



PATIENT HISTORY

Case# _____

PERSONAL INFO

Full Name: _____ Birthdate: _____ Age: _____

Marital Status: Single Married Divorced Widow Gender: Male Female

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

Home Phone () _____ Work () _____ Cell () _____

Employer: _____ Occupation: _____ Social Security # _____

Email: _____ Driver's Lic # _____ State: _____

Primary Doctor _____ Doctor Phone # _____

HEALTH INSURANCE INFO

Your Health Insurance Co. _____ Phone() _____

Insured Name: _____ DOB: _____ SS#: _____

Employer: _____ ID # _____ Group # _____

GUARANTOR (Person Financially Responsible)

Full Name: _____ M F Birthdate: _____ Age: _____

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

Home Phone () _____ Work () _____ Cell () _____

Employer: _____ Occupation: _____ Social Security # _____

Email: _____ Driver's Lic # _____ State: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE

- Physician Referral Family / Friend Yellow Pages Garland Chamber
- Insurance Company School / Church Internet / Website Drive By / Walk-in

If referred by an individual please write their name, so we may properly thank them. _____

Were you referred to a certain Doctor in our office? _____

Is your visit due to an accident? Yes No (if yes please see receptionist for an injury report.)

For appointment confirmations, please indicate your preference:

- _____ Text message to the cell phone listed above
- _____ Personal phone call to the phone #'s listed above
- _____ Email to the address listed above

YOUR PRESENT COMPLAINT

Briefly describe the "Chief Area of Complaint" that is concerning you most.

Describe your pain, 0 = none & 10 = unbearable: 0 1 2 3 4 5 6 7 8 9 10

About when did this problem start? _____ Since it started, is it: About the same Getting better Getting worse

Yes, it interferes with: Work Sleep Walking Sitting Hobbies Leisure

What activities are important to you that you would like to do or continue doing without pain interfering (ie..sports, gardening, hobbies): _____

Other Doctors seen for this problem in the past year: Chiropractor Medical Doctor Other

Describe any operations you've had and dates: _____

Are you taking any medication? No Yes What kind: _____

Do you have allergies? No Yes What kind: _____

How frequent do you take: Coffee _____ [↑]Day [↑]Week [↑]Month Tea _____ [↑]Day [↑]Week [↑]Month Alcohol _____ [↑]Day [↑]Week [↑]Month

Tobacco _____ [↑]Day [↑]Week [↑]Month Sugar _____ [↑]Day [↑]Week [↑]Month Dairy _____ [↑]Day [↑]Week [↑]Month

Are you allergic to any medication? No Yes What kind: _____

Are you Pregnant? Yes No Date of last menstrual period: _____

Please check all symptoms you have ever had, even if they do not seem related to your current problem:

- Headache
- Neck pain
- Neck stiff
- Sleeping problems
- Back pain
- Nervousness
- Tension
- Cancer
- Arthritis
- Fibromyalgia
- Irritability
- Chest pain
- Dizziness
- Diabetes
- Pins & needles in arms
- Pins & needles in legs
- Numbness in fingers
- Muscular dystrophy
- Scarlet fever
- Concussion
- Numbness in toes
- Shortness of breath
- Fatigue
- Light bothers eyes
- Loss of memory
- Ears ring
- Rheumatic fever
- Asthma
- Epilepsy
- Face flushed
- Buzzing in ears
- Loss of balance
- Fainting
- Loss of smell
- Loss of taste
- Diarrhea
- Sinus trouble
- Convulsion
- High blood pressure
- Feet cold
- Hand cold
- Stomach upset
- Constipation
- Cold sweats
- Fever
- Multiple Sclerosis
- Polio
- Tuberculosis
- Heart trouble

Symptoms other than above: _____

I understand and agree that health and accident insurance policies are in arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable, unless prior arrangements are made. I hereby authorize the doctors at Achieve Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that all the above information is true and correct.

Patient/Guardian Signature

Date

Dr. Initials



ASSIGNMENT of BENEFITS

Instruction for direct payment to Health, Group Accident, Personal Injury Protection, Third Party, and/or Attorney

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Achieve Chiropractic
1606 Wynn Joyce
Garland, TX 75043

If my current policy prohibits direct payment to Doctor Darcy Brunk, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

SEE ABOVE ADDRESS

This check is for the professional or chiropractic expense benefits allowable, and otherwise payable to me under my current insurance policy. By sending this check to the above address it will serve as payment toward the total charges for professional services rendered to me.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over, and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated this _____ day of _____ 20____.

Signature of Patient or Legal Guardian

Print Name of Patient



HEALTHCARE AUTHORIZATION FORM

Patient's Name _____

Patients SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES ACHIEVE CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to Achieve Chiropractic to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.

OPEN THERAPY ROOM

I give Achieve Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving Achieve Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Achieve Chiropractic The written notice must contain the following information:

Your name, Social Security number and date of birth; A clear statement of your intent to revoke this AUTHORIZATION; The date of your request, and your signature.

