AMC Chiropractic

Fill these forms out completely & bring them with you on your first appointment.

Forms:

Make sure you mark on the body pictures where you are having problems. put a star by the worst problem area.

On the symptoms sheet go thru and mark all the areas that you have problems in the Y(yes) column. Go back to all those marked yes and mark R-right, L-left, C-constant, I-infrequent, O-occasionally if they apply.

If you have questions about the forms, please call the office and we would be glad to help you.

Phone:
(806) 794-6252

PATIENT INFORMATION FORM

Do you desire lasting correction? (Y) (N)

Check here if you want the doctor to select the type of care, he feels is best. __

Date: ____/_____/_____
Age: _____
SS#: _____-_____-_____

Name: _____ DATE OF BIRTH: ____/____/____

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

HOME PHONE ( ) ____-____ OTHER PHONE: ( ) _____-_____

CHECK IF: MARRIED ___ SINGLE ___ WIDOWED ___ DIVORCED ___ SEPARATED _____

EMPLOYED? IF SO, WHERE? _____ DAYS OFF? _____

SPOUSE'S NAME: _____ # OF CHILDREN: ____ AGES: _____

SPOUSE'S EMPLOYMENT? _____ DAYS OFF? _____

EMAIL: _____ Who referred you to our office?: _____

WHO IS RESPONSIBLE FOR THE BILL? SELF __ SPOUSE __ EMPLOYER __ OTHER _____

HOW WILL PAYMENT BE MADE? CASH __ CHECK __ CREDIT CARD ____ INS

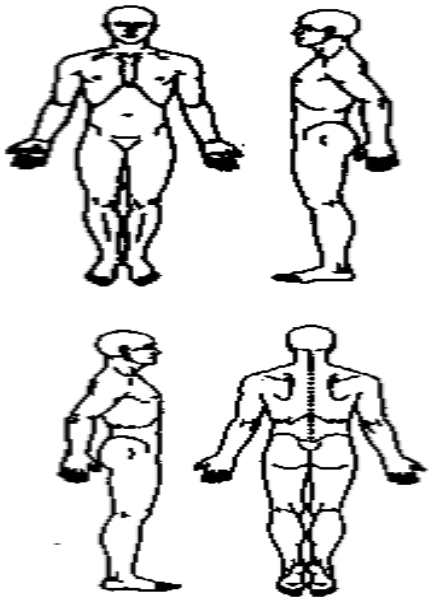
TPYE OF INSURANCE: WORKERS COMP __ HEALTHIER INSURANCE __ CASH ___ AUTOMOBILE _____

NAME OF INSURANCE COMPANY: _____

POLICY#: _____ PHONE NUMBER: ( ) _____-_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAM BELOW:



PRIMARY COMPLAINT: _____

_____

_____

SECONDARY COMPLAINT: _____

_____

_____

OTHER COMPLAINT(S): _____

_____

_____

_____

HOW DID THIS CONDITION DEVELOP? _____

_____

_____

WHEN DID YOU FIRST NOTICE THE PROBLEM? ____

_____

_____

HAST IT BECOME: BETTER __; WORSE __; SAME __

WHAT MAKES YOUR CONDITION WORSE? _____

WHAT MAKES YOUR CONDITION BETTER? _____

CURRRENT MEDICATION TAKING: PAIN KILLERS __ MUSCLE RELAXERS __ *PEP PILLS __

TRANQUILIZERS __ INSULIN __ BIRTH CONTROL PILLS __ NONE __ OTHER (PLEASE LIST BELOW)

_____

_____

HAVE YOU CONSULTED A CHIROPRACTOR BEFORE? ___: NAME: _____

DATES: _____ WHY? _____

ANY MEDICAL DOCTORS OR OSTEOPATHS? ___: NAME : _____

FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation

Patient: _____

Please Review the below-listed diseases and conditions and indicate those that are recurrent health problems of a family member. Leave blank those that do not apply. If you require more space, use the reverse side of this form. Circle you answers if your relative lives around this locality, as some hereditary conditions are affected by similar environments.

