Liberty Chiropractic Clinic

12325 Scarsdale BLVD. Houston TX 77089
281.484.9492 office 281.484.7527 fax

Appointment Date_____
Patient's Name_____
Patient's Address_____City/State_____Zip_____

D.O.B._____Age_____ ☐Single ☐Married ☐Divorced ☐Widowed No. of Children_____

Occupation_____Employer_____
Home phone_____Email address_____

Cell phone_____Appt. Confirmation Preference: ☐Phone Call ☐Text

Are you Insured? ☐Yes ☐No Name of Insurance Co. _____

Spouse Name_____ Phone #_____ Spouse D.O.B._____

Please list your family physician. May we have your permission to contact them? ☐Yes ☐No

_____

Date of your last physical exam_____Date of your last blood work_____

Emergency Contact_____Phone_____Relationship_____
Who referred you?_____Have you visited our website?_____

What is the PRIMARY reason for today's appointment?

_____

_____

_____

Are the conditions mentioned above due to a car accident? ☐Yes ☐No Date of accident:_____

Are the conditions mentioned above due to work related injury? ☐Yes ☐No Date of accident:_____

When and How did the condition(s) begin?_____

_____

What's the Quality of the Primary pain?☐Dull ☐Aches ☐Sharp ☐Shooting ☐Tingling ☐Burning

☐Throbbing ☐Deep ☐Nagging ☐Other_____

Does this pain radiate or travel into any other areas of your body? ☐Yes ☐No Where?_____

Do you have numbness or tingling in your body? ☐Yes ☐No Where?_____

How intense is your pain? ☐Mild ☐Moderate ☐Severe ☐Intense

Is your pain ☐CONSTANT or does it ☐COME AND GO?

Does anything aggravate the condition? ☐Yes ☐No - Describe _____

Does anything help/alleviate pain for the condition? ☐Yes ☐No - Describe_____

_____

Describe interventions, treatments, medications, surgery, or care that you have previously sought for your condition:

_____

List any additional conditions you are currently experiencing outside of the PRIMARY condition listed above:

Additional Condition(s):_____

Initials _____

Office Use Only: H: _____ W: _____ HR: _____ SpO_2: _____ BP: _____/_____

Past Health History: Please describe and list **YEAR** of each report.

Previous Illnesses + YEAR: _____

Previous Injury/Trauma + YEAR: _____

Broken Bones? Which + YEAR: _____

Allergies: _____

List any KNOWN DRUG ALLERGIES:_____

Medications:	Reasons for taking this medication:
1._____	_____
2._____	_____
Surgeries:	**Type of surgery + YEAR:**
1._____	_____
2._____	_____
3._____	_____

Females: Date of last menstrual period? _____ Are you currently pregnant? ☐Yes ☐No

Lifestyle:

How often do you exercise?	☐Daily	☐Weekly	☐Sometimes	☐Never
How often do you drink alcohol?	☐Daily	☐Weekly	☐Sometimes	☐Never
How often do you drink caffeine?	☐Daily	☐Weekly	☐Sometimes	☐Never
How often do you smoke?	☐Daily	☐Weekly	☐Sometimes	☐Never
How often do you vape?	☐Daily	☐Weekly	☐Sometimes	☐Never
How often do you recreational drugs?	☐Daily	☐Weekly	☐Sometimes	☐Never
How is your diet?	☐Healthy	☐Healthy Sometimes	☐Fast Food	

Auto Accident?

My Auto Insurance Co. _____ Claim # _____

Adjuster's Name _____ Adjuster's Phone # _____

Date of Injury _____ Time of Day _____ Location _____

Please describe the accident _____

_____

Is there any other Insurance Co involved? ☐Yes ☐No Do you have an attorney? ☐Yes ☐No

Insurance Co. Name _____ Attorney's Name_____

Phone # _____ Phone # _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Person responsible for payment_____

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me. I authorize Liberty Chiropractic Clinic to prepare and send any reports and forms necessary for collection of any payments from my Insurance Company or Attorney. I authorize payments to be made directly to Liberty Chiropractic Clinic. If I change Insurance Companies or Attorneys during my treatment I am obligated to inform Liberty Chiropractic Clinic immediately. I am aware that I am ultimately responsible for any and all balances due.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Liberty Chiropractic Clinic to provide me with chiropractic care, in accordance with this state's statutes.

