Creating Wellness™

Your Wellness History – Health Profile

Date: _____

Name: _____ **DOB:** _____ **Age:** _____/ **Male Female**

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home # ( )_____ **Work: ( )**_____ **Cell: ( )**_____

Best time to contact: _____

Email address: _____ **Status: Single Married Divorced Widowed**

# of Children: _____ **Names/Age:** _____

Occupation: _____ **Employer Name/Address:** _____

Rate your health and wellness.

Place an '**X**' that denotes where you believe is your current level of wellness.
Place an '**O**' indicating where you would like your wellness to be.

YOUR HEALTH PROFILE

➢ What brings you into our office today?

Please briefly describe, including the impact it has had on your life. If you're only here for chiropractic wellness services please skip this part and go to "General History" on the next page.

Rate Severity (scale 1-10, 1being mild) When and how did this start? Are symptoms constant or intermittent?

_____

_____

_____

➢ Since the problem started it is; ___the same ___getting better ___ getting worse

What makes the problem worse?_____

_____

➢ What, if anything, makes the problem feel better?_____

_____

➢ Does this interfere with your; ___Leisure ___Work ___Sleep ___Sports ___Other

_____

➢ Have you seen other doctors for this condition? ___Chiropractor ___MD ___Other

Name/Address: _____ Date: _____

What was the diagnosis: _____

Lone Star Chiropractic:
A Creating Wellness Center

2438 W Anderson Lane, Suite A2
Austin, TX 78757
Phone: 512-377-2663
Fax: 512-377-2664

GENERAL HISTORY

- Please list all medications you are taking, and why; (Prescription and non-prescription)

_____

_____

_____

- Have you had any surgeries and/or hospitalizations? ___Yes ___No

If yes, briefly explain:_____

_____

- Have you ever had any work related injuries? ___Yes ___No

If yes, briefly explain: _____

_____

- Have you ever had any slips, falls or auto accidents? ___Yes ___No

If yes, briefly explain:_____

_____

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

❑ Headaches	❑ Buzzing in ears	❑ Irritability	❑ Diarrhea
❑ Pins & needles in arms	❑ Ringing in ears	❑ Cold hands	❑ Cold sweats
❑ Pins & needles in legs	❑ Numbness in toes	❑ Cold feet	❑ Mood Swings
❑ Dizziness	❑ Depression	❑ Fever	❑ Loss of smell
❑ Numbness in fingers	❑ Constipation	❑ Urinary problem	❑ Loss of taste
❑ Fatigue	❑ Menstrual pain	❑ Fainting	❑ Back pain
❑ Sleeping problems	❑ Menstrual irregularity	❑ Eyes bothered by light	❑ Neck Pain
❑ Tension	❑ Hot flashes	❑ Stomach upset	❑ Stiff neck
❑ Ulcers			

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YOUR GOALS

➢ On a scale of 1 to 10 (1 = none, 10 = extreme), describe your emotional/psychological/lifestyle stress levels:
Scale =____ Occupational stress: _____
Scale =____ Personal stress: _____

➢ On a scale of 1 to 10 (1 = poor, 10 = excellent), describe your habits and condition as it relates to:

Eating_____ Exercise_____ Sleep_____ General Health_____ Wellness lifestyle_____

At our office we're concerned about your health and wellness goals. Please take a moment to list your goals

Wellness Goals

Be Fit. *(Physical)*	Eat Right. *(Nutritional)*	Think Well. *(Psychological)*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check all that are relevant.

Do you:	Would you like to know more about:
❑ Water - Drink ½ your body weight in ounces	❑ Proper Nutrition and meal planning
❑ Exercise regularly	❑ Proper exercise routines and techniques
❑ Take vitamins or supplements	❑ How to deal with LifeStyle stress

Thank you for filling out this form.
It is your first step to Creating Wellness!

I consent to a professional and complete chiropractic examination, and to any radiographic examination that the doctor deems necessary. I understand that all fee's for services rendered are due at the time of service and cannot be deferred to a later date.

