Cedar Park Sports and Wellness

Full Name:_____ Date:_____

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

Home Ph: (____)_____ Work Ph: (____)_____ Cell Ph: (____)_____

Email:_____ Gender: M F Birthdate:____/____/____ Age:_____

Social Security #:_____-_____-_____ Marital Status: M S D W Spouse Name:_____

Family Doctor:_____ City:_____ Phone #:_____

Occupation:_____ Employer:_____

Emergency Contact:_____ Emergency Ph:( )_____

How did you find us? Internet/Website Location Other health care provider(name)_____

Community Event (screening, seminar, health fair, massage event) Family/Friend (name)_____

Welcome to our practice, offering chiropractic, rehabilitation and nutritional counseling. Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties which we deem on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. We encourage questions and/or concerns, so please direct all questions to a member of our staff. As a courtesy to you, we may call/text you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or contact, you please let us know in writing for your file.

Informed Consent

I understand that this facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, exam or doctor's care, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I further understand that in the practice of chiropractic, nutritional counseling, massage, physical, occupational therapy there are some risks including but not limited sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments and/or other incidents which may be short or long term or side effects which cannot be pre-determined. I do not expect the doctor, therapist or provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor and/or provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment. Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you. Therefore, I give my full consent to the doctor, therapist, provider or staff member to render treatment on me or the minor for whom I am legally responsible by a health care provider of this facility.

Female Patients Only – non-pregnancy verification for x-rays

To the best of my knowledge I certify that I am NOT pregnant. Should I become pregnant during the course of treatment I will provide that information to the Doctor. Initials

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, the facility will attempt to obtain a verification of your insurance benefits and will report them to you or assume they are accurate as they are quoted to us but some third party payers, case managers and/or attorneys misquote benefits, coverage and liability so our facility & staff are not responsible for what a third party payer, representative, case manager and/or attorney may tell us. Any and all contractual, written, verbal or other obligations or arrangements between you and an attorney, case manager, insurance company, liable or third party payer are between you and said person or company and do not delay your obligation to pay.

1. Our facility will file initial and secondary insurance claims for you and will accept any amounts authorized by a patient to be paid directly to Cedar Park Sports and Wellness. Additional documents or reports sent on your behalf that require charges will be billed to you.
2. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
3. Patients are fully responsible for all charges for all service(s) and/or product(s) which may be denied or not covered for any reason by an insurance carrier, case manager, attorney and/or when a third party and/or insurance carrier does not reimburse this facility.
4. If during the course of care, you have a credit balance on your account, and would like a refund, it is the policy of this practice to refund patients any outstanding credit balance on their account within 30 days.

By my signature below I acknowledge that I have read or have had read to me and understand and agree to be irrevocably responsible for all terms and conditions. I also acknowledge that I have received a photocopy upon my request of this document and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

_____

Print Name of Patient

X

_____ _____

Signature (if minor, parent must sign) Date

Patient Name:_____

Please check the boxes that apply to any family members that have these symptoms below

Problem	Spouse	Child #1	Child #2	Child #3
Headaches				
Neck/Back Pain				
Stiff Joints				
Posture Issues				
Numbness				
Tingling				
Muscle Spasm				
Scoliosis				
Car Accident				

HOSPITALIZATIONS

TYPE	DATE
1.	
2.	
3.	

SURGERIES

TYPE	DATE
1.	
2.	
3.	

INJURIES

TYPE	DATE
1.	
2.	
3.	

Please list any medications you are taking:_____

Social History

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

Do you experience any (circle any) sleep Issues fatigue balance problems memory loss

Do any of your immediate family have: Neck/Back Pain, Headaches, Posture Issues, any Car Accidents

Do you have any family History of (circle any): Heart Disease Cancer Diabetes

General Health History

Please check any of the conditions below that currently (C) affect you or that you have experienced in the past (P):

MUSCULOSKELETAL

___stiff joints
___neck/shoulder/arm pain
___muscle pain

CARDIOVASCULAR

___high blood pressure
___chest pain
___heart attack
___stroke

Eyes, Ears, Nose, Throat

___Tinnitis
___Sinus Pressure
___Hearing Loss

RESPIRATORY

___asthma
___difficulty breathing
___sinus problems
___emphysema

GASTROINTESINAL

___abdominal Pain
___nausea
___vomiting
___constipation
___diarrhea

NEUROLOGICAL

___parkinson's disease
___bell's palsy
___spinal cord injury
___paralysis
___seizures

Cedar Park Sports and Wellness NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call (512) 257-9500 and you may make an appointment with our receptionist within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Cedar Park Sports and Wellness ***NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…***

I have received a copy of Cedar Park Sports and Wellness Patient 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 right to amend this "Notice of Privacy Practice" at a 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 and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name	DOB	HR#

Patient's Signature	Date

Witness	Date