CONDITION	FATHER Age ( )	MOTHER Age ( )	SPOUSE Age ( )	BROTHER(s) Age ( ) Age ( )		SISTER(S) Age ( ) Age ( )		CHILDREN Age( ) Age( ) Age( )		
Arthritis										
Asthma_Hay Fever										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disk Problem										
Emphysema										
Epiplepsy										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Neuralgia										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										

If any of the above family members are deceased, please list their age at death and cause:

_____

_____

PAST SURGERIES: __ DATE: _____ EXPLAIN: _____

PAST SERIOUS INJURIES __ DATE: ___ EXPLAIN: _____
PREVIOUS BROKEN BONES: ____ DATE: _____ EXPLAIN: _____
KNOCKED OUT? ___ DATE: ____ EXPLAIN: _____
PREVIOUS AUTO ACCIDENT: ___ DATE: _____ EXPLAIN: _____
WORK RELATED INJURIES: ____ DATE: _____ EXPLAIN: _____
DO YOU?
SLEEP WELL: (Y) (N)
EASILY TIRE: (Y) (N)
FEEL LOVED BY YOUR FAMILY: (Y) (N)
LIKE YOURSELF: (Y) (N)

ARE YOU OVERWEIGHT? __ ARE YOU UNDERWEIGHT? __
LAST MEAL: _____ WHEN? __:__
LAST BOWEL MOVEMENT: _____

FOR WOMEN:
LAST MENTRUAL CYLCE: __/__/__ ANY CHANCE OF BEING PREGNANT? ____
PRIOR MISCARRIAGES: ____ DATES(S): _____
DO YOU OR HAVE YOU HAD ANY BREAST OR OTHER IMPLANTS? (Y) (N) SPRECIFY: _____

IF YOU ANSWER IS NO/NONE/NOT APLICABLE: LEAVE BLANK, IF YOUR ANSWER IS POSITIVE, PLEASE CHECK THE APPROPRIATE BOX:
L-LEFT SIDE; R-RIGHT SIDE; C-CONTSTANT; I-INFREQUENT; O-OCCASIONALLY; Y- YES

HEAD	L	R	C	I	O	Y			L	R	C	I	O	Y
HEADACHE								ANKLE SWOLLEN						
MIGRAINE								ULCERS						
BLURRED VISION								UPSET STOMACH						
JAW PAIN/CLICKING								A-AFTER EATING						
RINGING IN EARS								B-ACID IN THROAT						
ITCHING SCALP								C-FEEL BLOATED						
SINUS PROBLEMS								DIARRHEA						
HAY FEVER								CONSTIPATION						
CONCENTRATION PROB								INTESTINAL WORMS						
SWEAT (CONSTANT)								HEMORRHOIDS						
TOOTHACHE								JAUNDICE						
TONGUE, COATED								HEPATITIS						
DIZZINESS								LIVER PROBLEMS						
KNOCKED UNCON								GALLBLADDER PROBLEM						
CONVULSIONS								CUTS SLOW TO HEAL						
MID-BACK								BOILS						
PAIN INSIDE SHOULDERS														
PAIN IN MID BACK								NUMBNESS/TINGLING IN						
ANGINA								A-ARMS						
BREAST BONE PAIN								B-LEGS						
A- OVULATION								TIRED/EXHOUSTED						
B-MENSTRATION								CONSTANT PAIN						
CHEST PAIN								POOR HEALTH						
CONGESTION								MALARIA						
HEART PAPLITATIONS								ANEMIA						
ASTHMA								SCARLET FEVER						
HEART ATTACK								DIABETES						
BRONCHITIS								GOITER						
TUBERCULOSIS								TUMOR						
COLD HANDS								CANCER						
COLD FEET								RHEUMATISM						
LEG CRAMPS								ARTHRITIS						
STOMACH CRAMPS								CHRONIC DISEASE						
								VARICOSE VEINS						
								AIDS/HIV POSITIVE						
								HEPATITIS A_B_C_						
								PNEUMONIA						

