

Azle Chiropractic Clinic

Name: _____ Date of Birth: _____ Social Security No: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (Home/Cell) _____ (Work) _____ E-mail: _____

Work Status: Employed / Full time student / Part time student / Retired

Marital Status: Single / Married / Divorced / Widowed How did you learn of this clinic? _____

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Purpose of this appointment and list your complaints: _____

If Injury, Date of Injury: _____ How did the injury occur? ___Auto ___On the job ___Other

Describe the circumstances of the injury: _____

Other Doctor seen for this condition: _____

List any x-rays, tests/studies and/or medications received for this condition: _____

Were you admitted to the hospital due to this condition? ___Yes ___No If yes, please describe _____

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What type of work do you do? _____

Do you have any current work restrictions due to this condition?

Off work: ___Yes ___No ___Previously From: _____ To: _____

Light duty: ___Yes ___No ___Previously From: _____ To: _____

Are you taking any medications (prescription or over-the-counter)? Yes No If yes, list: _____

Do you have allergies to medication? Yes No If yes, please list: _____

Have you ever had any surgeries? Yes No If yes, please list and approximate dates: _____

Habits: Current every day smoker Current some day smoker Former smoker Never smoker
 Drink alcohol daily Drink alcohol occasional / Exercise: Daily Occasional Never

Family History: Diabetes Cancer Back pain Other: _____

Mother: _____

Father: _____

Sibling(s) _____

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Azle Chiropractic Clinic, P.C. Notice of Privacy Practices. By signing below, I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient name (Type or Print) _____ Date: _____

Patient/Guardian Signature: _____

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees rendered to me will be immediately due and payable.

Patient/Guardian Signature: _____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and anyone he/she may designate as his/her assistants to administer treatment, physical examination, x-ray studies, lab procedures that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patients) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer.

Patient/Guardian Signature: _____

Azle Chiropractic Clinic PC

Review of Systems

Patient Name: _____

Today's Date: _____

Please check the signs and/or symptoms related to the following body systems you now have or have experienced in the past.

CONSTITUTIONAL

- Deny All
- Chills
- Drowsiness
- Fainting
- Fatigue
- Fever
- Night Sweats
- Weakness
- Weight Gain
- Weight Loss

EYES

- Deny All
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Dry Eyes
- Eye Pain
- Field Cuts
- Glaucoma
- Sensitivity to Light
- Tearing
- Wears Glasses

CARDIOVASCULAR

- Deny All
- Angina
- Chest Pain
- Claudication
- Heart Murmur
- Heart Problems
- High Blood Pressure
- Low Blood Pressure
- Orthopnea
- Palpitations
- Shortness of Breath
- Swelling of Legs
- Varicose Veins

RESPIRATORY

- Deny All
- Asthma
- Bronchitis
- Dry Cough
- Productive Cough
- Coughing up Blood
- Difficulty Breathing
- Difficulty Sleeping
- Hemoptysis
- Pneumonia
- Sputum Production
- Wheezing

MUSCULOSKELETAL

- Deny All
- Arthritis
- Neck Pain
- Decreased Motion
- Gout
- Injuries
- Joint Pain
- Joint Stiffness
- Locking Joints
- Back Pain
- Muscle Cramps
- Muscle Pain
- Muscle Twitching
- Muscle Weakness
- Swelling

INTEGUMENTARY

- Deny All
- Breast Lumps / Pain
- Change in Nail Texture
- Change in Skin Color
- Eczema
- Hair Growth
- Hair Loss
- History of Skin Disorders
- Hives
- Itching
- Paresthesia
- Rash
- Skin Lesions

GASTROINTESTINAL

- Deny All
- Abdominal Pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber
- Abnormal Stool Color
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood

GENITOURINARY

- Deny All
- Birth Control Therapy
- Burning Urination
- Cramps
- Erectile Dysfunction
- Frequent Urination
- Hesitancy / Dribbling
- Hormone Therapy
- Irregular Menstruation
- Lack of Bladder Control
- Prostate Problems
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

ENMT

- Deny All
- Bad Breath
- Dentures
- Deviated Septum
- Difficulty Swallowing
- Discharge
- Dry Mouth
- Ear Drainage
- Ear Pain
- Frequent Sore Throats
- Head Injury
- Hearing Loss
- Hoarseness
- Loss of Smell
- Loss of Taste
- Nasal Congestion
- Nose Bleeds
- Post Nasal Drip
- Sinus Infections
- Runny Nose
- Snoring
- Sore Throat
- Ringing in Ears
- TMJ Problems
- Ulcers