Signature: _____ Date: _____

Please return this form to our staff and someone will be right with you.

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INSURANCE INFORMATION

Health Insurance

Primary

Insurance Company_____ Insurance Phone #_____

Patient's Name_____ Patient's SSN_____

Insured's Name_____ Relationship_____

Insured's SSN_____ Insured's DOB_____

Name of Spouse_____

ID#_____ Group#_____

Secondary

Insurance Company_____ Phone #_____

Insured's Name_____ Relationship_____

Insured's SSN_____ Insured's DOB_____

Insured's Employer_____ Group#_____

Auto Insurance if billing due to a motor vehicle accident

Personal Injury Protection

Insurance Company_____ Phone #_____

Insured's Name_____ Relationship_____

Adjuster's Name_____ Claim #_____

Third Party

Insurance Company_____ Phone #_____

Insured's Name_____ Relationship_____

Adjuster's Name_____ Claim #_____

REMINDER: Your insurance coverage is a contract between you and your insurance company, **not between you and our office.** You are responsible for all charges on your account, including any charges not paid in full by your insurance company.

Signature_____ Date_____

PATIENT – DOCTOR AGREEMENT

The purpose of this agreement is to allow us to more completely serve you and for you to get the best results in the shortest amount of time. It is our experience that those who follow through with these agreements get the best results.

SIGNING IN
When you arrive, sign in. You will be called and assigned a treatment room in the order you signed in for the doctor. On each visit, pick up your card at the front desk, go to the assigned treatment room, and lie face down. Rest and relax, the doctor will be in as soon as possible.

NEW PATIENT ORIENTATION
It is the policy of this office that you, the patient, participate in your recovery. It is mandatory that all patients attend our Patient Orientation Workshop as soon as possible after starting care. This workshop explains how the body functions, how Chiropractic works, and how results are produced. Family and friends are always welcome. There is no charge for the class. While children are welcome in the office during our regular treatment times, child care is not available during our evening workshops, so it is important that other arrangements are made for children under the age of 12 during the Patient Orientation.

MISSING OR CHANGING APPOINTMENTS
The doctor will set up a specific course of treatment for you. A certain number of treatments in a set amount of time is required to get the results we both desire. Thus, if you need to change the time of your appointment, plan to come another time the same day, or if the same day is not possible, it is important that you make up the missed appointment within one week. If you want to be here and have your spine corrected, you will be expected to follow the doctor's treatment recommendations. There will be no exceptions on this matter. If you are not ready to make your health a priority by making a commitment to your treatment, then do not waste your time and money now; plan to have your spine corrected at a later date. **SCHEDULE YOUR LIFE AROUND YOUR HEALTH, NOT YOUR HEALTH AROUND YOUR LIFE.**

APPOINTMENT TIMES
We will set up a specific time for your adjustment. Try to be prompt as the doctor has set this time aside to detect and correct vertebral subluxations and during this time, that is all he will do. If you come to another time, you may have to wait a few minutes, as the doctor also sets aside specific times to see new patients and conduct extended consultations. We value your time and do not want you to wait needlessly. If you wish to sit down with the doctor to discuss your case, a specific Doctor/Patient Conference can be arranged at no additional charge.

PAYMENT OF BILLS
We will expect you to honor the financial agreement you make with our office. In order to serve you better, please plan to make any payments at the front desk before you go to the back office for your adjustment. Upon being released from care, a three-month period is allowed for settlement of your account. If a settlement has not been reached within this period, or if you have suspended or terminated your care without your doctor's approval, payment for services is due immediately.

PROGRESS EVALUATIONS AND RE-EXAMINATIONS
During your treatment series, re-examinations and progress reports will be done on a regular basis.

COMMUNICATION
Please communicate directly to the doctor any upsetting matter such as waiting too long, rudeness by any staff member, failure to understand treatment, need for extended consultation, etc. We are here to serve you. Your criticism will help us to help you as well as others.