_____ _____

Patient Signature Date

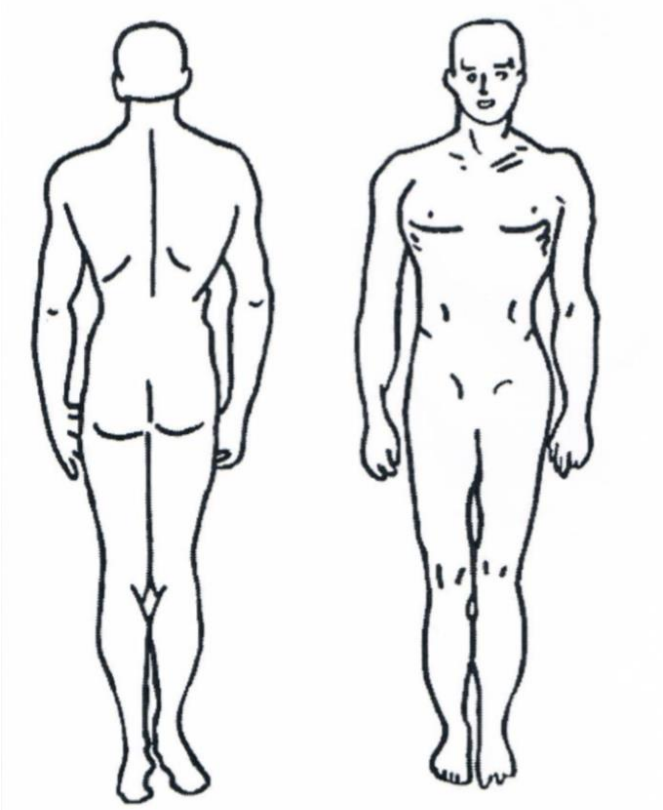
_____ _____

Guardian Signature Date

If you have had the following, or suffer from the following, please check below. If your Mother or Father have suffered from the following, please circle **(M)** mother, **(F)** father; or **(B)** both M & F if applicable.

Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally	Mother and/or Father		
Headache	☐	☐	M	F	B
Migraines	☐	☐	M	F	B
Neck Pain	☐	☐	M	F	B
Shoulder Pain	☐	☐	M	F	B
Arm/Hand Pain	☐	☐	M	F	B
Mid Back Pain	☐	☐	M	F	B
Low Back Pain	☐	☐	M	F	B
Hip Pain	☐	☐	M	F	B
Leg/Foot Problems	☐	☐	M	F	B
Disc Problems	☐	☐	M	F	B
Arthritis	☐	☐	M	F	B
Other Joint Pain	☐	☐	M	F	B
Numbness	☐	☐	M	F	B
Joint Swelling	☐	☐	M	F	B
Dizziness	☐	☐	M	F	B
Nausea	☐	☐	M	F	B
Weakness	☐	☐	M	F	B
Fatigue	☐	☐	M	F	B
Nervousness	☐	☐	M	F	B
Insomnia	☐	☐	M	F	B
Heart Problems	☐	☐	M	F	B
Frequent Colds	☐	☐	M	F	B
Nose Bleeds	☐	☐	M	F	B
Ringing in Ears	☐	☐	M	F	B
Earaches	☐	☐	M	F	B
Hearing Loss	☐	☐	M	F	B
Cough	☐	☐	M	F	B
Chest Pains	☐	☐	M	F	B
Female Problems	☐	☐	M	F	B
Allergies	☐	☐	M	F	B
Asthma	☐	☐	M	F	B
Cancer	☐	☐	M	F	B
Osteoporosis	☐	☐	M	F	B
Diabetes	☐	☐	M	F	B
Hypoglycemia	☐	☐	M	F	B
Digestive Problem	☐	☐	M	F	B
Urinary Problems	☐	☐	M	F	B
Skin Conditions	☐	☐	M	F	B

Circle the areas where you have any problems.
Please describe these problems.



