WELCOME

Patient Information

Date _____
SS ID# _____
Patient Name *(Last, First MI)* _____
_____
Address _____
_____
City _____
State _____ Zip _____
E-mail _____
Cell Phone # _____
DOB _____ Sex □ M □ F
□ Minor □ Single □ Partnered □ Married
□ Separated □ Divorced □ Widowed
Occupation _____
Employer/School _____
· Address _____
_____
· Phone (_____) _____

Spouse's Name _____
Birthdate _____
Spouse's Employer _____
SS# _____

Whom may we thank for referring you?

Insurance

Subscriber's Name _____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Company _____
Member ID# _____
Is this patient covered by additional insurance? □ Yes □ No

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with the insurance company I've stated above, and assign directly to Dr. Scott Kolling (Irving Chiropractic and Wellness, Inc.) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize my signature on all insurance submissions. Dr. Scott Kolling (Irving Chiropractic and Wellness, Inc.) may use my healthcare information, and may disclose such information to the insurance company that I've stated above, and their agents for the purpose of obtaining payment for services, and determining insurance benefits, or the benefits payable for related services. This consent with end when my current treatment plan is complete, or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian, or Personal Representative

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

_____ _____
Date Relationship to Patient

Emergency Contact

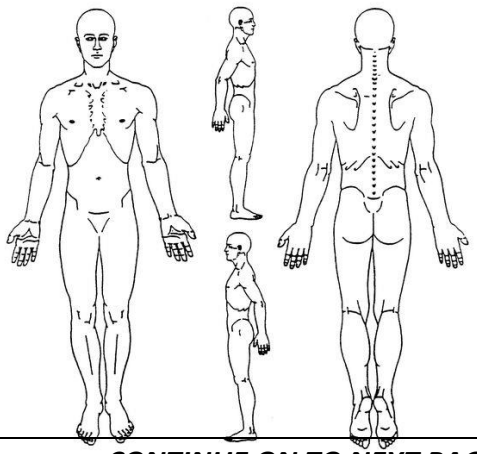
Name _____
Relationship _____
Cell Phone (_____) _____
Work Phone (_____) _____
Address _____

Accident Information

Is this condition due to an accident? □ Yes □ No
Date of accident _____
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*) _____

Patient Condition

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Reason for Visit _____
When did you symptoms appear? _____
Is this condition getting progressively worse? □ Yes □ No □ Unsure
Type of pain: □ Throbbing □ Numbness □ Aching □ Shooting □ Sharp
□ Dull □ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other
Rate the severity of you pain on a scale from 1 (least) to 10 (severe) _____
How often do you have this pain? _____
Is it constant, or does it come and go? _____
Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation
Activities or movements that are painful to perform: □ Sitting □ Standing
□ Walking □ Running □ Bending □ Lying Down □ Other: _____

CONTINUE ON TO NEXT PAGE

HEALTH HISTORY

What treatments have you already received for your condition?

□ Medications □ Surgery □ None
□ Physical Therapy □ Chiropractic Services □ OTHER: _____

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

_____

Date of Last:

Physical Exam	_____	Blood Test	_____
Spinal Exam	_____	Urine Test	_____
Dental X-Ray	_____	MRI	_____
Spinal X-Ray	_____	CT Scan	_____
Chest X-Ray	_____	Bone Scan	_____

Place a mark on "YES" or "NO" to indicate if you have any of the following:

AIDS / HIV	□ YES □ NO	Glaucoma	□ YES □ NO	Polio	□ YES □ NO
Alcoholism	□ YES □ NO	Gonorrhea	□ YES □ NO	Prostate Problem	□ YES □ NO
Allergy Shots	□ YES □ NO	Gout	□ YES □ NO	Prosthesis	□ YES □ NO
Anemia	□ YES □ NO	Heart Disease	□ YES □ NO	Psychiatric Care	□ YES □ NO
Anorexia	□ YES □ NO	Hepatitis	□ YES □ NO	Rheumatoid Arthritis	□ YES □ NO
Appendicitis	□ YES □ NO	Herniated Disk	□ YES □ NO	Rheumatic Fever	□ YES □ NO
Asthma	□ YES □ NO	Herpes	□ YES □ NO	Scarlet Fever	□ YES □ NO
Bleeding Disorders	□ YES □ NO	High Cholesterol	□ YES □ NO	Stroke	□ YES □ NO
Breast Lump	□ YES □ NO	Kidney Disease	□ YES □ NO	Suicide Attempt	□ YES □ NO
Bronchitis	□ YES □ NO	Migraine / Headaches	□ YES □ NO	Thyroid Problem	□ YES □ NO
Bulimia	□ YES □ NO	Miscarriage	□ YES □ NO	Tonsillitis	□ YES □ NO
Cancer	□ YES □ NO	Mononucleosis	□ YES □ NO	Tuberculosis	□ YES □ NO
Cataracts	□ YES □ NO	Multiple Sclerosis	□ YES □ NO	Tumors / Growths	□ YES □ NO
Chem. Dependent	□ YES □ NO	Mumps	□ YES □ NO	Typhoid Fever	□ YES □ NO
Chicken Pox	□ YES □ NO	Osteoporosis	□ YES □ NO	Ulcers	□ YES □ NO
Diabetes	□ YES □ NO	Pacemaker	□ YES □ NO	Vaginal Infections	□ YES □ NO
Emphysema	□ YES □ NO	Parkinson's Disease	□ YES □ NO	Venereal Disease	□ YES □ NO
Epilepsy	□ YES □ NO	Pinched Nerve	□ YES □ NO	Whooping Cough	□ YES □ NO
Fractures	□ YES □ NO	Pneumonia	□ YES □ NO	OTHER: _____	

