TROPHY CLUB CHIROPRACTIC
501 TROPHY LAKE DR. SUITE 322
TROPHY CLUB ,TX 76262

PATIENT INFORMATION

PATIENT NAME

Last Name_____ First Name _____Middle_____

Gender: M F Date of Birth____/_____/_____ Age_____ SS#_____-_____-_____

Home Address _____

City _____ State _____ Zip_____

Home Phone_____ Cell Phone_____/Carrier_____

Email_____

Employer Name _____Phone_____

Employer Address_____

INSURANCE INFORMATION

PERSON WHO HOLDS INSURANCE OR PARENT

Last Name_____ First Name_____ Middle_____

Employer Name_____ Phone_____

Employer Address_____

Date of Birth_____/_____/_____ SS#_____-_____-_____

EMERGENCY Name and address *of* nearest relative or friend not living with you

Last Name _____ First Name _____Middle _____

Home Phone _____ Cell Phone _____ Work Phone _____

Relation to Patient _____

MY CERTIFICATION

I certify that the above information is correct and I request services.

X_____ _____
Signature of patient or person acting on patient's behalf Date

MY PRIVACY

I have received a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payors; Conduct normal healthcare operations such as quality assessments and accreditation.

Trophy Club Chiropractic

Assignment of Benefits & Notice of Privacy Practices

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card. By signing below, I acknowledge that I have received and reviewed the Trophy Club Chiropractic's Notice of Privacy Practices in force as of April 14,2003 and all of my questions have been answered to my satisfaction in language that I can understand.

Signed: _____ Date:_____

Relationship to patient: _____

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to Trophy Club Chiropractic for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing.

Signed:_____ Date:_____

Primary Care Physician Information

We'd like to send your primary care physician a summary of the care we are providing for you. Please provide your doctor's:

Name:_____

Street: _____

City: _____ State:_____ Zip: _____

Office Telephone #: _____

How did you hear about Trophy Club Chiropractic?_____

_____

_____

_____

Trophy Club Chiropractic
NOTICE OF PRIVACY PRACTICES

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.

Trophy Club Chiropractic is committed to maintaining the privacy of **your PROTECTED HEAI.THL INFORMATION ("PHI").** PHI includes information about your health condition and the care and treatment you receive from Us. The Creation of a record detailing the care and services You receive helps this office to provide you with quality health care. We are required by law to maintain the privacy of PHI and to provide our patients with notice of our legal duties and privacy Practices with respect to PHI.

PERMITTED DISCLOSURES

We are permitted by law to use and disclose your PHI for the following purposes:

Treatment- In order to provide you with the health care you requite, we will provide your PHI to other health care professionals directly involved in your care so that they may understand your health condition and needs. For example, a Physician treating you for lower back pain may need to know the results of your latest examination in this office.

Payment— In order to get paid for services provided to you, we will provide your PHI, directly or through a billing service, to appropriate third party payors, according to their billing and payment requirements. For example, we may need to provide the Medicare program with information about healthcare services you received from us so that we can be properly paid. We may also need to tell your insurance company about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

Health Care Operations— In order for us to operate in accordance with applicable law and insurance 'requirements and to continue to provide quality and efficient care, it may be necessary for us to compile, Use and/or disclose your PHI: For, example; we and any health plans involved with· your care may use your PHI in order to evaluate the performance of our personnel in providing care to you.

Appointment Reminders- It is our practice to contact you to provide appointment reminders. We use the following appointment reminders; a) a postcard mailed to you at the address provided by you; and b) telephoning your home and/or work and leaving a message on your answering machine or with an individual answering the phone.

Family Notification— We may disclose your PHI to your family member, other relatives, a close Personal friend, or any person designated by you, to the extent that person is involved with your care or the payment for your care.

Workers' Compensation— We may disclose your PHI as necessary to comply with State Workers' Compensation Laws

Emergencies— We may disclose your PHI to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or your death.

Public Health— As required. by law, we may disclose your PHI to public health authorities for purposes related to: preventing or controlling disease, Injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and, reporting disease or infection exposure.

Judicial and Administrative Proceedings- We may disclose your PHI in the course of any administrative or judicial proceeding in response to a court order or a lawfully issued subpoena. **-**

Law Enforcement — We may disclose your PHI to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Public Safety— It may be necessary to disclose your PHI to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public\

Specialized Government Agencies- We may disclose your PHI for military, national security, prisoner and government benefits purposes.

Business Associates— We may disclose your PHI to a business associate that has provided us with Satisfactory written assurance that it will properly safeguard any. PHI we provide. A business associate is an entity that assists us with some essential function, such as a billing company that assists us with submitting claims for payment to insurance companies or other payers.

AUTHORIZATION

Any other uses and disclosures of your PHI by us will only be made with your written authorization. You may revoke your authorization in writing and we are required to honor and abide by your request with regard to our handling of your PHI after the date we have received your request

YOUR RIGHTS

You have the following rights, which you can exercise by presenting a written request to our Privacy Officer, Griselda Medrano.

- You have the right to request restrictions on certain uses and disclosures of your PHI. Please be advised, however, that we are not required to agree to a requested restriction.
- You have the right to request that communications regarding your PHI be received or sent by an alternative method and/or sent to an alternative location than is our normal practice. We will accommodate all reasonable requests.
- You have the right to inspect and copy your PHI. We may charge a reasonable fee to copy any records you have requested.
- You have the right to request that we amend your PHI. Please be advised, however, that we are not required to amend your PHI. We will provide an explanation to you in writing if we decline to amend PHI as you have requested.
- You have the right to receive an accounting of any disclosures of your PHI made by our office.
- You have the right to request a paper copy of this notice.
- You have the right to complain to us about our handling of your PHI. If you are not satisfied with our handling of your complaint, you may complain to the Secretary of the federal Department of Health and Human Services.

This notice is effective as of February 1, 2017. Trophy Club Chiropractic reserves the right to change the terms of this Privacy Notice and to make the new terms applicable to your PHI so long as we have provided you with advance notice of our revised Privacy Notice and have obtained your signature accepting its terms

I have received and reviewed this Privacy Notice, have had any questions I may have about it explained to my satisfaction and understand my rights as set forth in this notice.

_____

Patient Name — Please Print)

_____ _____

(Signature of Patient or Legally Authorized) (Relationship to Patient) (Date)

TROPHY CLUB CHIROPRACTIC
501 Trophy Lake Dr. Suite 322
Trophy Club, TX 76262

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are Certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

1 do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment I intend for this consent to cover the entire course, of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Sign only after you understand and agree to the above.

_____
Printed name of Patient

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Representative
(if patient is a minor or handicapped) **Date**

_____ _____
Witness to Patient's Signature **Date**

TROPHY CLUB CHIROPRACTIC

Effective Immediately

Cancellation/No Show Policy

Due to the limited number of appointments available, please honor our 24-hour cancellation policy. We understand that there are emergency situations, and ask for at least 4-hours notice during those times; otherwise we will implement the $10 cancellation fee.

The first late cancellation or NCNS* will be waived. In the event of an additional late cancellation or NCNS* there will always be the option to reschedule for a different day, after paying the $10 cancellation fee. By signing, the patient agrees to the terms listed above.

Thank you for your understanding.

*** - No call/ no show**

Patient Signature_____

Date_____