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____________________________________Primary Language: _________________________________

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
☐Stiffness ☐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 complicating factors in your daily life that the Dr. should be aware of: (stressful job, weightlifting, dieting, caregiver to elderly/newborn,etc.) ____
____

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: ______________________________

Seasonal or Food 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

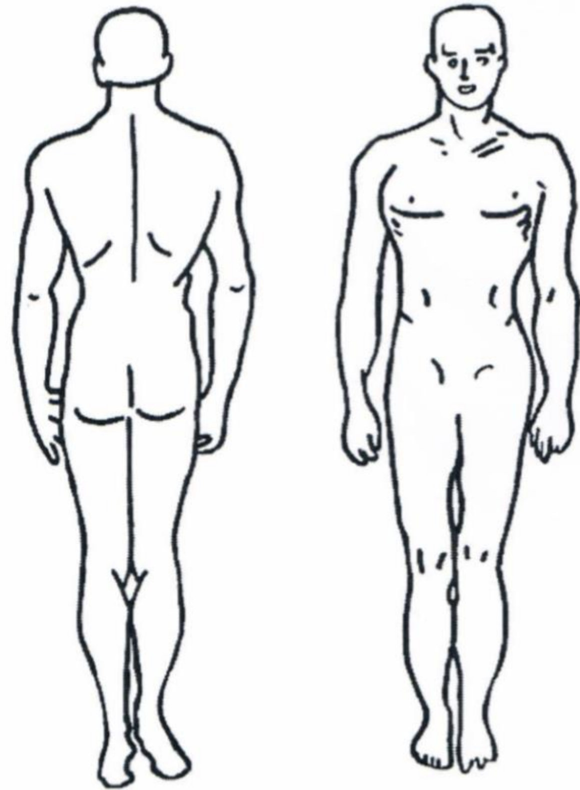
If you have had the following, or suffer from the following, please check below. If your Mother or Father have suffered from the following, please circle **(M)** mother, **(F)** father; or **(B)** both M & F if applicable.

Mother: ALIVE or DECEASED **Father:** ALIVE or DECEASED

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

Please Sign Below:

____



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

____

____

____

____

____

Today's Date:

____

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**.

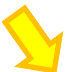
I understand that, as with any health care procedures, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to, fractures, dislocations, muscle strain, costovertebral strains and separations. Some type of manipulations of the 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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Houston, TX 77089

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

LIBERTY CHIROPRACTIC CLINIC
12325 Scarsdale Blvd.
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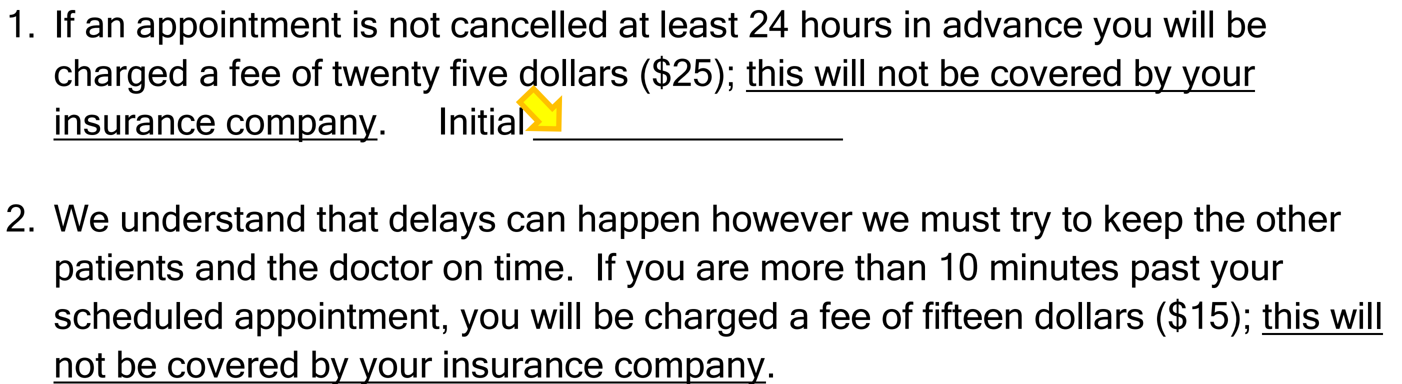
CANCELLATION / NO SHOW POLICY

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

FOR OFFICE USE ONLY:

97-	97140	98942	99214	S9090	G-Code		
97010	97530	98943	76-	L/S C/S	G0283	Tx Plan________________________	Copay ____________
97012	97535	99-	76140	____mins			
97014	98-	99203		____°	H/C Inst	Next Appt. ______________________	Payment __________
97035	98940	99204	S-Code	____lbs	P F G		C CK CC
97110	98941	99213	S8990			Insurance______________________	