CASH PATIENT FINANCIAL POLICY
We request that 100% of the first visit be paid at the time of the first visit. For your convenience, future payments may be arranged at the first visit of each week. We are happy to accept your check, MasterCard, Visa, Discover, American Express, or cash.

MAJOR MEDICAL/GROUP INSURANCE
You are expected to make a payment toward your services on the first day in this office. Complete the information regarding your insurance policy and make sure the Front Desk Assistant has a copy of your insurance card. Also, any checks sent to your home by the insurance company must be brought or sent to our office within three days.

AUTO ACCIDENT/PERSONAL INJURY
You are usually covered 100% for these injuries. You are responsible for obtaining the Personal Injury Protection forms and address from your insurance company to which we send statements for your care. You are also responsible for reporting your accident to the insurance company and your insurance agent.

WORKER'S COMPENSATION
If your care is related to an on the job injury, you must report your injury to your supervisor and make sure a claim has been initiated before you receive care at our office. Also, you must request that your employer notify their insurance company that you are under care at our office and that the Employer's First Report of Injury has been completed and sent to the Workers Compensation Insurance Company.

MEDICARE
Medicare will cover 80% of each of your visits after your deductible is met. Medicare does not pay for examinations or x-rays. However, Medicare does require that you have x-rays taken once a year or they will not pay for any of your Chiropractic visits.

I, _____, understand the above policy and agree to abide by it.
(PRINT NAME)

_____ _____
SIGNATURE DATE

HIPAA HAPPENINGS

This notice describes how your health information may be used and how you can gain access to this information. Please review it carefully.

Our Promise to You our Valued Patient…
This is not meant to alarm you. Quite the opposite. We want to assure you that we take the new Federal HIPPA (Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our offices because of fear that your personal heath information might be unnecessarily disclosed to others outside our office.

Why a Privacy Policy Now?

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review not only how your information is used within our computers but also with the Internet, phones, fax machines and any device used to copy or transfer that data.

We want to advise you that we have developed policies and procedures for our practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information. We will assure our adherence to those laws and we want you to understand our procedures and your rights as a valued patient.

Your health information will be communicated only for the purpose of conducting health care business and obtaining payment for services. Be assured that without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used To Provide Treatment

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health professionals providing you treatment.

To Obtain Payment

Your health information may be included with an invoice for the purpose of collecting payment for services provided to you in this office. We may do this with insurance forms filed for you by mail or electronically. We will make every effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, and associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or members of your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care chiropractic can provide. They may include postcards, newsletters, flyers, and telephone or electronic reminders such as e-mail (unless you tell us that you prefer not to receive reminders.)

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health and or national security.

For Law Enforcement

As permitted or required by state or Federal law, we may disclose your health information to proper authorities for the purpose of law enforcement including, under certain circumstances, if you are a victim of a crime or in order to report a suspected crime.

Family, Friends and Care givers

We may share your health information with those you tell us will be assisting you with your home hygiene, care, treatment or payment. We will be certain to obtain your permission prior to sharing you information. In the event of an emergency, if you are unable to tell us what you want, we will use our very best judgment when sharing your health information with anyone participating in your care.

Medical Research

Advancing health care knowledge often involves learning from the careful study of health histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements, and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time.

Patient Rights

This law is careful to describe that you have the following rights related to your health information. Be assured that our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately with or without other family members present or through sealed mail communications. We will make all reasonable effort to honor your request.

Inspect and Copy Your Health Information

You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request.

Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested sealed and or delivered to any authority for review.

Documentation of Health Information

You have the right to request from us a description of how and where you health information was used by our office for any reason other than for treatment or payment, or health care operations. Our documentation procedures will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes.

You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing, any concerns you may have regarding the privacy of your health information.

Thank you very much for taking time to review how we are carefully using your health information. If you have questions, please let us know. If not, we would appreciate your acknowledging by signature that you have received, thoroughly reviewed and understand this policy.

_____ Date _____/_____/_____

Patient Signature

Thank You For Your Trust and Confidence