BestHealth Chiropractic Clinic
New Patient Information

Date:

PATIENT INFORMATION					
Patient Name		DOB		o M o F	
Address		SSN			
City		State		Zip	
Home Phone		Pager			
Work Phone		Cell			
Driver Lic. #		State			
Nearest Relative		Phone			
How did you hear about this office?					

EMPLOYER INFORMATION					
Company					
Address					
City		State		Zip	
Medical Rep		Phone			
Job Descrip.		Fax			

RESPONSIBLE PARTY					
Insured		DOB		o M o F	
Home Phone		SSN			

INJURY INFORMATION			
Date of Injury		Injured Areas	
Reported to Supervisor?	o Yes o No	Supervisor's Name	

INSURANCE INFORMATION					
Company		Claim No.			
Address		Group #			
City		State		Zip	
Adjuster		Phone			
		Fax			

ATTORNEY INFORMATION					
Name		Phone			
Address		Fax			
City		State		Zip	
Do you have an accident report ? o Yes o No					

Signature: **Date:**

BestHealth
Chiropractic Clinic

6316 Azle Ave. Suite 600 *Office*(817) 237-5900
Fort Worth, TX 76106 *Fax*(817) 238-6318

Chiropractic • Acupuncture • Physical Medicine • Family Care • Injury Care

Informed Consent to Treatment

- **The nature of the chiropractic manipulation**

Your manipulations are performed by hand or mechanical instrument upon your body in such a way to move your joints, The manipulation can produce an audible "click" or "pop" much like when your have cracked your knuckles. You should realize that your bones are not cracking, but rather gases are being released from the joint and producing sound.

- **The material risks inherent in chiropractic manipulation**

As with any health care procedure, there are certain complications, which can arise during a chiropractic manipulation. Those complications include: fractures, dislocations, muscle strain, costovertebral (rib) strains and separations, and cervical myelopathy. Some type manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke, stiffness and soreness can be experienced following manipulation.

- **The probability of risks occurring**

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which is elevated during your history, examination, and x-rays (if deemed appropriate); Stroke resulting from cervical manipulation, although rare, and generalized stiffness and soreness following said manipulation.

- **Other treatments**

In addition to chiropractic manipulation, the following physiotherapy may be used to enhance your recovery and healing. These include hot/cold packs, interferential/electric stimulation, ultrasound, and intersegmental traction. We also involve the patient during their rehabilitation vigorous exercise programs utilizing several planned criteria's. These treatments involve the following risks: spreading of unknown infection, burns, soreness and electrical shock.

- **Referral for Diagnostic Testing and Evaluations**

In addition, you may be referred to other medical specialists for necessary testing and evaluation. Our office will schedule these tests and/or evaluations for your convenience.

- **Availability of other treatments**

Other treatment options for your condition include: over-the-counter medication and bed rest, medication for pain, inflammation and muscle spasm, hospitalization and surgery. If surgery is the option that is taking, then post-surgical rehabilitation is also implemented. By managing your care, we can make the appropriate referral to other specialists, when needed, to assist in the continuation of care and also be able to make educated suggestions for these treatments.

- **The material risks and probability of risks occurring in other treatment**

Professional literature describes highly undesirable effects from long-term use of over-the-counter medications. The probability of such complications arising is dependent upon the patient's general health, type of medication prescribed, and the amount of dosage and length of time taken.

- **The risks of remaining untreated**

Remaining untreated can lead to disc problems, arthritis, and neurological complications. Remaining untreated after an injury allows for the formation of adhesions from scar tissue resulting in decreased joint mobility. Decreased joint mobility can lead to neurological complications, pain, stiffness, and diminished blood flow commonly resulting in arthritis.

We do not offer to diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

By signing below, I acknowledge I have read the above explanations of chiropractic manipulations, treatments, and risks. I have weighed the risk involved in treatment and give my consent to the doctors of this clinic, their medical staff or their designees to perform the treatment, as may, in their professional judgment, be necessary. I also acknowledge no guarantee or assurances have been made to me as to the effect or results that can be obtained from the recommended treatment. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Printed Name: _____

Signature: _____

Date: _____

BestHealth Chiropractic Clinic
6316 Azle Ave. Suite 600 • Fort Worth, Texas 76135
(817) 237-5900 • Fax (817) 238- 6318
Julio Fajardo D.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgment.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____
_____
_____

_____ _____
Employee signature Date

BestHealth Chiropractic Clinic

6316 Azle Ave. Suite 600 • Fort Worth, Texas 76135

(817) 237-5900 • Fax (817) 238-6318

Julio Fajardo, DC

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name:

Patient's Date of Birth: Patient's SSN:

A. Person(s) or Organization(s) authorized to provide the information:

B. Person(s) or Organization(s) authorized to receive the information:

BestHealth Chiropractic Clinic

6316 Azle Ave. Suite 600

Fort Worth, Tx. 76135

C. Specific description of the information that may be used or disclosed (including date(s))

D. Specific description of how the information will be used:

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1) I understand that this authorization will **expire** *one year from signature date.*
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying *BestHealth Chiropractic Clinic* in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

NOTE:

You have the right to know specifically what information you are authorizing for release *(e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").*

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information *(e.g., the names of your health care provider(s)).*

You have the right to know who is going to use it and what it is going to be used for. *(e.g., John Smith, PhD / Research).*

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

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FINANCIAL POLICY AND AGREEMENT

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Incorporation of Assignment Terms and Definitions. In this Agreement "Office" and "Clinic" shall refer to **BestHealth Chiropractic Clinic.** I have reviewed the Office's Assignment form titled in short as "Assignment" or "Assignment / Lien." The terms and definitions contained in the Assignment are incorporated herein by reference.