NECK	L	R	C	I	O	Y		B-DISEASE	L	R	C	I	O	Y
NECK PAIN								PAIN DOWN:						
LUMP IN THROAT								A-FRONT OF LEG						
SORE THROAT								B-BACK OF LEG						
STREP INFECTION(S)								C-INSIDE OF LEG						
MUCUS IN THROAT								D-OUTSIDE OF LEG						
TONSILLITIS								RATIATING TO:						
TROUBLE SWALLOWING								A-KNEE						
HIGH BLOOD PRESSURE								B-ANKLE						
LOW BLOOD PRESSURE								C-FOOT						
COLD FLASHES														
HOT FLASHES								**UPPER EXT**						
PAIN RADIATING TO:								PAIN IN:						
A-SHOULDER								A-BICEP						
B-ELBOW								B-TRICEP						
C-WRIST								C-SHOULDER						
D-HAND								D-ELBOW						
								E-FOREARM						
LOW BACK								F-WRIST						
LOW BACK PAIN								G-HAND						
TAIL BONE PAIN								H-THUMB						
HIP PAIN								I-FINGERS						
MENSTRUAL CRAMPS								J-TENNIS ELBOW						
VAGINAL DISCHARGE								CARPAL TUNNEL SYN						
FREQUENT URINATION														
BLOOD WITH URINATION								**LOWER EXT**						
VENEREAL DISEASE								PAIN IN:						
BLADDER OR KIDNEY								A-KNEE						
A-INFECTION								B-ANKLE						
B-DISEASE								C-FOOT						
PROSTATE:								TRICK KNEE						
A-INFLAMATION								TRICK ANKLE						
								FALLEN ARCH						
								ARCH TO HIGH						
								FALLEN TRANS ARCH						
								WEAR HIGH HEELS						
								WEAR EARTH SHOES						

I Authorize the following people to know about my medical/financial information:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ _____

PATIENT SIGNATURE DATE

CONSENT OF SERVICES

INITIAL BESIDE EACH SERVICE LISTED BELOW.

____ Chiropractic manipulation ____ X-Ray diagnostics

____ Exam procedures ____ Massage/myofascial release

____ Physical modalities (i.e., ultrasound, electric stimulation, stretch activities)

____ Active care ____ Therapeutic Exercise

I understand that chiropractic treatment is not an exact science and that there is no guarantee that the outcome of my treatment will be what I want it to be. I consent to all necessary testing and treatment while I am here at the Alternative Medicine Center. By signing this form, I fully understand the new patient procedure, its conditions, and consent to services to be performed by or on me, or my charge (if guardian is signing)

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date : _____

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize:

Dr._____

And whomever he or she may designate as assistants to administer chiropractic care as deemed necessary to my _____ (indicate relationship of child),

_____

(Name of Child)

Dated at _____ _____

(City) (State)

This _____ day of _____, 20_____

Signed: _____

(Parent or Guardian)

Witnessed: _____

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.

We are required by law to:

maintain the privacy of your Personal Health Information; provide you this notice of our legal duties and privacy practices with respect to your Personal Health Information; and follow the terms of this notice.

We protect your Personal Health Information from inappropriate use or disclosure. Our employees, and those of companies that help us service Your health care needs, are required to comply with our requirements that protect the confidentiality of Personal Health Information. They may look at your Personal Health Information only when there is an appropriate reason to do so, such as to administer our products or services.

We will not disclose your Personal Health Information to any other company for their use in marketing their products to you. However, as described below, we will use and disclose Personal Health Information about you for business purposes relating to your Health insurance coverage.

The main reasons for which we may use and may disclose your Personal Health Care Information are to evaluate and process any requests for Coverage and claims for benefits you may make or in connection with other health-related benefits or services that may be of interest to you. The Following describe these and other uses and disclosures, together with some examples.

For Payment: We may use and disclose Personal Health Information to pay for benefits under your Health Insurance coverage. For example, we may review Personal Health Information contained on claims to reimburse the Advanced Pain and Injury Centre for services rendered. We may also disclose Personal Health Information to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose Personal Health Information to a health plan or an administrator of an employee welfare benefit plan for various payment-related functions, such as eligibility determination, audit and review or to assist you with your inquiries or disputes.

For Health Care Operations: We may also use and disclose Personal Health Information for our insurance operations. These purposes include evaluating a request for Health Insurance products or services, administering those products or services, and processing transactions requested by you. We may also disclose Personal Health Information to Affiliates, and to business associates outside of the Advanced Pain and Injury Centre, if they need to receive Personal Health Information to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of Personal Health Information. Examples of business associates are: billing companies, data processing companies, Or companies that provide general administrative services. Personal Health Information may be disclosed to reinsures for underwriting, audit or claim review reasons. Personal Health Information may also be disclosed as part of a potential merger or acquisition involving our business in order to make an informed business decision regarding any such prospective transaction.

Where Required by Law or for Public Health Activities: We disclose Personal Health Information when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases or providing Personal Health Information to a governmental agency or regulator with health care oversight responsibilities. We may also release Personal Health Information to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death.

To Avert a Serious Threat to Health or Safety: We may disclose Personal Health Information to avert a serious threat to someone's health or safety. We may also disclose Personal Health Information to federal, state, or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.

