

WOODWARD CHIROPRACTIC
CONFIDENTIAL PATIENT INFORMATION FORM

Date: _____ Gender: M or F

Name: _____ Email: _____

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

Home Phone: _____ Cell: _____ Work Phone: _____

Home Address: _____ City, Zip: _____

Employer: _____ Occupation: _____

Single Married Widowed Separated Divorced

Emergency Contact: _____ Daytime Phone: _____

(If Under 18) Name of Parent/ Guardian: _____ Work Phone: _____

Whom may we thank for referring you to us? _____

Patient Condition:

Describe the major complaints that brought you to our office: _____

Approx. when did your complaint begin? Gradually / Suddenly ____/____/____ Time _____ am pm

What caused it? _____

My pain is: Forgotten with Activity Noticeable but Able to Continue Activity Prevents Certain Activities

Activities that are difficult/ painful to perform: Sitting Standing Walking Lying Down
 Bending Turning Twisting

Does it affect your: Work Sleep Recreation Daily Routine

Has there been any change in the following since the onset of your complaint: No Change to Any of These

Balance Coordination Grip Weakness Breathing
 Hearing Vision Digestion Weight Menstrual
 Coughing Sneezing Urination Bowel Habits Sexual

Systems Review:

Are you currently having problems with any of the following? No Problems with Any of These

Skin/ Hair/ Nail Mouth/ Throat Nose/ Sinus Allergy/ Immunity
 Heart/ blood vessel Blood/ Lymph nodes Chest/ Lung Eye
 Arthritis/ Osteoporosis Glands/ Hormones Digestive Ear
 Prostate/ Testicular/ Vaginal Kidney/Bladder

Females only

Chance you are Currently Pregnant Breast problems Birth Control Pills (*check if taken ever*)

Past Medical History:

Has this condition occurred before? Yes No If yes describe: _____

Have you seen another doctor for this condition? Yes No Who? _____

Treatment Received Medication Surgery Physical Therapy Chiropractic Other: _____

Previous Chiropractor: Dr. _____ Phone: _____ Date of last visit? _____

Current Family Physician: Dr. _____ Phone: _____ Date of last visit? _____

May we communicate with your family doctor about your diagnosis/ treatment / progress in our office? Yes No

What **vitamins / over-the counter medications** are you taking? _____

What **prescription drugs** are you taking? _____

List any diseases you've had in the past **including childhood diseases**: _____

Tell us if you have been **diagnosed** as having a particular condition, such as diabetes, cancer, AIDS, etc: _____

List any **surgeries** you've had (ie. Appendix, tonsils, ear tubes, wisdom teeth, etc): _____

Hospitalizations other than those listed above? _____

List any physical **injuries** such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprain/strains, dislocations, and/or broken bones: _____

Family History:

List any diseases/ conditions that are common among your family members: _____

Lifestyle:

How often do you?

Exercise:	_____ per _____	Sit at a desk:	_____ Hrs/day
A lcohol:	_____ per _____	Work on the phone:	_____ Hrs/day
Tobacco:	_____ per _____	Work on a computer:	_____ Hrs/day
Coffee/ Caffeine Drinks	_____ per _____	How old is your bed's mattress?	_____ Yrs

Consent:

I do hereby request and authorize Dr. Jonathan Woodward DC, associates, or assistants to perform examination and diagnostic procedures on me, or the person for which I am acting as guardian, for the condition(s) described above. I certify all the above questions have been answered truthfully to the best of my knowledge, and do not hold the doctor or clinic responsible for any harm caused due to my failure to disclose information requested on this form that would have otherwise altered their diagnosis and plan of care.

I understand that they have the right to refuse to accept me (or said minor) as a patient at any time before treatment begins. The taking of a history, the conducting of a physical examination, and the performance of any diagnostic procedures, are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

Signature of Patient/ Parent / Guardian

Date

OFFICE USE ONLY

S: _____ Q: _____ I: _____ / _____
O: _____ T: _____
R: _____ Pa: _____ Pr: _____

S: _____ Q: _____ I: _____ / _____
O: _____ T: _____
R: _____ Pa: _____ Pr: _____

HIPAA & Our Privacy Pledge

At Woodward Chiropractic we are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to disclose your health information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition;
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services;
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing and mailed to 5353 Alpha Rd Ste 110A, Dallas, TX 75240, Attn: Dr Jonathan Woodward. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I also acknowledge that I have been offered a copy of this notice.

Printed Name of Patient / Personal Representative

Date

Signature of Patient / Personal Representative

Description of Representative's Authority



Financial Policy

Patients are responsible for payment at the time of service. We accept cash, check, Visa, MasterCard, Discover and American Express.

We are contracted providers with many insurance plans and will accept assignment of benefits. As a courtesy, we will file all claims, including secondary insurance, to the plans with which we participate. Please inform us of any special requirements in your plan.

You are responsible to pay for any co-payments, co-insurance and/or deductibles at the time of each visit. Many chiropractic procedures go toward your deductible. Please be aware that we will collect an estimated payment for these procedures at the end of each visit (please refer to our Price List for details). Should your insurance pay these procedures in full, we will refund your payment upon receipt of your insurance payment. You are required to pay the deductible or co-insurance amounts designated by your insurance company. If your insurance company denies your bill, you will be billed directly for those services and are held financially responsible.

In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We encourage our patients to understand their policy and to contact their plan for clarification of benefits prior to services being rendered.

In addition, if you have coverage with an insurance plan that we do not contract with, we will prepare a receipt for you at the time of service with all the necessary information needed for you to file the claim. All charges for your care and treatment are due at the time of service for these health plans.

You must inform the office of all insurance charges, authorization referral requirements, and address changes. In the event the office is not informed before care is rendered, you will be responsible for any charges that are denied.

In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of the costs, it is the authorizing parent's responsibility to collect from the other parent.

In an effort to serve our patients in a timely manner, we ask that you are on time for your scheduled appointment. In an event you are running late, please call our office. If you arrive more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.

Other Miscellaneous Fees	
Cancellation, Missed Appointments and Late Arrivals	If you need to cancel an appointment, we kindly request that you allow at least 24-hours notice so that your appointment may be given to another patient who may be in need of urgent care. If we do not receive 24-hours notice there may be a \$30.00 cancellation fee billed. Patients with multiple cancellations or missed appointments also may be discharged from our practice. In an event you are running late, please call our office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.
Returned Check Fee	There will be a \$25 charge for all returned checks.
Collection Fee	If your account is turned over to our collection agency, you will be responsible for the collection fee charged to us by the agency in addition to your outstanding balance.

I have read and understand the financial policy, and I agree to be bound by its terms. I understand and agree that such terms may be amended in the future by the practice.

Signature of Patient or Responsible Party

Date

Printed of Patient

Date of Birth