PATIENT INSURANCE INFORMATION SHEET

Please Complete the following information below so that we may efficiently serve you.

Patient Name _____
Home Phone _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Birth Date _____ Sex _____ Marital Status _____
Drivers Lic. # _____ Soc. Sec. # _____
Employment Status: Full Time _____ Part Time _____ Retired _____ Retirement Date ___/___/___
Employer Name _____ Employer Phone # _____
Employer Address _____ Occupation _____
Workman's Comp. Insurance Name _____ Phone _____

Primary Insurance Information

Name of Insured _____ Birth Date _____ Soc. Sec.# _____
Address _____ City _____ State _____ Zip _____
Insurance Company _____ Policy # _____ Group # _____
Insurance Company Address _____ City _____ State ___ Zip _____
Insured's Relationship to Patient: Self _____ Spouse Child _____ Other (please specify)
_____
Insured's Employer Name _____ Employer
Address _____ City _____ State ___ Zip _____
Employer Phone # _____ Occupation _____
Is there Secondary Insurance Coverage? Yes No (If yes please complete next section)

Secondary Insurance Information

Name of Insured _____ Birth Date___/___/___ Soc. Sec. # _____
Address _____ City _____ State ___ Zip _____
Insurance Company _____ Policy # _____ Group # _____
Insurance Company Address _____ City _____ State ____ Zip _____
Insured's Relationship to Patient: ____ Self ____ Spouse ____ Child ___ Other (please specify)
_____
Insured's Employer Name _____ Occupation _____
Employer Address _____ City _____ State _____ Zip _____
Employer Phone # _____

Patient Long-Term Signature Authorization

I hereby authorize the release of any medical or other information necessary to process my claim.
I also request payment of government benefits either to me or to the party who accepts assignment.
I also authorize payment of medical benefits to the above provider for any services.
This authorization also permits the release of information to this provider by HCFA, its intermediaries, or carriers on unassigned Medicare claims.
I further permit copies of this authorization to be used in place of the original.

_____
Patient / Insured Date

PATIENT:_____ DATE:_____

EDUCATION LEVEL

- ☐ Grade 8 or less
- ☐ Partial high school
- ☐ High school graduate
- ☐ Some college
- ☐ College graduate
- ☐ Masters or higher

EMPLOYMENT STATUS

- ☐ Paid full time
- ☐ Paid part time
- ☐ Homemaker
- ☐ Student
- ☐ Unemployed
- ☐ Retired
- ☐ Other_____

WORK ACTIVITY MAIN

- ☐ Heavy labor
- ☐ Light labor
- ☐ Mostly sitting at desk
- ☐ Mostly standing
- ☐ Mostly walking/moving about
- ☐ Driving or operating vehicle

ADDITIONAL INFORMATION

Do you smoke? Yes ☐ No ☐
If yes, how many packs/day? <1 ☐ 1 ☐ 2 ☐ 3 ☐ 3>☐
Do you drink? Yes ☐ No ☐ If yes, amount_____

Have you ever had x-rays taken of:	Yes	No	Describe:
Your low back:	☐	☐	_____
Your neck:	☐	☐	_____
Your chest:	☐	☐	_____
Other:	☐	☐	_____

How many days have you lost from work due to this current problem? _____days.

How many days have you lost from work in the past year due to your problem? _____days

Do you like your job? Yes ☐ No ☐ Really like my job ☐
No opinion ☐ Dislike my job ☐ Really dislike my job ☐

SYMPTOMS LIST: Please ___ symptoms you have from the list b

Your Name: _____ Date: _____

HEAD:

- _1. Headache
- __2. sinus (allergy)
- ___3. entire head
- ____4. back of head
- ____5. forehead
- ____6. temples
- ____7. migraine
- ____8. frequent and severe
- ____ 9. Head feels heavy
- ____10. Lightheadedness
- ____11. Fainting
- ____12. Face flushed
- ____13. Loss of memory
- ____14. Eye strain
- ____15. Light bothers eyes
- ____16. Blurred vision
- ____17. Double vision
- ____18. Loss of vision
- ____19. Loss of balance
- ____20. Dizziness
- ____21. Loss of hearing
- ____22. Pain in the ears
- ____23. Ringing in the ears R L
- ____24. Buzzing in the ears R L
- ____25. Loss of taste
- _ 26. Loss of smell
- 7. Sinus trouble

