NEW PATIENT FORM

Ennis Chiropractic Clinic & Wellness Center

Patient Information

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Email _____

Sex ☐ M ☐ F Age _____

Social Security # _____

Birth Date _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ____ years

Occupation _____

Patient's Employer/School _____

Employer/School Address _____

_____

Home Phone (_____) _____

Cell Phone (_____) _____

Work Phone (_____) _____

Best time and place to reach you _____

Spouse's Name _____

Birthdate _____

Spouse's Employer _____

IN CASE OF AN EMERGENCY, CONTACT
Name _____ Phone _____

How did you hear about of office? _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No
Date _____
Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Work Comp ☐ Other

Attorney Name (if applicable)
_____

Insurance

Health Insurance Name _____

Who is the primary insured? _____

Relationship to Patient _____

Policy # _____ Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS # _____

Relationship to Patient _____

Insurance Co. _____

Policy # _____ Group # _____

FINANCIAL RESPONSIBILITY
I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Ennis Chiropractic and Wellness Center and/or its affiliated entitles for any charges not covered by health care benefits. It is my responsibility to notify Ennis Chiropractic and Wellness Center of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Ennis Chiropractic and Wellness Center and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

ASSIGNMENT OF BENEFITS
I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Ennis Chiropractic and Wellness Center for all covered medical services and supplies provided to me during all courses of treatment and care provided by Ennis Chiropractic and Wellness Center and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Ennis Chiropractic and Wellness, and will constitute a continuing authorization, maintained on file with Ennis Chiropractic and Wellness Center, which will authorize and allow for direct payment to Ennis Chiropractic and Wellness Center of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies, and/or care provided to me by Ennis Chiropractic and Wellness Center.

The above-named doctor may use my healthcare information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my treatment plan is completed or one year from the dated signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

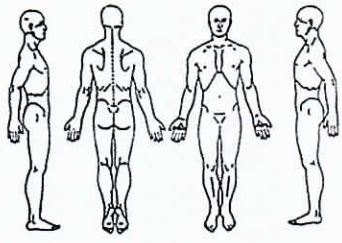
_____
Please print name of Patient, Parent, Guardian, or Personal Representative

_____ _____
Date **Relationship to Patient**

Ennis
Chiropractic Clinic
& Wellness Center

Patient Intake Form

1. Indicate with an X on the drawings below where you have pain/symptoms.



Please list/describe your symptoms in order of Severity

1. _____
2. _____
3. _____
4. _____
5. _____

2. How often do you experience your symptoms? (*Please Circle*)

Intermittently (1-25% of the time) Frequently (51-75% of the time)
Occasionally (26-50% of the time) Constantly (76-100% of the time)

3. How would you describe the type of pain? (*Please Circle*)

Sharp	Tingly	Numb	Sharp with motion
Diffuse	Shooting	Stiff	Shooting with motion
Dull	Achy	Burning	Stabbing with motion
Electric like with motion	Other: _____		

4. How are your symptoms changing with time? (*Please Circle*)

Getting worse Not changing Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 ***(please circle)***

6. How much has the problem interfered with your work? (*Please Circle*)

Not at all A little bit Moderately Quite a bit Extremely

7. How much has the problem interfered with your social activities? (*Please Circle*)

Not at all A little bit Moderately Quite as bit Extremely

8. Who else have you seen for your problem? (*Please Circle*)

Chiropractor	Neurologist	Primary Care Physician
ER Physician	Orthopedist	Other: _____
Massage Therapist	Physical Therapist	No One