EXCERSISE	WORK ACTIVITY	LIFESTYLE HABITS
☐ None ☐ Daily	☐ Sitting ☐ Light Labor	Smoking:_____ packs/day Caffeine:_____ cups/day
☐ Moderate ☐ Heavy	☐ Standing ☐ Heavy Labor	Alcohol:_____ drinks/wk High Stress:_____ (*reason*)

Are you pregnant? ☐*YES* ☐*NO* *if yes, due date:* _____

Injuries/Surgeries you have had:

	DESCRIPTION	DATE
FALLS	_____	_____
HEAD INJURIES	_____	_____
BROKEN BONES	_____	_____
DISLOCATIONS	_____	_____
SURGERIES	_____	_____

MEDICATIONS	ALLERGIES	SUPPLIMENTS
_____	_____	_____
_____	_____	_____
Pharmacy Name: _____	_____	_____
Pharmacy Phone: (_____) _____	_____	_____

CONTINUE ON TO NEXT PAGE

Irving Chiropractic & Wellness

580 Decker Dr, Irving, TX 75062

INFORMED CONSENT

Dear Patient,

Every type of health core is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic health-care before consenting to treatment. This is called INFORMED CONSENT.

Chiropractic adjustments are the moving of bones with the doctor's hands, or with the use of machine. Frequently, adjustments create a "pop" or "click" sound/sensation in the areas being treated.

In this office, we use trained staff personnel who may assist the doctor with portions of your consultation, examination, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another physician or a trained staff member may handle your care.

STROKE: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustment that is related to vertebral artery stroke is called "extension-rotation-thrust atlas adjustment". We DO NOT do this type of adjustments on patients, other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA Vol. 37 No. 2. June 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

DISC HERNIATIONS: Disk herniations that create pressure on a spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally, chiropractic treatment (adjustments. traction, etc.) will aggravate the problem, and rarely surgery may also cause of disk problem if the disk is in a weakened condition. These problems occur so rarely there are no available statistics
to quantify their probability.

SOFT TISSUE INJURY: Soft tissue refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain, and a necessary treatments for resolution, but there are no long-term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

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INFORMED CONSENT
PAGE 2

RIB FRACTURES: The ribs are found only on the thoracic spine, or mid-back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patient's who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your X-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their X-rays. These problems occur so rarefy that there are no available statistics to quantify their probability.

PHYSICAL THERAPY BURNS: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has a different sensitivity to these modalities and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

SORENESS: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous. but please do tell your doctor about it.

OTHER PROBLEMS: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that is is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any other health care delivery system, we can not promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel may assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, *please sign and date below*.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

PATIENT NAME (PRINTED) PATIENT OR GUARDIAN FOR MINOR

_____

WITNESS

CONTINUE ON TO NEXT PAGE

IRVING CHIROPRACTIC & WELLNESS, INC.

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.

Irving Chiropractic & Wellness, Inc. is required by law to maintain the privacy and confidentially of your protected health information, and to provide our patients with notice of our legal duties and privacy practices with respect for your protected health information.

Disclosure of Healthcare information:

Treatment
We may disclose your health information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations. (example:)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Irving Chiropractic & Wellness, Inc."
"It is our policy to provide a substitute health care provider, authorized by Irving Chiropractic & Wellness, Inc. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment
We may disclose your health information to your insurance for the purpose of payment or health care operations. (example:)

"As a courtesy to our patients. we will submit on itemized billing statement to your Insurance carrier for the purpose of payment to Irving Chiropractic & Wellness, Inc. for health care services rendered, if you pay for your health core services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Worker's Compensation
We may disclose your health information as necessary to comply with State Workers Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your core about your medical condition or in the event of an emergency.

CONTINUE ON TO NEXT PAGE

Public Health
As required by law, we may disclose your health information to public health authorities for purposes relating 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 health information in the course of *any* administrative or judicial proceeding.