The revocation is not effective until it is received by the Privacy Official.

Signature of Patient _____
Date

Signature of Personal Representative _____
Description of Representative's Authority To Act for Patient

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operation

Patient Signature _____
Date



Achieve Chiropractic HEALTH ASSOCIATES, LLC

1606 Wynn Joyce - Garland, Texas 75043
Tel: (972) 303-0683 - Fax: (972) 303-9683

PATIENT AGREEMENT

The purpose of this agreement is to outline our office policies and procedures so that we can serve you better and you can achieve the best results in the shortest amount of time. It is our experience that those who follow these policies do in fact get optimal results!

SIGNING IN

When you arrive, please sign in. You will be given your travel card and please proceed to the adjusting room, place the travel card in the next available spot just outside the room and begin the visit as instructed.

Initials

SCHEDULES

Your treatment plan will require you make and keep a specific schedule of adjustments, personally tailored for your needs. It is critical that you adhere to your recommended schedule in order to correct your spine and enhance your overall health! Any deviations from the schedule could result in a longer treatment plan or less than ideal results. If an emergency arises and you have to reschedule an appointment, please call the office within 24 hours. Your account will be charged a \$25.00 cancellation fee if 24 hours notice is not given.

Some patients are required to make a significant commitment of time in order to receive the care needed to properly align the spine and increase the quality of life.

SCHEDULE YOUR LIFE AROUND YOUR HEALTH, NOT YOUR HEALTH AROUND YOUR LIFE!

Initials

APPOINTMENT TIMES

In an effort to reduce the amount of time you need to be in our office, we will set specific appointment times for your adjustments. Please be prompt to all appointments, as the doctor has set aside this time specifically for you. If you're late, we will fit you in as quickly as possible, but you may have a slight delay in care. We value your time and want to get your adjustment quickly to allow you to proceed with your day. If you wish to sit down and talk to the doctor about your case, please let our front desk know and we can allot more time for you.

Initials

PAYMENTS

We expect you to honor your financial agreement with this office. In order to serve you better, please make all payments at the front desk before your adjustment. Settlement of your services is expected within three months. If an insurance payment has not been received, and a payment agreement has not been established within 3 months, or if you have suspended or terminated your care without your doctor's approval, payment for services is due immediately. In the event that you have not made official payment arrangements, Achieve Chiropractic reserves the right to process a transaction on your behalf to settle unpaid balances greater than 90 days. Please be aware that we will attempt to contact you prior to initiating this transaction. After 90 days all accounts that do not have financial arrangements will be referred to the collection agency of our choosing for collections and you may be liable for all costs of collection which may include attorney fees, plus a late fee of 18% per annum. Ultimately services received are your responsibility. Please ask our staff if you need additional details regarding insurance carrier or private payments.

Initials

COMMUNICATION

We are here to serve you! Patient communication and feedback is important to us. It helps us improve our processes and make your treatment more efficient and effective. Please communicate directly with your Doctor any situation that you feel needs attention (i.e. waiting times, customer service, care plans, adjustments, etc.). Your criticism or praise will help us to help you as well as other patients.

Initials

CASH PAYMENT POLICY

We request that 100% of the first visit be paid at the time of service. For your convenience, future payments may be made at the first visit of each week. We accept Visa, MasterCard, Discover, cash and personal checks. We also have Care Credit, and auto debit plans are available which offers additional payment options.

Initials

MAJOR MEDICAL /GROUP INSURANCE

We want to help you get the most benefits out of your insurance coverage. In order to facilitate this, please complete the information regarding your insurance policy and make sure the front desk gets a copy of your insurance card. Co-payments and co-insurance payments are due at the completion of your medical visit.

Initials

AUTO ACCIDENT/PERSONAL INJURY

You are responsible for reporting your accident to the insurance company and insurance agent. You are also responsible for obtaining the Personal Injury Protection Forms and an address and point of contact at your insurance company in order to submit statements. If your Personal Injury Protection policy does not cover the full-billed amount you have the right to retain an attorney but are responsible for keeping up with monthly payments of \$200.00 until your account is settled. Please plan to reclaim expenses through your attorney if your case is not settled within 6 months of your first visit.

Initials

WORKER'S COMPENSATION

If your care is related to an on the job injury, you must report your injury to your supervisor and make sure a claim has been initiated before you receive care at our office. Also, you must request that your employer notify his/her insurance company that you are under care at our office and that the Employer's First Report of Injury has been completed and sent to the Workers Compensation Insurance Company and the Texas Division of Workers Compensation. If your injury is deemed non-compensable, you are responsible for the balance.

Initials

MEDICARE

Medicare will cover 80% of each of your visits after your deductible is met. Medicare does not pay for therapy, examinations, or maintenance care or x-rays. You are responsible for paying \$60.00 for initial and Reexaminations and X-Rays.

Initials

I, (PRINT NAME) _____, UNDERSTAND THE ABOVE

POLICIES AND AGREE TO ABIDE BY THEM.

SIGNATURE _____ DATE: _____