Adams Chiropractic Health Center
3151 W. 15th. St.
Plano, TX 75075
www.adamsclinic.com

Phone: 972-596-1611
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www.adamsclinic.com

PATIENT DEMOGRAPHIC INFORMATION

Please Print

Patient's Name: _____ **Birthday:** _____

Address: _____ **City:** _____ **ZIP:** _____

Best Contact Phone #: _____ **Cell / Home / Work - Okay to message? Yes / No**

Alt. Contact Phone #: _____ **Cell / Home / Work - Okay to message? Yes / No**

E-Mail: _____ **Preferred Method of Communication** _____

Who can we thank for referring referring you here today _____:

BILLING AND PAYMENT OPTIONS

***If you would like us to submit billed services for payment to your insurance company, please provide the requested information along with a copy of your drivers license and insurance card. While we file insurance as a courtesy to you, it is ultimately patient responsibility to obtain and provide any needed referrals, co pays, co insurance and estimated out of pocket cost at the time of service ***

INSURANCE OPTION

Patient Relationship to Subscriber _____ **InsurancCo.Name** _____

Subscribers Name _____ **Subscribers Birthday** _____

Policy #: _____ **Group # (if available):** _____

I understand all copay's, deductibles and coinsurance are due at the time of service. I understand Adams Chiropractic Health Care may bill me for remaining balance insurance left due to eligibility, copay, deductible or non covered services. I give Adams Chiropractic Health care authorization to file claims on my behalf to my insurance company.

_____ *Initial Here*

PRIVATE PAY OPTION

I will not be using an insurance company, claim number or third party to pay for services rendered. I choose to pay with cash, credit card or check . I understand that full payment is due at the time of service.

_____*Initial Here*

_____ _____

Print Patient /Name *Patient Signature – Responsible Party*

SYMPTOM SURVEY

What caused the problem or symptoms to occur? _____

When did the problem or symptoms begin? _____

Have you seen another doctor for this problem? ☐ No. If yes, who _____

What tests/procedures have been performed? ☐ X-ray ☐ MRI ☐ Surgery ☐ Hospitalization ☐ _____

Have you had this problem or symptoms in the past? ☐ No. If yes, explain _____

Have you tried any other treatments for this problem? ☐ No. If yes, explain _____

Is the problem or symptoms getting worse? ☐ No. If yes, explain _____

☑ ALL OF THE ITEMS THAT APPLY TO YOU NOW AND IN THE PAST:

☐ Arthritis / Gout	☐ Depression/ Anxiety	☐ Pregnancy	☐ Seasonal Allergies	☐ Headaches
☐ Eye Pain-Strain	☐ Dizziness	☐ Seizures	☐ Ringing in Ears	☐ Blurred Vision
☐ Jaw Pain	☐ Bleeding Gums	☐ Neck Pain / Spasms	☐ Chronic Fatigue	☐ Heart Disease
☐ Gall Stones	☐ Swallowing Difficulty	☐ Thyroid Problems	☐ Chest Pain	☐ Chest Congestion
☐ Anemia	☐ Hypertension	☐ Stroke	☐ Kidney Stones	☐ Pancreatitis
☐ Shortness of Breath	☐ Irregular Heart Beat	☐ HIV / AIDS	☐ Asthma / Bronchitis	☐ Mid-Back Pain
☐ Shoulder/Elbow Pain	☐ Wrist or Hand Pain	☐ Low Back Pain	☐ Hip/Knee/Leg Pain	☐ Foot or Ankle Pain
☐ Abdominal Pain	☐ Diabetes	☐ Groin or Rectal Pain	☐ Female Disorders	☐ Urinary Problems
☐ Skin Problems	☐ Broken Bones	☐ Digestive Problems	☐ Nausea - Vomiting	☐ Irregular Bowels

PATIENT & FAMILY HISTORY

What is your occupation? _____ ☐ Full Time ☐ Part Time

What is your employment status? ☐ Working ☐ Sick Leave ☐ Unemployed ☐ Retired ☐ Temp Disability ☐ Perm Disability ☐ Last Day of Work

Do you use tobacco? ☐ No ☐ Yes Explain: _____

Do you consume alcohol? ☐ No ☐ Yes Explain: _____

Do you have a history of substance abuse? ☐ No ☐ Yes Explain: _____

List all past Surgeries: _____

Do you have any known drug allergies? ☐ No ☐ Yes, please explain: _____

List all current and past medications / drugs:

Drug Name: _____ _____

_____ _____

_____ _____

List all Physicians you have seen in the past 5 years:

