SCHERTZ CHIROPRACTIC

17323 IH 35 N #106
Schertz, TX 78154
ph: (210)646-6000

CONFIDENTIAL PATIENT INFORMATION (please print clearly)

First Name:_____ Last Name:_____ MI: _____
Address:_____ City/ST:_____ Zip:_____
Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____
E-mail:_____@_____ leave blank if you do not wish to receive educational newsletters
Would you like to receive electronic appointment reminders? ☐ Yes ☐ No If yes, ☐ E-mail ☐ Text
If text, who is your mobile provider? ○ AT&T/Cingular ○ Cricket ○ Nextel ○ Sprint ○ T-Mobil ○ Verizon ○ Virgin Mobil

Age: _____ Date of Birth: ____/____/____ Social Security #_____
Employer:_____ Occupation: _____

Marital Status: ○ M ○ S ○ W ○ D Name of Spouse (if applicable): _____
Spouse Employer: _____ Work Phone: (___)_____

How did you hear about our office? (Choose one) Internet Site_____ Walk In/Drive by
Friend's Name_____ Attorney's Name_____

Date of Last Physical Examination:____/____/____ Dr. Name: _____

Have You Ever Suffered From:

	Yes	No		Yes	No
1. Cancer	☐	☐	5. Respiratory Problems	☐	☐
2. Dizziness	☐	☐	6. Insomnia	☐	☐
3. Heart Trouble	☐	☐	7. Digestive Disorders	☐	☐
4. Diabetes	☐	☐	8. Arthritis	☐	☐

Purpose of this appointment: _____
Have you been evaluated for this or any other health conditions? ☐ Yes ☐ No
Treatment Provided: _____
Have you had any diagnostic tests? (circle) ☐ X-Ray ☐ MRI ☐ NCV/EMG Other: _____
Surgical History: _____
Current Medications: Rx or OTC: _____

Exercise: ○ Never ○ Occasional ○ 3-5x/wk ○ Daily
Alcohol: ○ Never ○ 2-5x/wk ○ Daily
Dominant Hand: ○ Right ○ Left
Tobacco: ○ Never ○ Occ ○ Light ○ Med ○ Heavy
Caffeine: ○ Never ○ Occ. ○ Daily

PAYMENT IS EXPECTED AT THE TIME OF VISIT
Are you insured? ☐ Yes ☐ No
If yes, please circle provider: ○ BCBS ○ Aetna ○ Medicare
Please provide the receptionist with a copy of your card.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Schertz Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and the amount authorized to be paid directly to Schertz Chiropractic will be credited to my account on receipt and all billing receipts will be provided only on request. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature:_____ Date:____/____/____
Guardian or Spouse's Signature:_____ Date:____/____/____

SCHERTZ CHIROPRACTIC

17323 Ih 35 N # 106
Schertz, TX 78154
ph: (210) 646-6000

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.

We want to assure you that we take the Federal HIPAA (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 office because of fear that your personal health 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 electronic technology in the 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 how your information is used within our computers, 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 health information will be shared only as required for the purpose of administering your care. Our office is subject to State and Federal laws regarding the confidentiality of your health information and we promise our adherence to those laws. We also 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 in order to collect payment for the services provided to you in this office. We may do this with insurance forms filed for you electronically or by mail. 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 to our staff. Some of the 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 insurance company audits or by 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 and your family. These communications are an important part of our philosophy, which is to partner with our patients to see they receive the best chiropractic care we can provide. This 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 necessary health information to Federal officials or military authorities in order to complete investigations related to public health and or national security.

For Law Enforcement

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

SCHERTZ CHIROPRACTIC

17323 Ih 35 N # 106
Schertz, TX 78154
ph: (210) 646-6000

Family, Friends and Care Givers

We may share your health information with those that assist you with your home hygiene, care, treatment, or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, if you are unable communicate your wishes; 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 will transpire only under the ethical guidance, requirements and approval of an Institution Review Board.

Authorization to Use or Disclose Heath Information

Other than the information stated above, or information that Federal, State and Local laws require, we will not disclose your health information without your written authorization. You may revoke that authorization in writing at any time.

Patient Rights

This law is careful to describe that you have rights related to you 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 efforts to honor your request.

Inspect and Copy Your Health Information

You have the right to read, review and copy your health information. This includes 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 a description of how our office used your health information for reasons other than treatment, payment, or health care operations. Our documentation procedure 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 greatly appreciate your limited request for 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. We are required by law to maintain privacy of our health information and provide to you or your representative this Notice of 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 will be notified of any such changes. You have the right to express concerns or complaints to any staff member of Schertz Chiropractic, or to 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.

Patient Acknowledgment

Patient's Name: (print) _____ **Date**: ____/____/____

Patient's Signature: _____

Privacy Officer: Patrick W. Martin, D.C.