NECK:

- ____30. Neck pain
- ____31. Neck stiffness
- ____32. Neck pain and stiffness
- ____33. Moderate to severe neck pain
- ____34. Neck pain with movement
- ____35. forward
- ____36. backward
- ____37. turning to the left
- ____38. turning to the right
- ____39. bending to the left
- ____40. bending to the right
- ____41. Pinched nerve in the neck
- ____42. Neck feels "out of place"
- ____43. Muscle spasms in the neck
- ____44. Grinding sounds in the neck
- ____45. Arthritis in the neck

HOULDERS:

- ____50. Pain in shoulder joint R L
- ____51. Pain across shoulders
- ____52. Pain between shoulder blades
- ___ 53. Stiffness in shoulder R L
- '. Tension in the shoulders
- _ 5. Pinched nerve - shoulder R L
- ____56. Muscle spasms - shoulder R L
- ____57. Unable to raise arm R L
- ____58. above shoulder level R L
- ____59. over head R L

ARMS & HANDS:

- ____65. Pain in the upper arm R L
- ____66. Pain in the elbow R L
- ____67. Tennis elbow R L
- ____68. Pain in forearm R L
- ____69. Pain in hands R L
- ____70. Pain in fingers of R L hand
- ____71. Sensation of pins & needles in the arm R L
- ____72. Sensation of pins & needles in the fingers R L
- ____73. Numbness in arms R L
- ____74. Numbness in fingers R L
- ____75. Fingers go to sleep R L
- ____76. Hands get cold
- ____77. Swollen joints in fingers
- ____78. Stiffness in fingers R L
- ____79. Loss of grip strength R L

MID-BACK:

- ____82. Mid-back pain
- ____83. Mid-back stiffness
- ____84. Mid-back pain and stiffness
- ____85. Mid-back muscle spasms
- ____86. Pain in kidney area

CHEST:

- ____90. Chest pain
- ____91. Shortness of breath
- ____92. Pain around the ribs
- ____93. Breast pain
- ____94. Irregular heartbeat

ABDOMEN:

- ____100. Nervous stomach
- ____101. Nausea
- ____102. Gas
- ____103. Constipation
- ____104. Diarrhea
- ____105. Hemorrhoids

LOW BACK:

- ____110. Low back pain
- ____111. Low back stiffness
- ____112. Low back pain and stiffness

Low back pain is worse when:

- ____114. working
- ____115. lifting
- ____116. stooping
- ____117. standing
- ____118. sitting
- ____119. bending
- ____120. coughing
- ____121. lying down (sleeping)
- ____122. walking

____125. Low back feels out of place

____126. Muscle spasms in low back

HIPS, LEGS & FEET:

- ____130. Pain in buttocks R L
- ____131. Pain in the hip joint R L
- ____132. Pain down the leg R L
- ____133. Pain down both legs
- ____134. Leg cramps R L
- ____135. Cramps in feet R L
- ____136. Knee pain R L
- ____137. inside R L
- ____138. outside R L
- ____139. Pins & needles in legs R L
- ____140. Numbness of leg R L
- ____141. Numbness of feet R L
- ____142. Numbness of toes R L
- ____143. Swollen ankles R L
- ____144. Swollen feet R L
- ____145. Feet feel cold

WOMEN ONLY:

- ____150. Menstrual pain (where) _____
- ____151. Menstrual cramping
- ____152. Irregular period
- ____153. Abnormal discharge
- ____155. Tumors

MEN ONLY:

- ____160. Urinary frequency
- ____161. Difficulty in starting urination
- ____162. Night urination
- ____163. Prostate pain/swelling

GENERAL:

