Patient Health History

Today's Date _____ **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

Please PRINT

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____**Suffix** _____

Mobile Phone_____**Home Phone** _____

Secondary Contact _____(PH #)_____❑ Spouse ❑ Parent ❑ Other____

Home email _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Contact Method *(check one)* ❑ Mobile Phone ❑ Home Phone ❑ Secondary Phone ❑ Home Email

Date of Birth _____ **Age** _____ Gender *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one for patio)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check all that apply)*

❑ Black/African American ❑ Caucasian ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other_____❑ I choose not to specify

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Other_____ ❑ I choose not to specify

Street Address _____

Zip Code _____ **City/ State** _____

Mailing Address (If different than street address) _____

Zip Code _____ **City/ State** _____

❑ **OUT OF POCKET/ NO INSURANCE:** By checking this box I understand that I am financially responsible for all services at the time they are rendered. If someone other than the patient is responsible for this account, please complete **Name of person responsible for this account:** _____

Phone Number of person responsible for this account: _____

Date of Birth of person responsible for this account: _____

A credit card can be put on file for your convenience. If you would like to do so, please let the receptionist know.

PLEASE PROVIDE RECEPTIONIST WITH YOUR IDENTIFICATION

(Medicare patients please provide Insurance cards as well as your ID)

PLEASE CONTINUE TO THE NEXT PAGE

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1)		**5)**	
2)		**6)**	
3)		**7)**	
4)		**8)**	

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

The doctor may request imaging to be done, the following questions will help with recommendations:
Are you claustrophobic? ❑ Yes ❑No **Do you have metal in your body?** ❑ Yes ❑No Where? _____

Chief Complaints (check all that apply)
❑ Neck ❑ Midback ❑ Low Back ❑ Chest ❑ Ribcage ❑ Abdomen ❑ Headaches ❑Other: _____
❑ Shoulder R L ❑ Upper Arm R L ❑ Elbow R L ❑ Forearm R L ❑ Wrist R L ❑ Hand R L
❑ Hip R L ❑ Leg R L ❑ Knee R L ❑ Calf R L ❑ Ankle R L ❑ Foot R L

Have you ever been involved in a motor vehicle accident? ❑ Yes ❑ No If yes, when?_____

Have you had any recent bodily trauma? (i.e. slip and fall, surgeries)? _____

Are you Pregnant? ❑ Yes ❑ No If yes, how far along?_____

Date recent pain/s started: _____/_____/_____ What caused your recent pain: _____

Is it getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

How often do you experience your symptoms? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

<u>PLEASE CONTINUE TO THE NEXT PAGE</u>

How often do you experience your symptoms? ❑ 25% ❑ 50% ❑ 75% ❑ 100% of the day

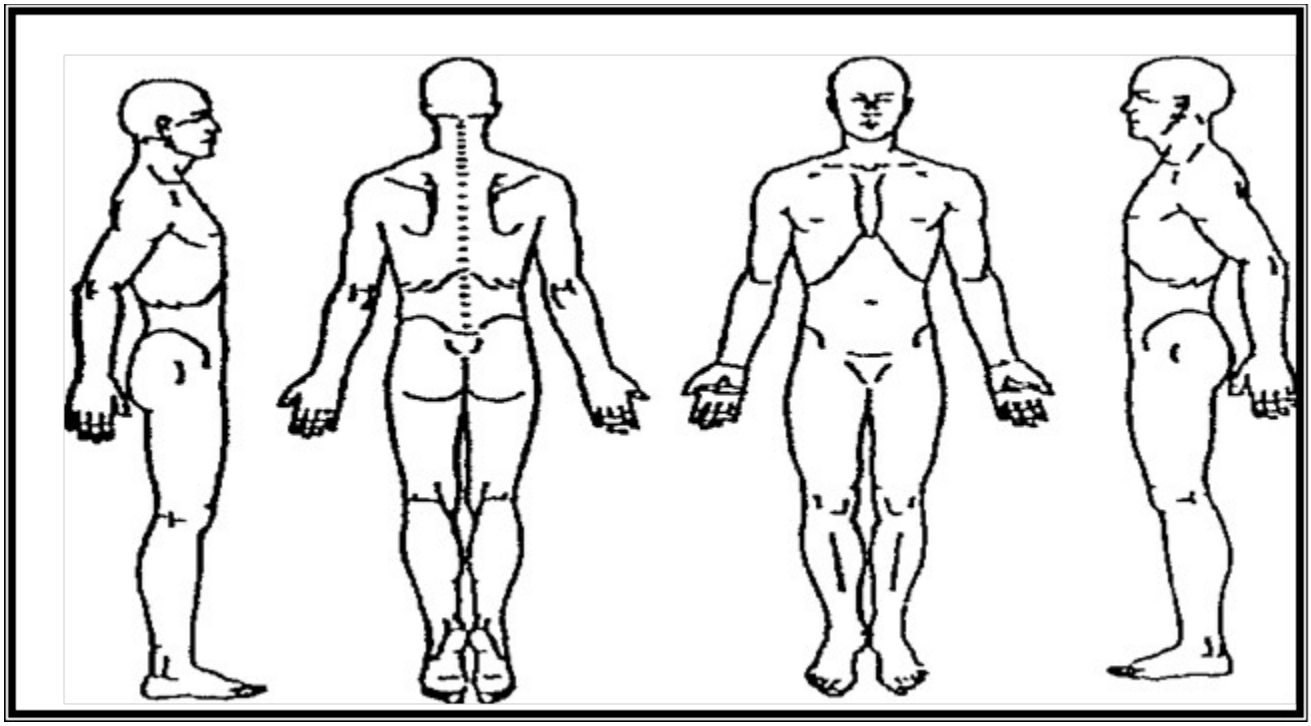
What area(s) does the pain radiate, shoot, or travel to (if applicable)? _____