For Health-Related Benefits or Services: We may use Personal Health Information to provide you with information about benefits available to you under your current coverage or policy and, in limited situations, about health-related products or services that may be of interest to you.

For Law Enforcement or Specific Government Functions: We may disclose Personal Health Information in response to a request by law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose Personal Health Information about you to federal. officials for intelligence, counterintelligence, and other national security activities authorized by law.

When Requested as part of a Regulatory or Legal Proceeding: If you or your estate are involved in a lawsuit or a dispute, we may disclose Personal Health Information about you in response to a court or administrative order. We may also disclose Personal Health Information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the Personal Health Information requested. We may disclose Personal Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

Other Uses of Personal Health Information: Other uses and disclosures of Personal Health Information not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose Personal Health Information about you, you or your legally authorized representative may revoke that authorization, in writing, at any time, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition or obtaining your Health Insurance coverage. You should understand that we will not be able to take back any disclosures we have already made with authorization.

Your Rights Regarding Personal Health Information We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your Personal Health Information. Should you have questions about a specific right, please write to the administrator of your Health Insurance coverage as follows:

Right to Inspect and Copy Your Personal Health Information: In most cases, you have the right to inspect and obtain a copy of the Personal Health Information that we maintain about you. To inspect and copy Personal Health Information, you must submit your request in writing to the applicable administrator listed above. To receive a copy of your Personal Health Information, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. However, certain types of Personal Health Information will not be made available for inspection and copying. This includes psychotherapy notes; and also includes Personal Health Information collected by us in connection with. or in a reasonable anticipation of any claim or legal proceeding. In very limited circumstances we may deny your request to inspect and obtain a copy of your Personal Health Information. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

Right to Amend Your Personal Health Information: If you believe that your Personal Health Information is incorrect or that an important part of it is missing, you have the right to ask us to amend your Personal Health Information while it is kept by or for us. You must provide your request and your reason for the request in writing and submit it to the applicable administrator listed above. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend Personal Health Information that:

is accurate and complete; was not created by us, unless the person or entity that created the Personal Health Information is no longer available to make the amendment; is not part of the Personal Health Information kept by or for us; or is not part of the Personal Health Information which you would be permitted to inspect and copy.

Right to a List of Disclosures: You have the right to request a list of the disclosures we have made of Personal Health Information about you. This list will not include disclosures made for treatment, payment, health care operations, for purposes of national security; made to law enforcement or to corrections personnel or made pursuant to your authorization or made directly to you. To request this list, you must submit your request in writing to the applicable administrator listed above. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before February 26, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on Personal Health Information we use or disclose about you for treatment. payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, we are not required to agree to it. If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing to the applicable administrator listed above. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example. disclosures to your spouse or parent). We will not agree to restrictions on Personal Health Information uses or disclosures that are legally required, or which are necessary to administer our business.

Right to Request Confidential Communications: You have the right to request that we communicate with you about Personal Health Information in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the applicable administrator listed above and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to File a Complaint: If you believe your privacy right have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact: Diana Gonzales, HIPAA Compliance Officer, Advanced Pain and Injury Centre, Institutional Business HIPAA Privacy Office, 630-C North Central Expressway, Plano, Texas 75074. All complaints must be Submitted in writing. You will not be penalized for filing a complaint. If you have questions as to how to file a complaint, please contact us at (469) 995-9907.

ADDITIONAL INFORMATION

Changes to This Notice: We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for Personal Health Information we already have about you as well as any Personal Health Information we receive in the future. The effective date of this notice and any revised or changed notice may be found on the last page on the bottom right hand comer of the notice. You will receive a copy of any revised notice from Advanced Pain and Injury Centre by mail or by e-mail, but only if email delivery is offered by Advanced Pain and Injury Centre and you agree to such delivery.

Treatments are done in open bays unless there is a procedure or consultation that needs to be done in a private room.

(Initial)

Name or Names of anyone you want to have information given to and initial beside each name.

_____

I have read, fully understand, and agree to this document.

Patient Signature_____ Date_____

AMC

Alternative Medicine Center

12402 Slide Rd. Suite 202 Lubbock, TX. 79424

806 794-6252

OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will provide invoice with the diagnostic and procedural codes to file with your insurance.
2. You are responsible for your entire bill should your insurance company not pay the anticipated charges for any reason.
3. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.
4. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.
5. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent.
6. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full expected immediately; regardless of any claims submitted.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient's Signature Date