

WELCOME

Patient Information

Date _____
Patient Name _____
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?

Emergency Contact

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

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: _____

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

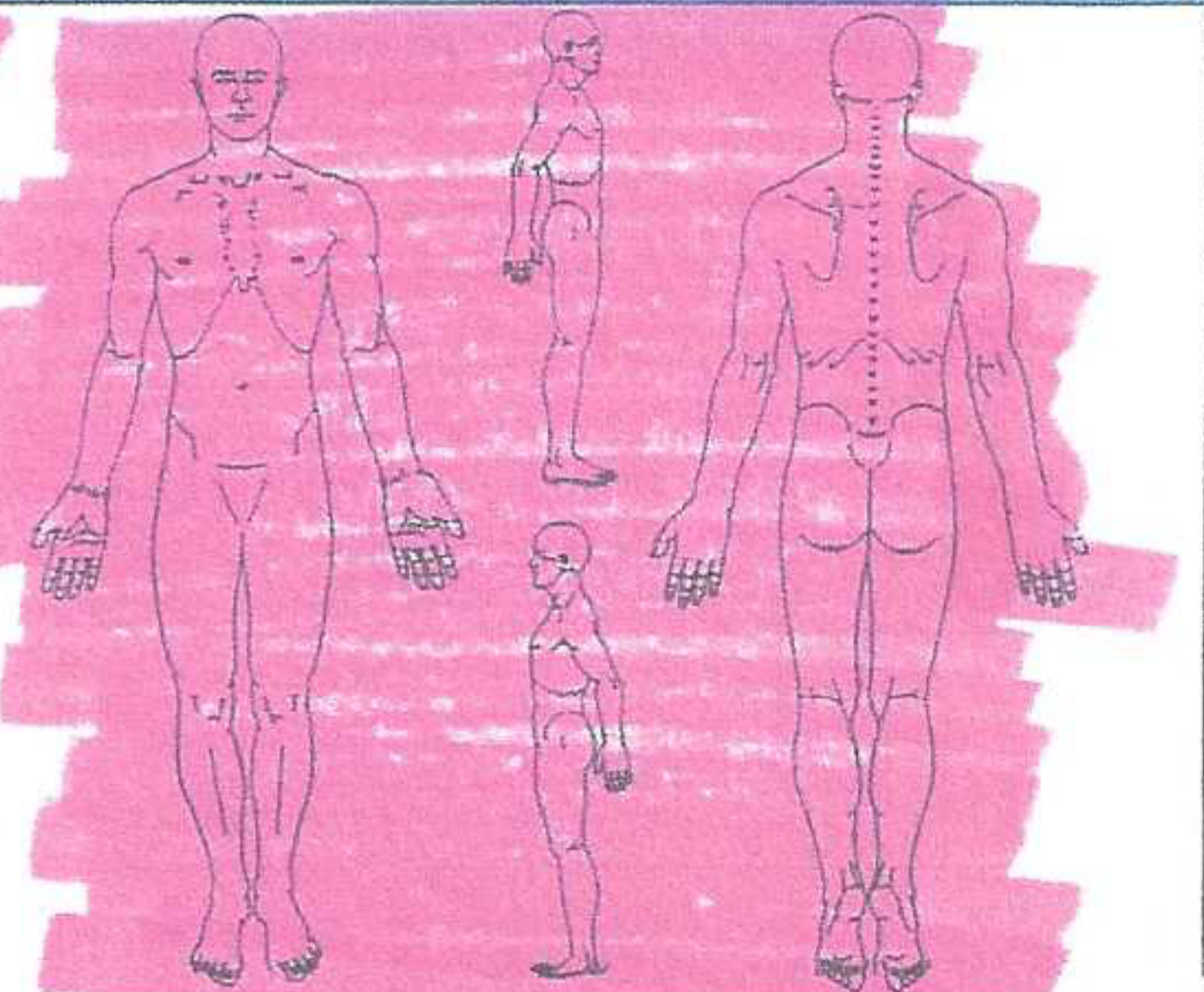
Please print name of Patient, Parent, Guardian, or Personal Representative

Date

Relationship to Patient

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) _____



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

EXERCISE	WORK ACTIVITY	LIFESTYLE HABITS
<input type="checkbox"/> None <input type="checkbox"/> Daily <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy	<input type="checkbox"/> Sitting <input type="checkbox"/> Light Labor <input type="checkbox"/> Standing <input type="checkbox"/> Heavy Labor	Smoking: _____ packs/day Caffeine: _____ cups/day 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: (_____) _____	_____	_____

I C W E L L N E S S

Helping your body heal itself naturally

COVID-19 Policy

Due to the current landscape of the current pandemic, we are screening all patients to not only protect our staff, but also our other patients. If you fall into any of the following conditions, you are obligated to inform the office before moving forward with care.

1. Have you recently been exposed to anyone diagnosed with COVID-19? yes no
2. Are you experience any COVID-19 symptoms (fever, cough, trouble breathing)? yes no
3. Have you been vaccinated? yes no if yes, which/when? _____

PATIENT CONSENT

Name: _____ DOB: _____

Address: _____

Email: _____ Last four digits of SS# _____

Cell: _____ Home/Work: _____

The purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Practices: You have the right to read our Private Practice Policies before you sign this consent. Our Practice Private Policy explains the use and disclosure we may make of your protected health information for treatment, payment activities, and health care operations, along with other important matters concerning your health information. We advise you carefully and completely read before signing this Consent.

We reserve the right to change our privacy policies as described in the Practice Privacy Policy, but we will make those updates available for review. The changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this consent at any time. You are required to give us written notice of your revocation. Revocation of this consent will not affect any action Irving Chiropractic & Wellness had taken in reliance of this consent before we receive your revocation. From that point, we hold the option to decline your treatment if you revoke consent.

All payments are due at the time of services rendered. You are responsible for all outstanding balances. By signing, you consent to paying all outstanding balances.

I have read and understood the aforementioned consent. I consent to the use and disclosure of my health information for purposes of treatment, payment activities, and health care operations.

Signature

Date

Representative/Guardian

Relationship to Patient

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Irving Chiropractic & Wellness

580 Decker Dr, Irving, TX 75062

INFORMED CONSENT

Dear Patient,

Every type of health care 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

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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 rarely 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 it 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 confidentiality 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 an 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 care 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 care 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 an 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 Ownership

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 information. 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.
- You 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

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 are 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