Please complete: List any other health information that you feel would be beneficially known regarding your wellbeing and care. **Please be thorough and detailed**.

_____

_____

_____

_____

_____

Please Sign Below:

_____

Today's Date:

_____

Office Use Only

LIBERTY CHIROPRACTIC CLINIC
12325 Scarsdale Blvd.
Houston, TX 77089

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-ray(s), physical therapy techniques, on me (or on the named patient below for which I am legally responsible) which are recommended by John Doyle, D.C. and or any other licensed doctors or chiropractic who now or in the future render treatment to me while employed by, associated with or observing as a back up for **Liberty Chiropractic Clinic**.

I understand that, as with any health care procedures, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to, fractures, dislocations, muscle strain, costovertebral strains and separations. Some type of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in one to three million chance). I understand that **Liberty Chiropractic Clinic** screens patients for indications that they are candidates for chiropractic manipulation to the best of their ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) which the doctor feels at the time, based on all the facts then known, are in my best interest.

I have had an opportunity to discuss with John Doyle, D.C. and/or with office personnel the nature, purpose and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____
Print name of patient

_____ _____
Signature of patient Date

_____ _____
Signature of patient's representative Date
(if patient is a minor)

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Assignment of Benefits

Patient Information

Name: Last _____First _____ Middle Initial _____

Address_____

City, State _____ Zip Code _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (If other, please describe below.)

Other Relationship_____

Patient Date of Birth:_____

Insurance Subscriber/Holder Information

Name: Last _____First _____ Middle Initial _____

Health Plan Provider_____

Subscriber ID # _____ Group ID# _____

Insurance Subscriber Date of Birth:_____

Patient Declaration

I hereby authorize and direct payments to:

John Doyle, D.C.
Liberty Chiropractic Clinic
12325 Scarsdale Blvd.
Houston, TX 77089

_____ _____
Signature Date

LIBERTY CHIROPRACTIC CLINIC
12325 Scarsdale Blvd.
Houston, TX 77089

Patient Consent for Purpose of Treatment, Payment and Health Care Operations

I acknowledge that **Liberty Chiropractic Clinic's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices described the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Liberty Chiropractic Clinic**. I understand that I have the right to review the Notice of Privacy Practices prior to signing this document and the right to request restrictions as to how my health information may be used.

I understand that I may revoke this consent in writing, except in the instance **Liberty Chiropractic Clinic** has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, **Liberty Chiropractic Clinic** may refuse to treat me. I understand that **Liberty Chiropractic Clinic** reserves the right to change its Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by mail or in person.

Patient Name (Please print) _____ Date of Birth _____

Representatives Authorized to Act for Patient _____

Patient Signature _____ Date _____

Specific Health Care Authorization

The patient identified below authorizes **Liberty Chiropractic Clinic** to use and or disclose and Protected Health Information in accordance with the following:
1) I give **Liberty Chiropractic Clinic** to use my address, phone number, e-mail and clinical records to contact me with holiday cards, cards of other occasions and health related information. 2) I give **Liberty Chiropractic Clinic** to treat me in an open room. Should I need to speak with the doctor in private, the doctor will provide this.
You have the right to revoke this authorization in writing, at any time. However, your request to revoke this authorization is not effective to the extent that we have provided services or take action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written to the Privacy officer of **Liberty Chiropractic Clinic**. The written notice must contain your Name, date of birth, a clear statement of your intent to revoke this authorization, the date of your request and your signature. This revocation is not effective until it is received by the Privacy officer.

This authorization is requested by **Liberty Chiropractic Clinic** for its own use and disclosure of Protected Health Information.

_____ _____
Signature Date

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CANCELLATION / NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are *unable to schedule you* due to a seemingly "full" appointment book.

1. If an appointment is not cancelled at least 24 hours in advance you will be charged a fee of twenty five dollars ($25); this will not be covered by your insurance company. Initial _____

2. We understand that delays can happen however we must try to keep the other patients and the doctor on time. If you are more than 10 minutes past your scheduled appointment, you will be charged a fee of fifteen dollars ($15); this will not be covered by your insurance company.

_____

Patient Name (Print)

_____

Patient / Guardian Signature Date