Patient Health History-Personal Injury

Please PRINT

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

First Name_____ **Nick Name**_____

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

Mobile Phone_____**Home Phone** _____

Secondary Phone _____

Personal 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 one)*

❑ 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** _____

ATTORNEY (ATTY)		
Contact Person:	Fax:	
Address:		Phone:
PERSONAL INJURY PROTECTION (MVA) or (PIP)		
Claim #:	Date of Accident:	
Your Vehicle Insurance Co.		State Accident Occurred:
Phone:	Fax:	
LIABILITY (LI) (3rd PARTY)		
Name of 3rd Party Driver/Owner	Policy #	
3rd Insurance. Co.	Phone:	
Adjuster's Name:	Phone:	

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

If yes, how often do you smoke: ❑ Current everyday 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)** _____

Have you been seen at a different provider's office and/or Hospital for your most recent injuries? _____
(Please complete all the information on page 6 if you answered YES)

Have you had an ❑X-ray ❑CT scan ❑MRI of your ❑neck ❑mid-back ❑low back in the past 28 days? ❑None
(check which ones apply)

Are you claustrophobic? ❑ Yes ❑No **Do you have metal in your body?** ❑ Yes ❑No Where? _____

Are you pregnant? ❑ Yes ❑ No **If yes, how many weeks? _____**

Have you had any surgeries or injuries (burns, broken bones, etc.) that we need to be aware of?

_____

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: _____

Did you lose any time from work due to your injuries? ❑ YES ❑ NO

How many days / hours did you lose from work to date? _____

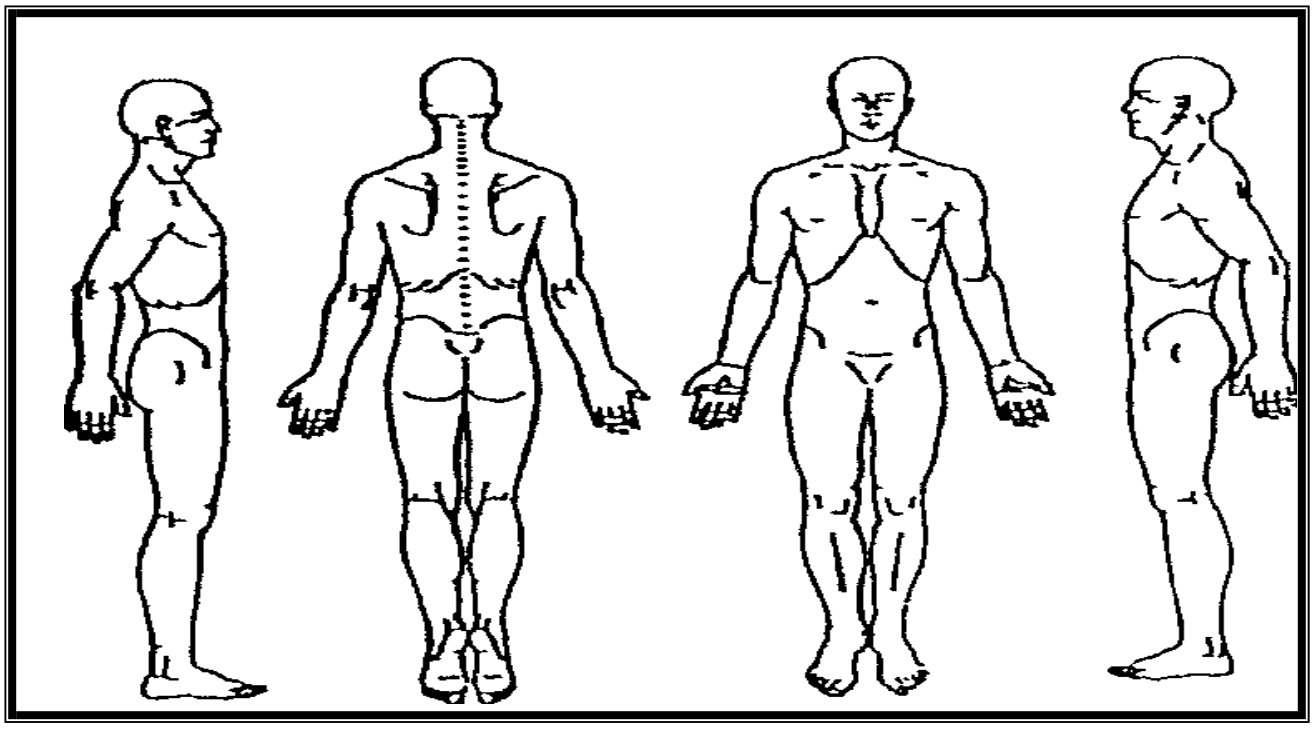
Today's Date ____ . ____ . ____ **Signature of Patient** _____

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

NAME: _____ DATE:_____

PLEASE USE THE FOLLOWING DRAWING TO ACCURATELY MARK THE AREAS IN WHICH YOU FEEL THE DESCRIBED SENSATIONS. USE THE APPROPRIATE SYMBOLS AND INCLUDE ALL AFFECTED AREAS.
Por favor use los simbolos en el siguiente dibujo para demonstrar la area que esta afectada.