NEUROLOGICAL

- Deny All
- Change in Concentration
- Change in Memory
- Dizziness
- Headache
- Imbalance
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors

PSYCHIATRIC

- Deny All
- Agitation
- Anxiety
- Appetite Changes
- Behavioral Changes
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Homicidal Indication
- Insomnia
- Location Disorientation
- Memory Loss
- Substance Abuse
- Suicidal Indication
- Time Disorientation

ENDOCRINE

- Deny All
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

HEMATOLOGIC / LYMPHATIC

- Deny All
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusions
- Bruise Easily
- Lymph Node Swelling

ALLERGIC / IMMUNOLOGIC

- Deny All
- History of Anaphylaxis
- Itchy Eyes
- Sneezing
- Specific Food Intolerance

HIPAA Notice of Privacy Practices

Effective as of March/1/2010

Azle Chiropractic Clinic, P.C.
Dr. Rodney P. Gatlin, D.C.
400 Boyd Ct. / Azle, TX 76020
(817) 444-HELP (4357)

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

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Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Azle Chiropractic Clinic

Financial Arrangement Agreement

In an effort to serve our patients better and to help them know what is expected in the area of financial arrangements, we have devised the following format.

Please understand that your bill with the Doctor is your responsibility and that we will file on your insurance for you as a courtesy. Any discrepancies between the insurance payment and our bill will be your responsibility.

Insurance

- _____ Auto Accident Assignment (Personal Injury Protection)
- _____ Workman's Compensation Assignment
- _____ Health Insurance (must pay deductible to have us file insurance)
_____ deductible _____ % co-payment due
- _____ Liability Insurance with Doctors Lien
- _____ Attorney Assignment with Letter of Protection
(If your attorney drops your case you are responsible for your bill unless other arrangements are made).
- _____ PPO - HMO Patient pays \$_____ per visit as per contract

Cash

- _____ Pay as you go (Cash, check, Visa, Mastercard, Discover or Am Ex.)
- _____ Payment plan (with approval) of \$_____ per _____
- _____ Other

I agree to pay for my bill in the above indicated manner. In the event that my insurance will not pay for the Doctor's services, I understand that I will be responsible for paying this bill.

Patient signature: _____ Date: _____

Azle Chiropractic Clinic, P.C.

Assignment of Benefits, Assignment of Cause of Action, Letter of Protection Authorization

The undersigned patient and or responsible party, in addition to continuing responsibility, and in consideration of treatment rendered or to be rendered assigns and transfers to **AZLE CHIROPRACTIC CLINIC, P.C. / RODNEY P. GATLIN, D.C.**, the following rights, power and authority.

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, revocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 30 days following your receipt of such bills for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to **AZLE CHIROPRACTIC CLINIC, P.C.** and to send all checks to **400 Boyd Court Azle, Texas 76020.**

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable directly to **AZLE CHIROPRACTIC CLINIC, P.C.** and to send any and all checks to **400 Boyd Court Azle, Texas 76020.**

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility names above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment of healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

LETTER OF PROTECTION/LETTER OF DIRECTION: With this letter I advise my Attorney/Legal Representation that I am undergoing treatment at Azle Chiropractic Clinic, P.C. for injuries sustained in my accident. I authorize and direct my attorney/legal representation to pay Azle Chiropractic Clinic, P.C. out of the proceeds of any settlement or collection made by you for my injuries. I authorize my legal representation to submit a Letter of Protection to Azle Chiropractic Clinic, P.C. on my behalf. I agree that said Letter of Protection cannot be revoked or modified without written consent from Azle Chiropractic Clinic, P.C. Furthermore I authorize Azle Chiropractic Clinic, P.C. to withhold any and all medical records and/or billing records until said Letter of Protection is received.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. If my carrier is unable to provide said rejections in a timely manner, I acknowledge that I am entitled to minimum levels of coverage, as per section 1952.152 of the Texas Insurance Code, and further instruct my carrier to pay up to available limits directly to physician/clinic named above, and to send any checks or financial instruments to 400 Boyd Court Azle, Texas 76020.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

_____ **Print Name of Patient and / or Responsible Parties**

_____ **Signature of Patient and / or Responsible Parties**

_____ **Witness**

_____ **Date**