Vomiting
- Heartburn
- Abdominal pain
- Bowel problems

- Bladder problems
- Irregular period
- Forgetfulness
- Confusion
- Fainting
- Tingling / Numb extremities
- Loss of balance / coordination

## Past Medical History

Please answer the following questions. If "Yes," please describe.

- Have you ever had any serious accidents? Y / N \_\_\_\_\_
- Have you ever broken any bones? Had dislocations? Y / N \_\_\_\_\_
- Have you ever been hospitalized? Y / N \_\_\_\_\_
- Have you ever had surgery of any type? Y / N \_\_\_\_\_

Please fill in the dates (year) that you have ever had any of the following.

Blood test \_\_\_\_\_ MRI \_\_\_\_\_ Urinalysis \_\_\_\_\_

CT scan \_\_\_\_\_ Ultrasound \_\_\_\_\_ Radiation treatment \_\_\_\_\_

X-rays \_\_\_\_\_ Other special tests or treatment \_\_\_\_\_

What were the reasons for these tests/treatments? \_\_\_\_\_

Date of your last physical: \_\_\_\_\_ Primary care physician's name and phone #: \_\_\_\_\_

Have you ever been to a chiropractor before? Y / N Chiropractor's name / Date of last visit: \_\_\_\_\_

Pt. Initials: \_\_\_\_\_ Date: \_\_\_\_\_

BestHealth Chiropractic Clinic  
Chief Complaints

**Patient Name (please print):** \_\_\_\_\_

Please list your symptoms that brought you to our office. List in the order of severity with your **most severe symptom first** and your least severe symptom last.

SYMPTOM	SEVERITY	QUALITY	DATE BEGAN	FREQUENCY
1)	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Dull <input type="radio"/> Sharp <input type="radio"/> Burning <input type="radio"/> Tingling <input type="radio"/> Stabbing	____ / ____ / ____	<input type="radio"/> Constant <input type="radio"/> Daily <input type="radio"/> 3+ times/wk <input type="radio"/> 1-2 times/wk <input type="radio"/> other _____
2)	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Dull <input type="radio"/> Sharp <input type="radio"/> Burning <input type="radio"/> Tingling <input type="radio"/> Stabbing	____ / ____ / ____	<input type="radio"/> Constant <input type="radio"/> Daily <input type="radio"/> 3+ times/wk <input type="radio"/> 1-2 times/wk <input type="radio"/> other _____
3)	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Dull <input type="radio"/> Sharp <input type="radio"/> Burning <input type="radio"/> Tingling <input type="radio"/> Stabbing	____ / ____ / ____	<input type="radio"/> Constant <input type="radio"/> Daily <input type="radio"/> 3+ times/wk <input type="radio"/> 1-2 times/wk <input type="radio"/> other _____
4)	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Dull <input type="radio"/> Sharp <input type="radio"/> Burning <input type="radio"/> Tingling <input type="radio"/> Stabbing	____ / ____ / ____	<input type="radio"/> Constant <input type="radio"/> Daily <input type="radio"/> 3+ times/wk <input type="radio"/> 1-2 times/wk <input type="radio"/> other _____
5)	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Dull <input type="radio"/> Sharp <input type="radio"/> Burning <input type="radio"/> Tingling <input type="radio"/> Stabbing	____ / ____ / ____	<input type="radio"/> Constant <input type="radio"/> Daily <input type="radio"/> 3+ times/wk <input type="radio"/> 1-2 times/wk <input type="radio"/> other _____
6)	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Dull <input type="radio"/> Sharp <input type="radio"/> Burning <input type="radio"/> Tingling <input type="radio"/> Stabbing	____ / ____ / ____	<input type="radio"/> Constant <input type="radio"/> Daily <input type="radio"/> 3+ times/wk <input type="radio"/> 1-2 times/wk <input type="radio"/> other _____
7)	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> Dull <input type="radio"/> Sharp <input type="radio"/> Burning <input type="radio"/> Tingling <input type="radio"/> Stabbing	____ / ____ / ____	<input type="radio"/> Constant <input type="radio"/> Daily <input type="radio"/> 3+ times/wk <input type="radio"/> 1-2 times/wk <input type="radio"/> other _____

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**BestHealth Chiropractic Clinic**

6316 Azle Ave. Suite 600 • Fort Worth, Texas 76135

(817) 237-5900 • Fax (817) 238-6318

Julio Fajardo, DC

**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name:

Patient's Date of Birth:

Patient's SSN:

**A. Person(s) or Organization(s) authorized to provide the information:**

**B. Person(s) or Organization(s) authorized to receive the information:**

BestHealth Chiropractic Clinic

6316 Azle Ave. Suite 600

Fort Worth, Tx. 76135

**C. Specific description of the information that may be used or disclosed (including date(s))**

**D. Specific description of how the information will be used:**

- 1) I understand that this authorization will **expire one year from signature date**.
- 2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying *Texas Injury Clinic* in writing.
- 3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
- 4) I may **inspect or copy** any information used or disclosed under this agreement.
- 5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

\_\_\_\_\_  
Patient's Signature or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient's Representative

\_\_\_\_\_  
Relationship to Patient

**NOTE:**

You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g., the names of your health care provider(s)).

You have the right to know who is going to use it and what it is going to be used for. (e.g., John Smith, PhD / Research).

**YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM**

**HIPAA Authorization for Release of Information**

*This form does not constitute legal advice and covers only federal, not state, laws.*



PARTIAL ASSIGNMENT OF THE CAUSES OF ACTION, ASSIGNMENT OF PROCEEDS

CONTRACTUAL LIEN & AUTHORIZATION

Purpose. The purpose of this Assignment is to improve the ability of the Office to collect my Charges directly from various Payers. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to BestHealth Chiropractic Clinic; "Payer" shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for any reason; "Proceeds" shall include, without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; "Charges" shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony), any Collection Costs incurred by the Office, interest and delinquency penalties to the extent permitted by law, and any other charges incurred by me at the Office; "Collection Costs" shall include, without limit, any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Partial Assignment of the Causes of Action, Assignment of Proceeds, and Contractual Lien. I hereby assign to the Office, insofar as permitted by law, but only to the extent of my Charges, all of my rights, remedies, and benefits relating to any Payer, including without limit my right to receive Proceeds from any Payer now or in the future, and any and all causes of action that I might have against any Payer now or in the future, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further grant a contractual lien to the Office with respect to my Charges. I further intend for this Agreement to create a secured interest under the applicable Uniform Commercial Code and hereby direct the Office to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such lien. Consistent with these provisions, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the extent of my Charges.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of any Proceeds received by the attorney is to pay my Charges.

Other Disclosure Authorization. I hereby direct all Payers to release to the Office any pertinent information regarding any coverage I may have including without limit the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize and direct the Office to release any information regarding my treatment or pertinent to my case(s), including without limit a copy of my Charges and a copy of this Assignment, to all Payers in order to facilitate collection of my Charges.

Miscellaneous Provisions. Except as provided in this paragraph, this Assignment shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment. I agree that each and every provision of this Assignment is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Assignment be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment shall, nevertheless, remain in full force and effect. This Assignment shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens as such term is defined by law. I further waive any statute of limitations, which may apply in any action based upon this Assignment.

I have read, understood, and agree to the terms of this Assignment.

Patient Name (print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## **Informed Consent to Treatment**

- **The nature of the chiropractic manipulation**

Your manipulations are performed by hand or mechanical instrument upon your body in such a way to move your joints, The manipulation can produce an audible “click” or “pop” much like when your have cracked your knuckles. You should realize that your bones are not cracking, but rather gases are being released from the joint and producing sound.

- **The material risks inherent in chiropractic manipulation**

As with any health care procedure, there are certain complications, which can arise during a chiropractic manipulation. Those complications include: fractures, dislocations, muscle strain, costovertebral (rib) strains and separations, and cervical myelopathy. Some type manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke, stiffness and soreness can be experienced following manipulation.

- **The probability of risks occurring**

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which is elevated during your history, examination, and x-rays (if deemed appropriate); Stroke resulting from cervical manipulation, although rare, and generalized stiffness and soreness following said manipulation.

- **Other treatments**

In addition to chiropractic manipulation, the following physiotherapy may be used to enhance your recovery and healing. These include hot/cold packs, interferential/electric stimulation, ultrasound, and intersegmental traction. We also involve the patient during their rehabilitation vigorous exercise programs utilizing several planned criteria's. These treatments involve the following risks: spreading of unknown infection, burns, soreness and electrical shock.

- **Referral for Diagnostic Testing and Evaluations**

In addition, you may be referred to other medical specialists for necessary testing and evaluation. Our office will schedule these tests and/or evaluations for your convenience.

- **Availability of other treatments**

Other treatment options for your condition include: over-the-counter medication and bed rest, medication for pain, inflammation and muscle spasm, hospitalization and surgery. If surgery is the option that is taking, then post-surgical rehabilitation is also implemented. By managing your care, we can make the appropriate referral to other specialists, when needed, to assist in the continuation of care and also be able to make educated suggestions for these treatments.

- **The material risks and probability of risks occurring in other treatment**

Professional literature describes highly undesirable effects from long-term use of over-the-counter medications. The probability of such complications arising is dependent upon the patient's general health, type of medication prescribed, and the amount of dosage and length of time taken.

- **The risks of remaining untreated**

Remaining untreated can lead to disc problems, arthritis, and neurological complications. Remaining untreated after an injury allows for the formation of adhesions from scar tissue resulting in decreased joint mobility. Decreased joint mobility can lead to neurological complications, pain, stiffness, and diminished blood flow commonly resulting in arthritis.

**By signing below, I acknowledge I have read the above explanations of chiropractic manipulations, treatments, and risks. I have weighed the risk involved in treatment and give my consent to the doctors of this clinic, their medical staff or their designees to perform the treatment, as may, in their professional judgment, be necessary. I also acknowledge no guarantee or assurances have been made to me as to the effect or results that can be obtained from the recommended treatment. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.**

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# BestHealth Chiropractic Clinic

6316 Azle Ave. Suite 600 • Fort Worth, Texas 76135

(817) 237-5900 • Fax (817) 238- 6318

Julio Fajardo D.C.

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on **April 14, 2003** and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Debbie Marcum. Information on contacting us can be found at the end of this Notice.

### **TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION**

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

HIPAA Notice of Privacy Practices

*This form does not constitute legal advice and covers only federal, not state, law.*

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

## **YOUR PRIVACY RIGHTS AS OUR PATIENT**

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$ 1.00 for each page. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (*Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.*)

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

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## **QUESTIONS AND COMPLAINTS**

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

## **HOW TO CONTACT US**

BestHealth Chiropractic Clinic

Julio Fajardo D.C., Privacy Officer

6316 Azle Ave. Suite 600., Fort Worth, Texas 76135

817-237-5900 phone      817-238-6318 fax