Law Enforcement
We *may* disclose *your* health information to a few enforcement officials 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.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by on Institutional Review Board.

Public Safety
It may be necessary to disclose your health information 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 health information for military, national security, prisoner, and government benefits purposes.

Marketing
We may contact you for marketing purposes, or fundraising purposes, as described below: (example)

"As a courtesy to our patients, it Is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine, or with the person answering the phone. No personal health information will be disclosed during this recording, or message, other than the date and time of your scheduled appointment, along with a request to call our office. If you need to cancel or reschedule your appointment.

CONTINUE ON TO NEXT PAGE

"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times we may send you a letter, post card, invitation, or call your home to invite you participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Irving Chiropractic & Wellness, Inc. sponsored fund-raising events."

Change of Ownershlp

In the event that Irving Chiropractic & Wellness, Inc. is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health informatlon. Please be advised, however, that Irving Chiropractic & Wellness, Inc. is not required to agree to the restrictions that you requested.
- You have the right to have your health Information received, or communicated through an alternative method, or sent to an alternative location other than the usual method of communication, or delivery, upon your request.
- You have the right to inspect, and copy your health information.
- Your have a right to request that Irving Chiropractic & Wellness, Inc. amend your protected health Information. Please be advised, however, that Irving Chiropractic & Wellness, Inc. is not required to agree to amend your protected health information. If you request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s), and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Irving Chiropractic & Wellness, Inc.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Irving Chiropractic & Wellness, Inc. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Irving Chiropractic & Wellness, Inc. is required by law to comply with this notice.

Irving Chiropractic & Wellness, Inc. is required by law to maintain the privacy of your health information, and to provide you with notice of Its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact Dr. Scott Kolling, or his assistant, by calling this number 972-714-0800. If Dr. Kolling, or his assistant, are not available you may make an appointment for a personal conference or by telephone within two working days.

CONTINUE ON TO NEXT PAGE

Complaints
Complaints about your privacy rights, or how Irving Chiropractic & Wellness, Inc. has handled your health information should be directed to Dr. Kolling, or his assistant, by calling this office at 972-714-0800. If Dr. Kolling, or his assistant, are not available, you may make an appointment for a personal conference, or call by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of ____/____/____

I have read the Privacy Notice, and understand my rights contained in the notice.

By way of my signature, I provide Irving Chiropractic & Wellness, Inc. with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

CONTINUE ON TO NEXT PAGE

I C W E L L N E S S

Helping your body heal itself naturally

Financial Policy

IC Wellness is committed to providing you with the best possible care. If you have medical insurance, our staff is determined to help you receive the maximum allowable benefits, as stated in your specific plan. In order to achieve these goals, we need your understanding of our payment policy.

As medical care providers, our relationship is with you, and not your insurance company. While the filing of the insurance claim is a courtesy that we extend to our patient all charges rue your responsibility from the date services are rendered. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. All co-payments, co-insurances, and applicable deductible amounts, are due at the time of service. Please be advised that the eligibility and benefit information supplied by your insurance company is only an estimate and is not a guarantee of payment Actual benefits are subject to all plan terms, definitions, limitations, **and exclusions** in effect on the date of service. Furthermore, you agree to pay any portion of the charges that are not covered by insurance. All payments are due at the time services are rendered. You are responsible for all outstanding balances. By signing, you consent to paying all outstanding balances.

Authorizations: If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining the referral prior to your appointment. Failure to obtain a referral and/or pre-authorization will not relieve you of your obligation to make full payment to us for services rendered. If you have an HMO plan. please check with our front desk, as these plans require a PCP referral.

Cancellation/No Show Fees: Reminder text messages for your appointment is an office courtesy. It is your responsibility to remember your appointment date and time that you chose to schedule. There is a $40.00 fee in the event of a no show/no call and/or same day cancellation without a 24 hour notice. Should you reschedule on same day and/or switch therapists same day, there is a $10.00 transfer fee. No exceptions. **ALL FEES ASSOCIATED WITH CANCELLATIONS, NO-SHOWS, OR TRANSFERS, WILL BE CHARGED TO THE CREDIT CARD ON FILE.**

Returned checks: There is a $30.00 fee for any check returned, for any reason.

Past Due Accounts: If your account becomes past due, we will take steps to collect on that debt, and if your account is referred to a collection agency or attorney, you agree to pay all collection costs that are incurred. If financial problems affect timely payment of your account. we encourage you to contact us promptly to arrange a payment plan and to avoid your account being sent to collections.

Waiver of Confidentiality: You also understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment and the type of treatment received by our office, may become a matter of public record, or is disclosed to third parties.

I have read and understand the above financial policy and agree to the terms presented.

_____	_____	_____
Patient/Responsible Party (Print)	Patient/Responsible Party (Signature)	Date