Dull: DDDDD	**Stabbing/cutting**: /////	**Burning**: XXXX
Agudo	**Cortaduras**	**Quemaduras**
Numb: NNNN	**Tingling:** TTTT	**Cramping:** SSSS
Dormido	**Cosquillas**	**Calambres**



Please place a circle on the line below to indicate your present pain level.

Por favor circule el nivel de dolor que le corresponde

MILD	**MODERATE**	**INTENSE**
Minimo	Moderado	Intenso

No Pain 1----2----3----4----5----6----7----8----9----10 Worst Pain

PATIENT SIGNATURE: _____
Firma de paciente

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: _____

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 (24-hour policy is listed on page 7).

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.

3 MISSED OR CANCELLED APPOINTMENTS WILL RESULT IN THE CLOSING OF YOUR CASE (Your attorney will then need to give us the approval to reopen your case)

If you arrive 15 minutes late for your appointment, you will 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. For personal injury cases we do report compliance to your attorney weekly. 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

Rice Chiropractic Clinic

204 N. First St.
Conroe, Texas 77301
Fax: 936-756-2415/936-463-6170
ricechiropractic@me.com

Patient Name: _____

Soc. Sec. #: _____-_____-_____ Date of Birth: ___/___/_____

Hospital/Facility patient was seen:

- ☐ Conroe HCA
- ☐ St. Luke's-Woodlands or (other location) _____
- ☐ St. Luke's Chi (location) _____
- ☐ Kingwood Hospital
- ☐ Houston Methodist The Woodlands Emergency
- ☐ Huntsville Memorial
- ☐ Hermann Memorial-Woodlands or (other location) _____
- ☐ Other: _____

Numbers for the Hospital/Facility you were seen:
Phone: _____ Fax: _____

For the purpose of treatment, I request and consent to the release of my complete health record. If there is information you want to exclude, please list:

_____

This authorization for release of information covers the period of healthcare from:

- ☐ _____ to _____ (Date of accident: _____)
- ☐ All past, present, and future periods

I authorize Rice Chiropractic Clinic to use and disclose the protected health information described above for my medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I certify that the information above is true and that when releasing this Protected Health Information for the above patient you are releasing Rice Chiropractic Clinic of any liability and certify that under perjury of law you are who you say you are. This clinic complies with all applicable federal privacy statutes.

Patient/Guardians Signature: _____ Date: _____

HIPPA Privacy Authorization Form **Authorization for Use or Disclosure of Protected Health Information This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: _____

You are welcome to keep pages 7,8,9

Clinic Policies

- When attending your appointments with the doctor you are welcome to bring other people with you to hear the 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 may ask the person with you to leave or ask you both to leave.

- If you do not have transportation, please contact your attorney or insurance company so they can help you set something up. We no longer provide transportation through our office.

- As a courtesy to other patients and our staff, we ask that you please remain off your phone when you are pulled back for treatment. We may ask you to leave the room so someone else can receive treatment if you are on the phone. If you are on the phone in the waiting room, we will take you back once you are done with your call. If you need to take a phone call while in the waiting room, we ask you to remain off Facetime and Speaker phone. Phone calls lasting longer than 15 minutes after your appointment time may result in your appointment being rescheduled.

    - While waiting or treating we ask you and the people with you please use headphones to listen to music, videos, etc. Headphones will be provided to borrow while here if needed.

- 24-hour policy: Please call to reschedule or cancel your appointment 24 hours ahead of your appointment time. We have a lot of patients to treat and sometimes have a waiting list of patients who need appointments. If you do not call 24 hours ahead of time to cancel, reschedule, or if you no-show consistently to your appointments, it will result in you having to become a walk-in patient and not being able to schedule appointments.

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.

What to Expect as a Personal Injury Patient

After your initial visit with the doctor, you may be referred out for:

- X-rays
- MRI's (please notify us if you have any metal in your body, or if you're claustrophobic so we can get you sedation or schedule CT's instead)
- MD, for an evaluation and pharmaco management
- Specialist (such as Pain Management and/or Orthopedic) if prior MRI/CT has been done

Attorney or insurance approval is needed; you should be seen by MD in less than a week and imaging should be done around 2-3 weeks into therapy. If you have not heard from these facilities in a reasonable time, please let us know.

Therapy appointments will be scheduled:

- 3 days a week for approximately 2-3 weeks
- 2-3 days a week for approximately 3-4 weeks
- 1-2 days a week for approximately 4-5 weeks

More therapy in the beginning of treatment while you are usually in the most pain. Less at the end while you are usually treating with a specialist.

Re-evaluations:

- After 6-8 visits of therapy
- After we receive imaging reports
- After you have seen a specialist
- If there is a break in your care

Therapy Services:

- Corrective Exercises
- General Conditioning
- Spinal Decompression
- Massage Therapy
- E-Stem
- Ultrasound
- Chiropractic Care (after MRI's and with approval from treating doctor)

Our Goal: Treat your injuries to restore mobility, strengthen your muscles, stabilize your body once again.

The information on this page is an approximation. Not all injuries are the same, not all cases are the same, not all therapies are included. The doctor and other providers working with us make treatment plans based on each individual patient.

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.