Back To Health Chiropractic
12107 Toepperwein Rd. #8
Live Oak, TX 78233
210-599-9570

Welcome To Our Office

Confidential Patient Case History

Please complete this questionnaire. The confidential history will be part of your permanent records.

Today's Date [/ /] **Patient/ Guardian Signature:** _____

First Name: _____ **Nickname:** _____

Last Name: _____ **SSN:** _____

Middle Name: _____ **Suffix:** _____

Address 1: _____

Address 2: _____

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

E-Mail: _____

☐ **Primary Phone:** _____ ☐ **Mobile Phone:** _____

Date of Birth [/ /] **Age** _____ **Gender** **Male** **Female** **Other** (please circle one)

Marital Status (please circle one) **Single** **Married** **Other**

Race/ Ethnicity _____ **Preferred Language** _____

Employment Status (please circle one) **Employed** **FT/PT Student** **Retired** **Self Employed**

Occupation _____ **Employer** _____

Who referred you to us? _____ **How else did you hear about us?** _____

Health Information

List all current medications-

_____ _____

_____ _____

_____ _____

List any allergies you may have-

_____ _____

_____ _____

Health Information Continued...

List all surgeries & year completed-

_____ _____

_____ _____

What is your major complaint? _____

How long have you had this condition? _____

Family Physician Name/ Phone Number _____

Briefly list your main health problems -

_____

_____

Back To Health Chiropractic
Notice Of Privacy Practice

I have received or reviewed a copy of Back To Health Chiropractic Wellness Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the rights to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me. At this time, I do not have questions regarding my rights or any information I have received.

Patient's Printed Name **Date of Birth** **Social Security Number**

Patient's Signature **Today's Date**

Patient Consent to X-Ray

I authorize the performance of diagnostic x-ray examination of myself or minor,_____ which Back To Health may consider necessary or advisable in the course of my examination and treatment.

Females: Regarding Pregnancy

This is to certify that , to the best of my knowledge, I am not pregnant, and Back To Health has my permission to perform a diagnostic x- ray exam. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child. ☐ **Patient Initials**

Signature_____ **Date**_____

Back To Health Chiropractic
Informed Consent for Examination & Treatment

I hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic in practice in this clinic.

I have had the opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different procedures and treatments (Therapy/Adjustments). I understand that chiropractic is not an exact science and that my care may be provided based on facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected.

I further understand that there is a certain risk associated with chiropractic health care which includes rarely, but not limited to fractures, disk injuries, strokes, strains/ sprains and am therefore willing to accept and consent to the risk associated with the are that I am about to receive.

I have read the above information and by signing below, I agree and intend this consent to cover the procedures prescribed by the doctor for my condition and for any future conditions in which I may seek treatment.

Patient's Printed Name

Patient's Signature **Today's Date**

Office Financial Policy

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces out- of pocket- expenses.

1. **If you do not have insurance** – All payments are expected at the time of service or by an authorized payment plan.
2. **If you have Insurance-** All deductibles and co-payments are expected at the time of service or by authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

- You are considered a cash patient until you provide us with your primary and secondary insurance card, a signed Advanced Beneficiary Notice.
- If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim(s). If your insurance carrier has not paid your claim(s) within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.
- Scheduled visits of once a month or longer will not be eligible for insurance assignment. Charges of services rendered will be due as they are rendered.
- If treatment is discontinued for any reason other than discharge from the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Printed Name_____

Signature_____ **Date**_____

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Authorization to Use and Disclose Protected Health Information

I, _____ hereby authorize that Back To Health Chiropractic may disclose my protected health information. This may include the release of medical records, x-rays, test results, reports, billing, and other data in connection with my care given while being treated. I give you permission to forward the records via fax, mail, or e-mail to my primary care physician or any referring physician and my insurance company(ies).

Patient Signature_____ **Date**_____

Printed Name _____

Phone Number _____