RICE CHIROPRACTIC CLINIC - MINOR (ENGLISH) **Date:** _____

PERSONAL INFORMATION

Please print

First Name_____ **Nickname**_____

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

Mobile Phone_____**Home Phone** _____

Parent Information: Name _____ **Phone Number**_____

Other Parent Information: Name _____ **Phone Number**_____

Parent/guardian email _____

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

Preferred Contact Method ❑ Phone ❑ Email ❑ Text

Date of Birth / / **Age:** _____ **SSN:** _____

Gender *(check one)* ❑ Male ❑ Female ❑ Unspecified

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** _____

Attorney Information: _____ **Phone Number:** _____

Case Manager: _____ **Date of Accident:** ____/____/_____

Do you 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: ❑

_____

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

_____

Have you had any recent radiology imaging? ❑ No ❑ Yes, **please list what you had and where it was done?**

_____

REASON FOR VISIT

What is the reason for your visit today? □ **Headache** □ **Neck Pain** □ **Mid-Back Pain** □ **Low Back Pain** □**Other**_____

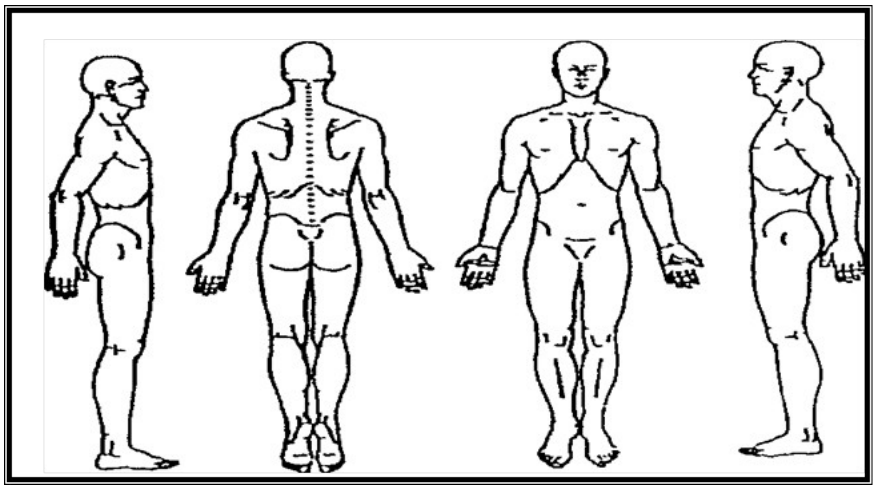
What caused this complaint(s)? _____

_____

When did this complaint begin? ____/____/____ **Is it getting worse?** □ Yes □ No □ Constant □ Comes and goes

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.

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

_____

HEALTH HISTORY

Are there any Diagnosis/Medical Problems that we need to be aware of? _____

_____

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

_____

_____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____

_____

To be performed by clinic staff: **Height:** __inches **Weight:** _____pounds **BP:** _____ / __

Area for Doctor
Notes:_____
_____

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: _____