SCHERTZ CHIROPRACTIC

17323 IH 35 N #106
Schertz, TX 78154
ph: (210)646-6000

INFORMED CONSENT

PRINT
PATIENT NAME:_____ DATE:_____/_____/_____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

spinal manipulative therapy	Palpation	vital signs
range of motion testing	orthopedic testing	basic neurological
muscle strength testing	postural analysis	ultrasound
radiographic studies	hot/cold therapy	EMS

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

If you chose to use one of these "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read the above explanation of the chiropractic adjustment and related treatment. I have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Signature (of Parent or Guardian if a minor)_____

SCHERTZ CHIROPRACTIC

17323 IH 35 N #106
Schertz, TX 78154
ph: (210)646-6000

Name: _____

Date: _____

I,_____, in signing this form, state to the best of my knowledge, there is no pregnancy, confirmed or suspected at this time.

Patient Signature: _____

Witness Signature: _____

SCHERTZ CHIROPRACTIC

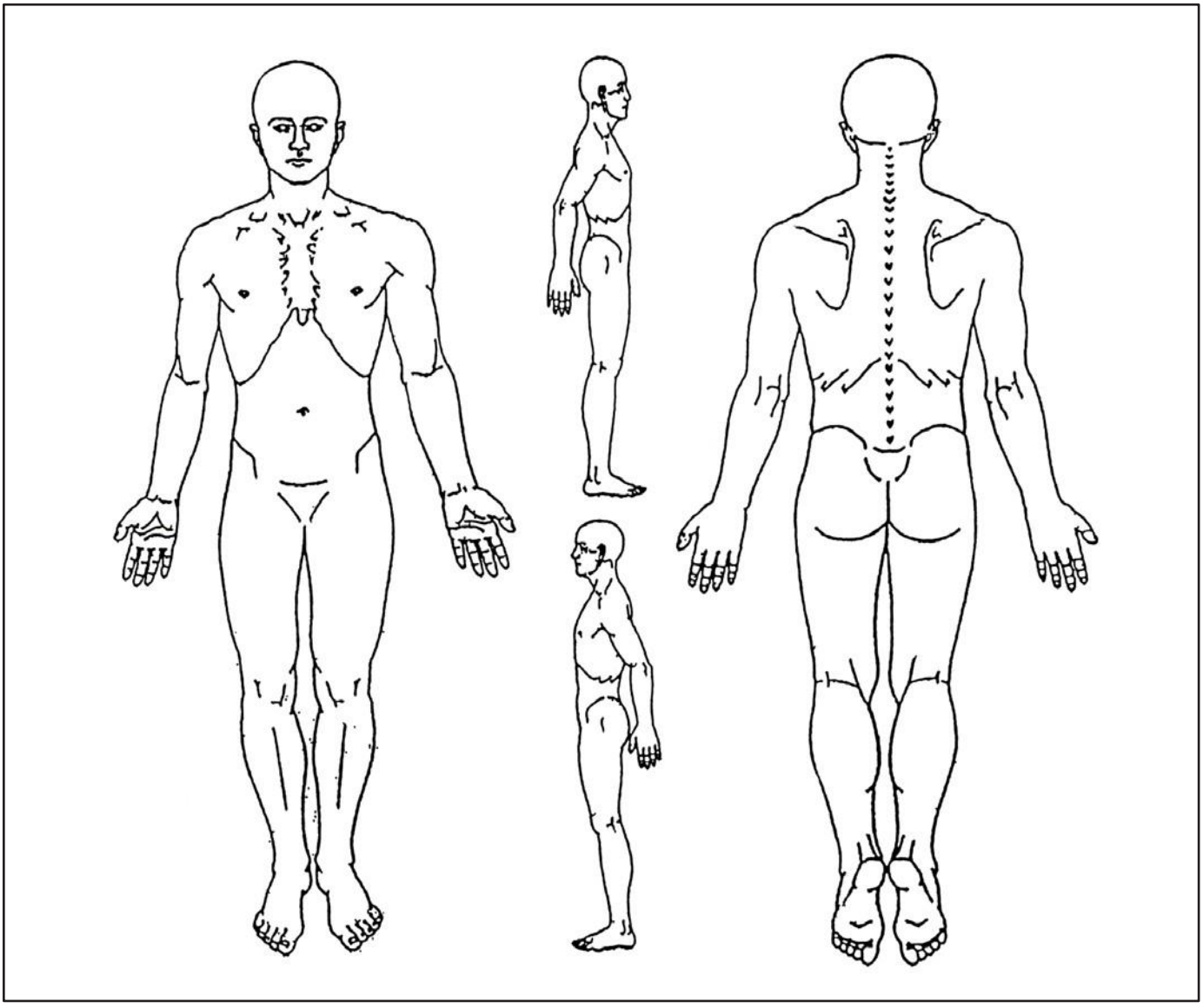
17323 IH 35 N #106
Schertz, TX 78154
ph: (210)646-6000

Name: _____

Date: _____

Complete this pain diagram by putting a letter or letters on the figures below to indicate your symptoms.