What aggravates this complaint? Circle all that apply: Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other: _____

What relieves this complaint? Circle all that apply: Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Laying down / Medication / Acupuncture / Nothing / Other: ____

Have you had this or a similar complaint in the past? ❑ Yes ❑ No If "Yes", when? _____

What do your complaint (s) feel like? Circle all that apply: Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other: _____



Please Circle or make an "X" on the body diagram above where you have pain or other symptoms.

On the scale below, please circle the severity of your main complaint right now:

No Pain				**Moderate Pain**					**Worst Possible Pain**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Have you seen other doctors for this complaint? ❑ Yes ❑ No (If "Yes", we may have you complete a release to get those records)

To be performed by clinic staff: **Height:** ____inches **Weight:** _____pounds **BP:** ____ / ___

Area for Doctor Notes:_____

_____

PLEASE CONTINUE TO THE NEXT PAGE

Rice Chiropractic Clinic
Dr. Eliseo Cummings, D.C.
204 North First Street Conroe, Texas 77301
Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information (PHI) will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, _____ (print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my Personal Health Information (PHI) in accordance with the Privacy Practices.

I, _____ (print) acknowledge that I have reviewed the above information and DO NOT give my permission to release any information to my insurance carrier or other healthcare professionals. I do understand that PHI will be used within the office for purposes of my care, to those individuals designated by the doctor.

Assignment of Benefits / Assignment of Cause of Action / Contractual Lien

Our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. In the event that your insurance company does not pay in a timely manner, you may be asked to contact your insurance carrier. **If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.**

Assignment of Rights and Conveyance of Lien Interest

I hereby execute and provide Irrevocable Lien Interest and Assignment of Proceeds to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request.

To any insurance company providing benefits or settlement of a claim, you are instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds to pay the total dollar amount of all sums which I owe on account to the above-named doctor and treating facility within 30 days following your receipt of medical bills submitted by the doctor and/or treating facility. **I instruct checks to be made payable to Rice Chiropractic Clinic, and the payment sent to 204 N. First St. Conroe, Texas 77301.**

This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account and remit payment of all such sums directly to the above-named doctor and/or treating facility upon receipt of my settlement award(s).

Informed Consent for Treatment

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as “rare” and the probability of adverse reaction due to ancillary procedures is also considered “rare”.

• I, the undersigned parent or legal guardian of _____ (minor child), hereby give my permission to the staff of Rice Chiropractic to treat said child.

I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I understand that failure to complete my recommended treatment plan may jeopardize my case. By signing below I agree to the terms I have read above.

Patient or Parent Signature: X_____ Date: _____

PLEASE CONTINUE TO THE NEXT PAGE

Appointment/Electronic Communication Agreement

Here at Rice Chiropractic Clinic, we schedule patients in the most efficient way possible. As a courtesy to our staff and other patients, we ask that you please call or text (936)756-2415 or email ricechiropractic@me.com as soon as you know you need to reschedule or cancel your appointment. Preferably 24 hours ahead of time.