Name _____ For What? _____

_____ _____

_____ _____

_____ _____

Family History

Father	☐ Living	Age: _____	☐ Deceased – cause of death	_____
Mother	☐ Living	Age: _____	☐ Deceased – cause of death	_____
Brother	☐ Living	Age: _____	☐ Deceased – cause of death	_____
Brother	☐ Living	Age: _____	☐ Deceased – cause of death	_____
Sister	☐ Living	Age: _____	☐ Deceased – cause of death	_____
Sister	☐ Living	Age: _____	☐ Deceased – cause of death	_____
Children	☐ Living	Age: _____	☐ Deceased – cause of death	_____
Children	☐ Living	Age: _____	☐ Deceased – cause of death	_____

☐ Other problem(s) not listed: _____

Below is for office use only

BP: _____ *PULSE:* _____ *OX:* _____ *HEIGHT:* _____ *WEIGHT:* _____

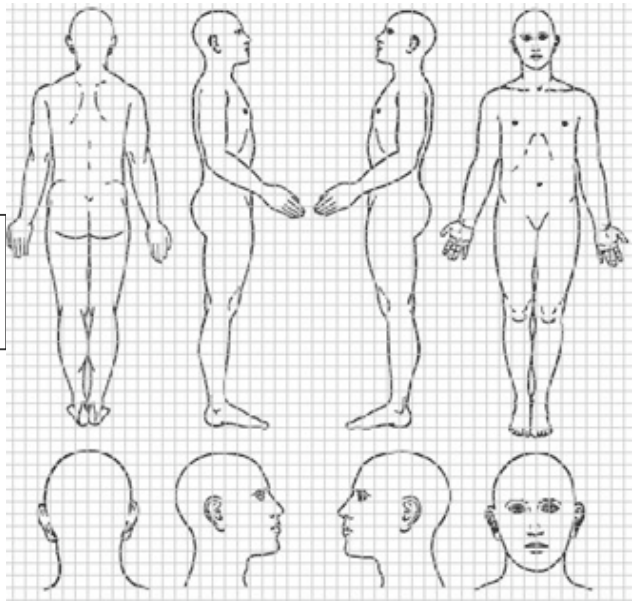
PAIN DRAWING

Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation.

Describe your pain (check all that apply):

- ☐ Constant
- ☐ Intermittent
- ☐ Recurring
- ☐ Stabbing
- ☐ Dull Ache
- ☐ Sharp
- ☐ Deep Ache
- ☐ Throbbing
- ☐ Tingling
- ☐ While Resting
- ☐ Daily
- ☐ During Exercise
- ☐ Nightly
- ☐ _____

Pain	•
Numbness	+
Burning	/
Ache	X



Onset of Pain:

- ☐ Sudden
- ☐ Gradual

On a scale of 1 to 10 how would you rate your pain level? _____ (1 = Mild, 10 = Intense)

What if anything gives your relief? _____

~IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN ACCIDENT OR INJURY PLEASE COMPLETE BELOW~

☐ NOT APPICABLE
☐ AUTO ACCIDENT Date _____ Time _____ (am) (pm) Location _____

Were You:	☐ Driver	☐ Passenger
	☐ Unconscious	☐ Treated in E.R.
	☐ Wearing a seat belt	☐ Yes ☐ No
	☐ Transported by ambulance	☐ Yes ☐ No
Vehicle Damage:	☐ Minimal – Moderate	☐ Severe – Totaled
	Was the vehicle towed away?	☐ Yes ☐ No
Police Report:	☐ None	☐ Yes with Police Department _____
Activities:	☐ No Restrictions	☐ Missed _____ days of work or school
	☐ I felt fine before the accident	

☐ NOT APPLICABLE
☐ WORK RELATED Date _____ Time _____ (am) (pm) Location _____

or Other Injury Describe the injury and how it happened:

_____
_____
_____
_____
_____
_____
_____
_____.

Accident Reported to _____ on _____ (date)

☐ No restrictions ☐ Missed _____ days of work or school
☐ I felt fine before the injury

PATIENT'S PRIVACY AGREEMENT AUTHORIZATION FOR USE AND DISCLOSURE

Patient Name: _____ Date: _____

I, _____, authorize Adams Health Center to use and/or disclose my protected health information (PHI) to family members and/or friends listed below:

☐ Please DO NOT disclose my personal information to anyone at this time!

Family member/friend 1:

Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ - _____

Family member/friend 2:

Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ - _____

I was advised of the purpose for which my protected health information (PHI) will be used, and authorize the release of medical and billing information to the above-mentioned individual(s).

I understand that I may refuse to sign this authorization, and I will not be denied treatment because of my refusal. The clinic may disclose and use my PHI for all health care delivery purposes (i.e., treatment, payment, and health care operations).

I have the right to revoke this agreement at any time by delivering written notice to the compliance officer.

I fully understand this authorization for use and disclosure of my protected health information, and I agree to this authorization.

_____ _____

Patient's Signature Date

HEALTH CARE PRIVACY NOTICE

Our team is committed to maintaining the privacy or your protected health information known as (PHI). PHI is information about you, including demographic information, that may identify you and that may relate to your present, future and past physical or mental health or condition and that care and treatment you receive from our practice. This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and ask any questions, misunderstanding or concern to the Compliance Officer of this office.

