

PATIENT PERSONAL/CONFIDENTIAL DATA

No. _____ Date: _____
Patient: _____ Date of Birth: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Social Security No.: _____ Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____
Employer: _____ Address: _____
Name of Spouse: _____ SS No.: _____ No. of Children: _____
Spouse's Employer: _____ Address: _____
How did you learn of this clinic? _____
Nearest relative not living with you? _____ Phone: _____
Who is responsible for payment? Self Spouse Other _____

PATIENT'S INSURANCE

Name of Company: _____
Address: _____
ID & Group No.: _____
Phone No.: _____

SPOUSE'S INSURANCE

Name of Company: _____
Address: _____
ID & Group No.: _____
Phone No.: _____

Purpose of this appointment and list your complaints: _____

Date of illness: _____ Time: _____ AM PM Location: _____

How did accident occur? Auto On the job Other: _____

Please describe the circumstances and what makes the condition(s) better or worse: _____

Other Doctor seen for this condition: _____

Have you been treated by a Doctor for any health condition in the last year? Yes No

If Yes, please describe? _____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature Physician: _____ Signature Patient: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case, and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient Signature: _____

Patient's or Guardian's Signature: _____

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ No.: _____

MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?
 YES NO

GASTRO-INTESTIONAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

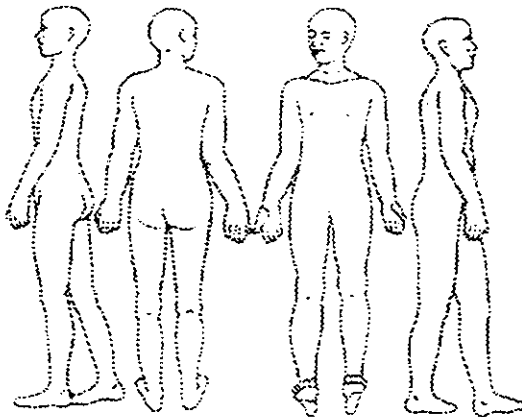
NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- _____

SYMPTOM LOCALIZATION



P ___ Pain T ___ Tender
 N ___ Numb H ___ Hypoesthesia
 S ___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

 Patient's Signature

..... DO NOT WRITE BELOW THIS LINE.....

Patient Accepted? Yes No Doctor's Signature _____

NOTICE OF PRIVACY PRACTICES

Randy W. Butler D.C.
1026 West Main Street # 100
Lewisville, Texas 75067
(972) 221-7533 (972) 219-6901

The health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill of your visit to your insurance company for payment.
- Health care operations including the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or health care operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such a consent as soon as reasonably practicable after the delivery of such treatment:
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to obtain such consent; or
- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicate with you, and we determine that, in our professional judgement, your consent to receive treatment is clearly inferred from circumstances.

We may contact you to provide appointment reminders, missed appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we already have taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- **The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.**
- **The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.**
- **The right to inspect and copy your protected health information.**
- **The right to amend your protected health information.**
- **The right to receive an accounting of disclosures of protected health information.**
- **The right to obtain a paper copy of this notice from us upon request.**

We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal and privacy practices with respect to protected health information.

This notice is effective as of November 01, 2002 and we are required to abide by terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

**Randy W. Butler D.C.
1026 West Main Street #100
Lewisville, Texas 75067
(972)221-7533
(972) 219-6901 Fax**

For more information about HIPAA or to file a complaint:

**The U.S. Department of Health
& Human Rights Services/
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1 (877) 696-6775**

CONSENT FOR USE AND DISCLOSURE OF INFORMATION

I have reviewed the *"Notice of Privacy Practices"* of Randy W. Butler D.C. and have had all questions answered by this office.

I also consent to the use or disclosure of my protected health information for the following purposes:

TREATMENT

IT WILL BE NECESSARY TO SHARE PROTECTED HEALTH INFORMATION WITH ALL MEMBERS OF THE TREATMENT TEAM FOR TREATMENT PURPOSES. THIS CAN INCLUDE EMPLOYEES IN THIS OFFICE AS WELL AS OTHER PROVIDERS.

PAYMENT

NECESSARY INFORMATION WILL BE SHARED WITH THE APPROPRIATE PAYER SOURCES AND THEIR REPRESENTATIVES FOR PAYMENT PURPOSES INCLUDING, BUT NOT LIMITED TO ELIGIBILITY, BENEFIT DETERMINATION, AND UTILIZATION REVIEW. IT WILL ALSO BE NECESSARY FOR YOUR BILLING PERSONNEL INCLUDING BUT NOT LIMITED TO EMPLOYEES, CASE MANAGERS, CLAIM REPRESENTATIVES, THIRD PARTY BILLING SERVICES OR CLEARINGHOUSES TO HAVE ACCESS TO PROTECTED HEALTH INFORMATION TO CARRY OUT THEIR JOB FUNCTIONS.

HEALTHCARE OPERATIONS

NECESSARY INFORMATION WILL BE SHARED FOR THE CONTINUING OPERATIONS OF THIS OFFICE. SOME EXAMPLES INCLUDE, BUT NOT LIMITED TO PEER REVIEW, ACCREDITATION, CREDENTIALING PROCESSES, AND COMPLIANCE WITH THE FEDERAL AND STATE LAWS.

I release Randy W. Butler D.C. to discuss my case with my spouse, parent or gaurdian.

I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing which will apply to disclosures and uses made subsequent to the revocation date.

Patients Name (Printed): _____

Date: _____

Patient Signature: _____

LETTER OF NO ACCIDENT OR INJURY

_____ I hereby state with my signature that I was not involved in any auto accident, slip and fall, or work injury. My treatment is in no way associated with any 3rd party, and no other party is responsible or liable for the cost of my treatment.

Please process and pay all claims immediately.

Sincerely,

Patient Signature

Date