9. How long have you had this problem? _____

10. How do you think your problem began?

_____

11. Do you consider this problem to be severe?

_____

12. What aggravates your problem?

_____

13. What makes your problem better?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ Weight _____

16. How would you rate your overall health? (*Please Circle*)

Excellent Very Good Good Fair Poor

17. What type of exercise do you do? (*Please Circle*)

Strenuous Moderate Light None

18. Indicate if you have any immediate family with any of the following: (*Please Circle*)

Rheumatoid Arthritis Diabetes Lupus
Heart Problems Cancer ALS Other: _____

19. What treatment have you already received for your condition? (*Please Circle*) Medication Surgery Physical Therapy
Chiropractic Services None Other: _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Please **circle** "YES" or "NO" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Diabetes	Yes	No	Liver Dieses	Yes	No	Rheumatoid Arthritis	Yes	No
Alcoholism	Yes	No	Emphysema	Yes	No	Measles	Yes	No	Rheumatic Fever	Yes	No
Allergy Shots	Yes	No	Epilepsy	Yes	No	Migraine	Yes	No	Scarlet Fever	Yes	No
Anemia	Yes	No	Fractures	Yes	No	Headaches	Yes	No	Sexually Transmitted		
Anorexia	Yes	No	Glaucoma	Yes	No	Miscarriage	Yes	No	Disease	Yes	No
Appendicitis	Yes	No	Goiter	Yes	No	Mononucleosis	Yes	No	Stroke	Yes	No
Arthritis	Yes	No	Gonorrhea	Yes	No	Multiple Sclerosis	Yes	No	Suicide Attempt	Yes	No
Asthma	Yes	No	Gout	Yes	No	Mumps	Yes	No	Thyroid Problems	Yes	No
Bleeding Disorders	Yes	No	Heart Disease	Yes	No	Osteoporosis	Yes	No	Tonsillitis	Yes	No
Breast Lump	Yes	No	Hepatitis	Yes	No	Pacemaker	Yes	No	Tuberculosis	Yes	No
Bronchitis	Yes	No	Hernia	Yes	No	Parkinson's			Tumors, Growths	Yes	No
Bulimia	Yes	No	Herniated Disc	Yes	No	Disease	Yes	No	Typhoid Fever	Yes	No
Cancer	Yes	No	Herpes	Yes	No	Pinched Nerve	Yes	No	Ulcers	Yes	No
Cataracts	Yes	No	High Blood			Pneumonia	Yes	No	Vaginal Infections	Yes	No
Chemical			Pressure	Yes	No	Polio	Yes	No	Whooping cough	Yes	No
Dependency	Yes	No	High Cholesterol	Yes	No	Prosthesis	Yes	No	Other: _____		
Chicken Pox	Yes	No	Kidney Disease	Yes	No	Psychiatric Care	Yes	No	_____		

20. What habits do you currently do?

Smoking Packs/Day _____ Alcohol Drinks/Week _____
Coffee/Caffeine Drinks Cups/Day _____ High Stress Level Reason _____

21. Are you pregnant? (Please circle) Yes No Due Date _____

22. List all prescription medications/supplements you are currently taking:

_____

23. List all of the over-the-counter medications you are currently taking:

_____

24. List all surgical procedures you have had:

_____

25. What activities do you do at work? (Please check and circle)

☐	Sit:	Most of the day	Half of the day	A little of the day
☐	Stand:	Most of the day	Half of the day	A little of the day
☐	Computer Work:	Most of the day	Half of the day	A little of the day
☐	On the phone:	Most of the day	Half of the day	A little of the day

26. What activities do you do outside of work?

_____

27. Have you ever been hospitalized? (Please circle) Yes No

28. Have you ever seen a chiropractor? (Please circle) Yes No

29. Have you had significant past trauma? (Please circle) Yes No

30. Anything else pertinent to your visit today? _____

Print Patient Name _____ Date of Birth _____

Patient Signature _____ Date _____

HIPPA Notice of Privacy Practices at Ennis Chiropractic and Wellness Center

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Ennis Chiropractic and Wellness Center we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including of you clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest of you.

In effective, we do send text messages to remind you of your appointment, or may leave a message on your answering machine or voicemail due to certain circumstances. Further, you have the right to inspect or obtain a copy of the information we use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care we provide to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provided the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities you should direct your complaint to: Front office.

If you would like further information about our privacy policies and practices please feel free to contact us at (972)875-9377.

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care areas open. As a result, patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matter related in an "open-door" environment are incidental matters, in the event you or someone else would not agree with us, we are providing this disclosure and requesting your authorization.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. If you choose not to be adjusted in an "open-door" adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from Ennis Chiropractic and Wellness Center or on your relation with our staff.

This notice is effective as of January 1, 2015. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (printed)	Signature	Date

If you are a minor, or if you are being represented by another party

Personal Representative (printed)	Personal Representative (Signature)	Date

Description of the authority to act on behalf of the patient

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy, and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well- being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____

Print Name Signature Date

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to and unborn child.
Date of last menstrual cycle: _____

_____

Signature Date

Ennis
Chiropractic Clinic
& Wellness Center

109 NW Main St., Ennis, Texas 75119
Ph. (972)875-9377 Fax: (972)875-4325

Ennis Chiropractic & Wellness Center, P.A.

Dr. William C. Davis, D.C., D.A.A.C.A, C.D.T.P

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Ennis Chiropractic Clinic reserves the right to charge a fee of $25.00 for all missed appointments ("NO SHOWS") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advanced notice.

"NO SHOW" fees will be billed to the patient. The fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "NO SHOWS" in an 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

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