- ____170. Anxiety
- ____171. Nervousness
- ____172. Irritable
- ____173. Difficulty in prolonged riding in an automobile
- ____174. Depression
- ____175. Fatigue
- ____176. Generally feel run down
- ____177. Difficulty sleeping
- ____178. Loss of weight _____lbs.
- ____179. Gain weight _____lbs.
- ____180. Excessive perspiration
- ____181. Pallor
- ____182. Tremors

Write in your own symptoms: _____

_____

_____

_____

_____

_____

_____

_____

_____

Please use the following key to accurately mark the areas in which you feel the described sensations. Use the appropriate symbols and include all affected areas.

Dull NNN

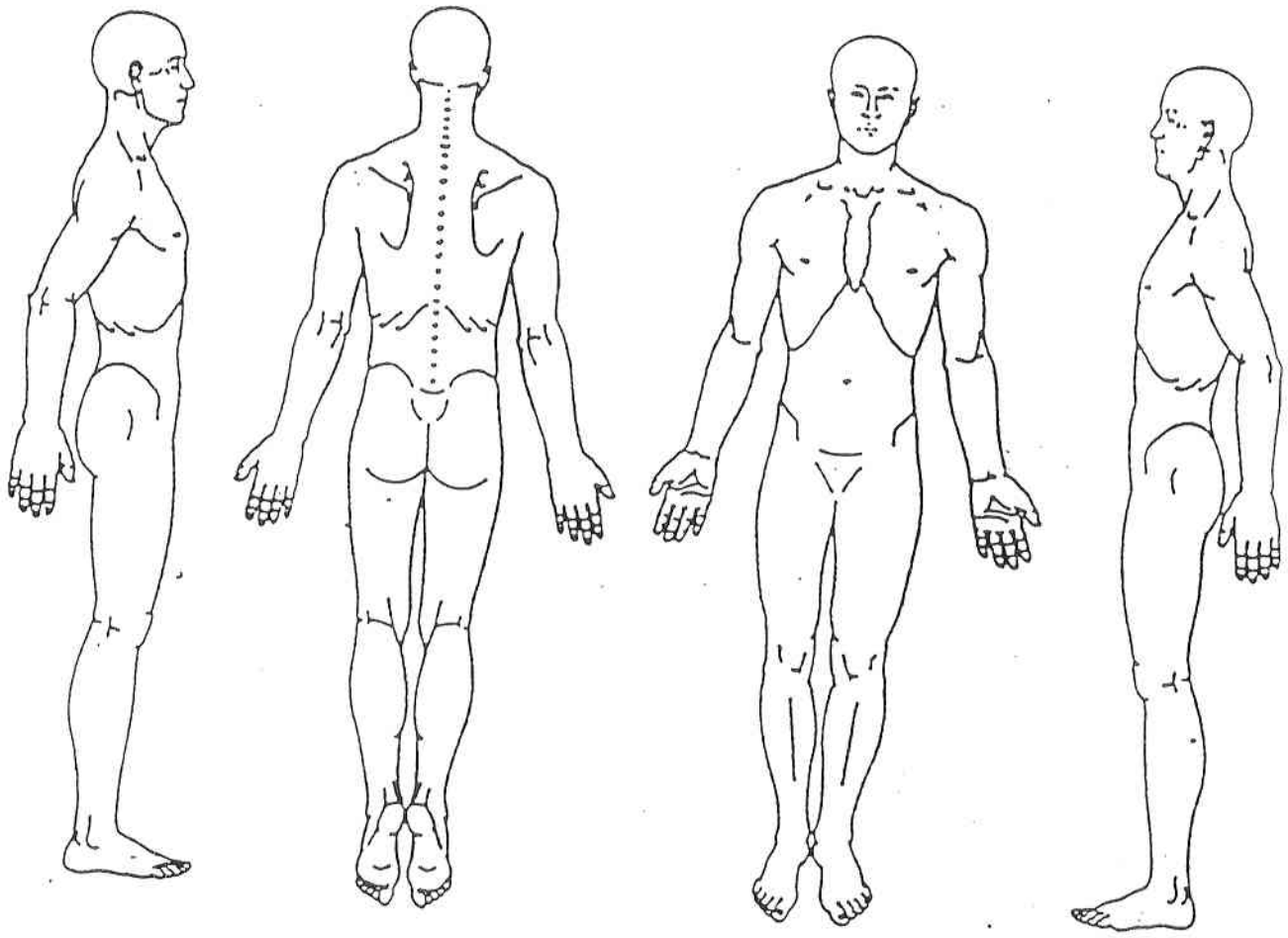
Stabbing/Cutting /// /// ///

Burning XXX

Numb = = =

Tingling (Pins & Needles) : : : : : : : : : :

Cramping SSS



Please rate your pain using the following scale: (0 = no pain and 10 = worst possible pain)

	0	1	2	3	4	5	6	7	8	9	10
Current pain intensity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Average pain intensity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Worst pain intensity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

FINANCIAL POLICY – GENERAL HEALTH OR MANAGED CARE

This office will file your claims for you with the understanding that you are fully responsible in ensuring that Dr. Johnson and Hillsboro Chiropractic Clinic gets paid. It takes at least 45-60 days for this office to get payment on each day of service. We will follow-up and re-submit until payment or final denial is received. At which time, you will be responsible for the balanced owed. It is advisable that you contact your carrier within 45 days to check the status of your claim.

Your coverage is a contract between you and your carrier. You will be responsible for deductibles, co-pays, con-insurance and any denied services due to policy limitations. Some services performed in this office may be applied to your deductible; such as physical therapy or massage therapy. Your carrier applies these services at their discretion and we are not fully aware of this until an Explanation of Benefits (EOB) is received in our office. You may also have co-pay and a co-insurance, again this in contained within your insurance contract.

Upon verification of your coverage, the disclaimer stated by the insurance stated by the insurance company does not guarantee payment. Sometimes we are told that you have specific benefits and when the EOB is sent to this office, your claim is paid differently depending upon how your carrier apples your chiropractic charges. This will correspond to any additional amount owed to this office and a statement will be mailed. If your claims are denied due to policy limitations, you will be responsible for all services performed.

Patient billings are sent out monthly. Due to re-file of claims, you may not receive a bill every month. When all attempts at getting your claim paid have been exhausted, you are then billed for the balance.