This office is required by law to abide by the terms of this Health Care Privacy Notice as well as all other applicable federal and state laws governing privacy practices in health care. Our office may change and/or modify the terms of this Notice at any time without additional notice to you except to publicly post in our office and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request.

USE & DISCLOSURE OF PHI

Our office may use & disclose your PHI for health care delivery purposes. Your PHI may be used by doctors and staff of this office for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. Following is a list of situations in which your PHI can be disclosed without your written authorization.

Business Associate: Your PHI may be used or disclosed to a business associate, from whom we have obtained assurances that they will safeguard your PHI and use it only for the purposes for which it was intended.

Emergency Situations: In an emergency situation, where written acknowledgment from you is not practical until after the situation has ended.

Employee Limitations: Your PHI will be limited to the members of the clinic and its workforce who may need access for treatment, payment or health care operations.

Health Care Operations: For certain administrative, financial, legal, and quality control activities that are necessary to run its business and support the core functions of treatment and payment.

Legal Proceeding: If requested by judicial or administrative proceedings, court order, subpoena or law enforcement purpose.

Minimum Necessary Standard: The disclosure of and requests for your PHI will be the minimum required to accomplish the intended purpose.

Payment: The provider may disclose your PHI to third party and/or other parties to obtain reimbursements and/or payments for your health care services.

Personal Representative: Your PHI may be disclosed to a person who is authorized by state law to act on your behalf in making your health care decisions.

Public Health Purposes: Your PHI may be disclosed to legally authorize public health authorities for the purpose of the prevention, control, investigations, intervention, and reporting of disease, injury, disability and vital events such as births or deaths. Your PHI may be disclosed for public health activities such as child abuse, neglect, safety and effectiveness of a product regulated by the FDA, and persons at risk of contracting and spreading disease.

Research Purposes: Your PHI may be disclosed for research purposes either with your written permission or without any identifying characteristics.

Treatment: For the coordination or management or your health care services, your health care provider may consult with another health care provider, a third party, or for the referral to another health care provider.

Worker's Compensation: State laws may permit disclosure of your PHI to comply with worker's compensation laws without your authorization and no minimum necessary standard is required.

Miscellaneous: We may use or disclose your PHI in the normal course of operations, notifying you of appointments, services, and clinic news.

The Privacy Rule allows you the right to receive and receive copies of your records as it relates to your health care. The request must be in writing, allowing your doctor 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your doctor may charge a copy fee, which will not exceed the amount permitted by State Law.

The Privacy Rule allows you the right to request that the disclosure of your PHI have restrictions on how your doctor will use your PHI regarding treatment, payment and health care operations. Your doctor may not agree to your restrictions, but would be bound by any restrictions you agree upon.

Your doctor must comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed on your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the doctor has the right to respond with a rebuttal statement if he/she feels it is necessary.

You have a right to receive your doctor's Notice of Privacy Practices.

You may revoke authorization, in writing, at any time, except in the even that the doctor has acted as indicated in the doctor's Authorization Notice.

HEALTH CARE PRIVACY NOTICE - (continued)

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer, and it must be filed within 180 days of when you knew or should have known that the violation occurred. You may also contact a written complaint, either on paper or electronically with the Office of Civil Rights (OCR). The Privacy Law prohibits our office from taking any retaliatory actions against anyone who files a complaint.

I, _____, (patient's name) acknowledge that I have read and was given a copy of the Notice of Privacy Practices for Adams Chiropractic Health Center and fully understand the same and have all my questions answered to my satisfaction.

_____ _____

Patient's Signature Date

_____ _____

Signature of Team Member Date

MISSED APPOINTMENT POLICY

Due to the rise in Patient No-Show appointments, it has become necessary for our office to discourage late or no-show appointments. When a patient does not keep their appointment time or does not cancel, it inhibits us from offering our services to another individual. We request that should you be unable to keep your appointment, please notify us at least 1day prior to the appointment time to avoid a potential $25 service fee. You and not your insurance company will owe this amount.

We appreciate your understanding .

If you have any questions or concerns, please contact one of our team members at

(972) 596-1611.

Respectfully,

Adams Health Center

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AUTHORIZATION
TO KEEP CREDIT CARD ON FILE

You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

Credit Card Information			
Card Type: ☐ MasterCard	☐ Visa	☐ Discover	☐ American Express
Cardholder Name (as shown on card):			
Card Number:			
Expiration Date (mm/yy):			
Cardholder ZIP Code (from credit card billing address):			
CVC Number:			
Email Address to Send Three Day Notice of Intent to Charge:			
Authorized Account Users:			

I, (print name) _____ , authorize **Adams Chiropractic Health Center** to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future payments on my account. I understand I am leaving this card on file as a convenience and it can remove the card on file at anytime per my request.

_____ _____

Patient Signature Date

_____

Team Member Signature