Please arrive as close to your appointment time as possible. Arriving more than 15 minutes early for your appointment could constitute a long wait. You will be considered a walk-in if you are more than 15 minutes early and our walk-ins are seen after our scheduled appointments, so it's likely you will not be able to be seen till close to your appointment time. No shows and late cancellations (less than 24 hours prior to your appointment) may be charged a fee of $20.

If you arrive 15 minutes late for your appointment, you will need to be rescheduled. Being late for your appointment could cut into the length of time we are able to treat you.

Please call if you know you will be more than 15 minutes late or early; we may be able to get you scheduled for the same day. If not, we will try and book your appointment for a time that works better for the both of us. Please contact us for any reason you may not be able to attend your appointments. By signing you agree to the above and will let us know you need to cancel or reschedule your appointment in a timely manner. You further agree to understand that this is a medical facility, and we will do our best to see you quickly and without an excess waiting time, however things happen, and we may get put behind. By signing you agree to be patient with our staff and other patients if we get put behind, and we will work on getting you seen as soon as possible.

Patient, Parent or Guardian Signature _____ Date _____

Patient Name (Please Print) _____

Rice Chiropractic Clinic may communicate with me electronically at the email address and/or phone number listed on my demographic's paperwork. This includes patient appointment reminders. E-mails are rarely used; we will mainly contact you by phone.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the business with any updates to my email address and / or mobile phone number.

- ○ I agree:
- ○ I do not agree:

(Check one of the circles above, to agree to receive correspondence from Rice Chiropractic Clinic)

204 N. First St.
Conroe, TX 77301

(936) 756-2415
Fax (936) 756-2415

ricechiropractic@me.com

Clinic Policies

- When attending your appointments with the doctor you are welcome to bring other people with you to hear results or hear what the doctor has to say. Please do not bring children, other friends, or family members with you when attending therapy. They are welcome to wait in the waiting room but will not be allowed to come back with you while treating. *Unless* you have spoken with the doctor to receive special permission for extenuating circumstances. If you do receive special permission and the child or person attending with you destroys property, disturbs other patients, is rude/uncontrollable, etc. We will ask the person with you to leave or ask you both to leave.
- As a courtesy to our staff and other patients we ask that you please keep your phone/electronic device on silent and stowed away until your visit is completed. If you are on your phone/electronic device in the waiting room, you will not be pulled back until you are finished, and your phone/electronic device has been put away. We ask you to remain off Facetime and Speaker phone while in our office. If you are pulled back and receive a call or are on your phone/electronic device while staff are in the room you will be asked to leave, and we will call you back once you're finished. We will need to reschedule your appointment if your conversation on your phone/electronic device puts you past your 15-minute grace period (Which is 15 minutes after your scheduled appointment time. i.e. Appointment time 11:00 am<Grace Period>11:15 am) or your time is now running into other patients' appointment times.
- While waiting or treating we ask you and the people with you please use headphones to listen to music, videos, Facetime, etc. We have headphones, please ask our staff to borrow them if needed.

We want everyone to feel comfortable when treated here at Rice Chiropractic. Thank you for helping us keep a nice environment for all our patients to receive treatment as we help them with their healing process.

This page is for you to take home.

RICE CHIROPRACTIC CLINIC HOURS

Dr. Eli Cummings (Chiropractor)

Tuesday 9:00 am – 6:00 pm

(Closed Tuesday 12:30-2:30 for lunch)

Friday 8:30 am – 1:00 pm

Dr. William Espinoza (Chiropractor)

Monday 12:00 pm-6:00 pm

Wednesday 10:00 am-6:00 pm

Saturday 9:00 am-3:00 pm

Office/Therapy

Monday 12:00 pm – 6:00 pm**

Tuesday 9:00 am – 6:00 pm

(Closed from 12:30-2:30 for lunch)

Wednesday 10:00 am – 6:00 pm

Thursday 10:00 am – 6:00 pm

Friday 8:30 am – 1:00 pm

Saturday 9:00 am – 3:00 pm**

Monday and Saturday by appointment ONLY

** You **MUST** have an appointment to be seen. You can schedule appointments by calling 936-756-2415 or emailing ricechiropractic@me.com

** **Walk-ins** will be put on our schedule for the next available appointment time, which could result in a long wait or being scheduled for another day. Walk-ins will be seen after our patients with confirmed appointments.

NO walk-ins for DOT physicals.

** As a reminder, if we have seen our last **scheduled** patient we may close early, or the doctor may leave early. The last patient is scheduled 30 minutes prior to closing.

The BEST way to schedule appointments is consistently. We can put you on reoccurring appointments, however if you "No Show" you will be taken off our reoccurring appointments list.