The level of service in regards to examinations, x-rays, manipulations (determined by regions), therapy, supports and supplements will be determined and prescribed during your initial and follow-up visits by Dr. Johnson. Each patient is treated on an individual basis and will receive a different level of service and treatment plan. As part of your recovery, you will need to keep scheduled appointments and will need to do home exercises and treatment as designated by Dr. Johnson.

Payments plans can be set up at any time so that you will not have to stop treatment due to policy limitations.

I have read the above financial policy and acknowledge my obligations.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical modalities and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and informed that, as in the practice of medicine, the practice of chiropractic posses some risks to treatment, including, but not limited to, fracture, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. Therefore, I wish to rely on the Doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, and is in my best interest.

I have read, or have read to me, the above consent I have also had and opportunity to ask questions about its content, and by signing below 1 agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

All charges incurred at Hillsboro Chiropractic Clinic are my total Responsibility regardless of payment by my insurance policy or not.

If this account is placed with an attorney for collection, I am aware of having additional attorney fees added. If the attorney should have to pursue litigation, I also understand I will be responsible for additional court cost or attorney fees.

Print Patient's Name: _____

Patient's Signature: _____

Patient's Representative's Signature: _____

Date Signed: _____/_____/_____

HIPAA Notice of Privacy Practices

Hillsboro Chiropractic Clinic

211 East Franklin Street
Post Office Box 706
Hillsboro, Texas 76645

(254) 580-0701

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 or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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 activities, employee review activities, training of medical students, licensing, 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.

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, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

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 this 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

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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 for the purposes of treatment, payment or healthcare operations. 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.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications 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 may have the right to have your physician amend 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 we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____