A = ACHE	**B** = BURNING	**N** = NUMBNESS
P = PINS & NEEDLES	**S** = STABBING	**O** = OTHER



SCHERTZ CHIROPRACTIC

17323 IH 35 N #106
Schertz, TX 78154
ph: (210)646-6000

Legal Assignment of Benefits, Release of Medical and Plan Documents, Release of Testimonial

In considering the amount of medical expense to be incurred, I, the undersigned, have insurance and/or employee healthcare benefits coverage. I hereby assign and convey directly to Schertz Chiropractic (facility) all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such performing physician and facility. I understand that I am financially responsible for all charges regardless of any applicable insurance or medical benefit payments. I hereby authorize Schertz Chiropractic to release any medical records necessary to process my insurance claims. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to Schertz Chiropractic any and all plan documents, insurance policy and/or settlement information upon written request in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee benefit claim submissions.

Schertz Chiropractic may bill my insurance on my behalf. Although Schertz Chiropractic may have verified benefits for me, the patient, the verification is not a guarantee of benefits and ultimate coverage and payment lies in the sole discretion of the insurance company based on policy guidelines. Ultimately, the patient is responsible for the charges, except contrary to federal or state law and will pursue any disputes with my insurance company, self-insured employer or other third party payer to enable proper health care benefits to be paid. I hereby authorize Schertz Chiropractic and/or its affiliates to appeal claims under Employee Retirement Income Security Act (ERISA) and/or state laws when applicable situations occur.

I hereby convey to Schertz Chiropractic to the full extent permissible under the law and under any applicable insurance policies and/or employee healthcare plan and claim, chose in action, or other right I may have to such insurance and/or employee healthcare benefits coverage under any applicable insurance policies and/or employee healthcare plan with respect to medical expenses incurred as a result of the medical services I received from Schertz Chiropractic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with Schertz Chiropractic in any attempts to pursue such claims, including, if necessary, bring suit with Schertz Chiropractic against such insurers and/or employee healthcare plan in my name but at Schertz Chiropractics expense.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing within thirty (30) days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and do fully understand this agreement.

SCHERTZ CHIROPRACTIC

17323 IH 35 N #106
Schertz, TX 78154
ph: (210)646-6000

INSURANCE PAYMENT INFORMATION

As Schertz Chiropractic may not be a plan provider for your insurance provider, please be advised that your insurance provider may forward payment or payment information directly to you the Patient/ Beneficiary. When written communication from your insurance regarding medical services provided by facility is received, I, the undersigned insured, promise to send a copy to facility immediately. In the event that a benefits check for medical services provided by Schertz Chiropractic is received, I promise to endorse the check promptly and forward to facility by certified mail, or send a personal check within 48 hours for the value of the benefits check. In the event that I send a personal check, I promise also to send a copy of the explanation of benefits from my insurance carrier, explaining the payment received by me.

I, the patient/beneficiary understand that failure to reimburse facility for insurance benefits received for medical services rendered will cause the full open balance on all charges to become due and payable immediately, and that I will be responsible for legal or collection fees if incurred.

TESTIMONIAL

I hereby testify that any testimonial I communicate, whether in writing or verbal, to Schertz Chiropractic, along with my image may be used in part, or in its entirety, for the purpose of in office patient education or any other type of advertising, including but not limited to direct mail, newspaper, newsletters etc.

Patient/Responsible Party (print) :_____

Patient/Responsible Party (sign):_____

Date:_____/_____/_____

SCHERTZ CHIROPRACTIC

17323 IH 35 N #106
Schertz, TX 78154
ph: (210)646-6000

REVISED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE

Name _____ Date _____

Please read carefully:

This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ***ONE CHOICE*** *which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please onlyt* ***mark the one box which most closely describes your problem right now.***

SECTION 1 – Pain Intensity

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain comes and goes and is severe.
- F. The pain is severe and does not vary much.

SECTION 2 – Personal Care

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do some washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights but it gives me extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned-eg, on a table
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F. I can only lift very light weights, at the most.

SECTION 4 – Walking

- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more than 1 mile.
- C. Pain prevents me from walking more than ½ mile.
- D. Pain prevents me from walking more than ¼ mile.
- E. I can only walk using a stick or crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me sitting more than 1 hour.
- D. Pain prevents me sitting more than ½ hour.
- E. Pain prevents me sitting more than 10 minutes.
- F. Pain prevents me from sitting at all.

OTHER COMMENTS:

_____

_____

SECTION 6 – Standing

- A. I can stand as long as I want without pain.
- B. I have some pain while standing, but it does not increase with time.
- C. I cannot stand for longer than 1 hour without increasing pain.
- D. I cannot stand for longer than ½ hour without increasing pain.
- E. I cannot stand for longer than 10 minutes without increasing pain.
- F. Pain prevents me from standing at all.

SECTION 7 – Sleeping

- A I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping well.
- C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D. Because of pain, my normal night's sleep is reduced by less than one-half.
- E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of my pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. I have hardly any social life because of the pain.

SECTION 9 – Traveling

- A. I get no pain while traveling.
- B. I get some pain while traveling but none of my usual forms of travel make it any worse.
- C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- C. My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

_____
Examiner

With Permission from:Hudson-Cook N, Tomes-Nicholson K, Breen AC. A Revised Oswestry Back Disability Questionnaire. Manchester Univ Press, 1989.