Personal Responsibility for My Charges. I understand that I remain personally responsible for all my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to Office upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that any partial payments received by the Office towards my Charges shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full upon demand, and shall not constitute an accord and satisfaction of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). Without limiting the foregoing, I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or down coded. I further understand that a Payer may require certain Charges to be pre-certified or pre-authorized. I understand that there may be other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office ("Term of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I further agree that should the Office assist me in the verification process, I assume the risk that the Payer and/or the Office may fail to accurately understand or communicate to me the Terms of Non-Coverage. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office liable in any of the foregoing instances.

Collection of Higher of Allowed Amounts When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize and direct the Office to submit my Charges, as well as a copy of an Assignment, to any and all Payers including, without limit, my health benefit plan. I understand that some or all of these Payers may utilize fee schedules to which the Office has agreed or as imposed by law ("allowed fees"). I further understand that the fees allowed or utilized by one Payer may exceed the fees allowed by another Payer. In the event that the fees allowed or utilized by one Payer exceed the fees allowed by another Payer, I hereby authorize and direct the Office insofar as permitted by law to collect its Charges up to, but not in excess of, the higher of the two amounts. In the event that a particular Payer does not utilize any fee schedule at all, I direct the Office to collect up to its full Charges.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all checks listing me as a payee that are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, my treatment, or my Charges, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens as such term is defined by law. I further waive any statute of limitations that may apply in any action based upon this Agreement, my treatment, or my Charges.

I have read, understand, and agree to the terms of this Agreement.

Patient Name (print): _____

Patient Signature: _____ Date: _____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (print): _____

Parent/Guardian Signature: _____ Date: _____

BestHealth Chiropractic Clinic
Chief Complaints

Patient Name (please print): _____

Please list your symptoms that brought you to our office. List in the order of severity with your most severe symptom first and your least severe symptom last.

SYMPTOM	SEVERITY	QUALITY	DATE BEGAN	FREQUENCY
1)	o Mild o Moderate o Severe	o Dull o Sharp o Burning o Tingling o Stabbing	___/___/___	o Constant o Daily o 3^+ times/wk o 1-2 times/wk o other _____
2)	o Mild o Moderate o Severe	o Dull o Sharp o Burning o Tingling o Stabbing	___/___/___	o Constant o Daily o 3^+ times/wk o 1-2 times/wk o other _____
3)	o Mild o Moderate o Severe	o Dull o Sharp o Burning o Tingling o Stabbing	___/___/___	o Constant o Daily o 3^+ times/wk o 1-2 times/wk o other _____
4)	o Mild o Moderate o Severe	o Dull o Sharp o Burning o Tingling o Stabbing	___/___/___	o Constant o Daily o 3^+ times/wk o 1-2 times/wk o other _____
5)	o Mild o Moderate o Severe	o Dull o Sharp o Burning o Tingling o Stabbing	___/___/___	o Constant o Daily o 3^+ times/wk o 1-2 times/wk o other _____
6)	o Mild o Moderate o Severe	o Dull o Sharp o Burning o Tingling o Stabbing	___/___/___	o Constant o Daily o 3^+ times/wk o 1-2 times/wk o other _____
7)	o Mild o Moderate o Severe	o Dull o Sharp o Burning o Tingling o Stabbing	___/___/___	o Constant o Daily o 3^+ times/wk o 1-2 times/wk o other _____

Signature: _____ **Date:** _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ *Date* _____

1. Describe your symptoms _____

_____

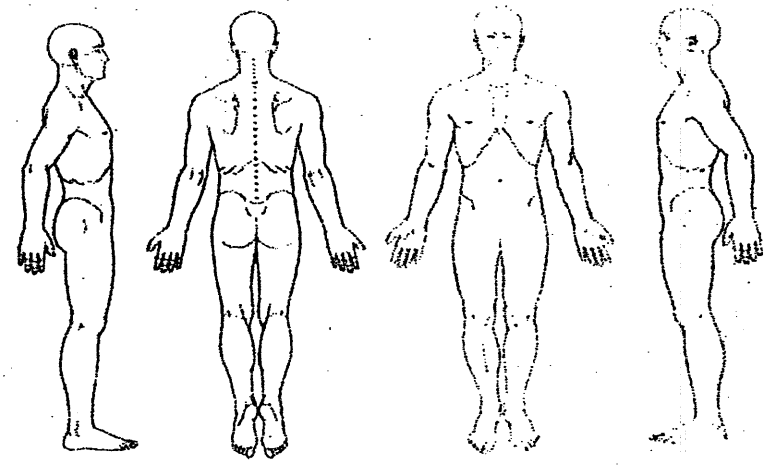
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

10. What is your occupation?

_____

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ *Date* _____

BestHealth Chiropractic Clinic

General Health / Social History

Are you taking any medications for *any* reason? Y / N Please list: _____

_____

Please list any medications to which you are *allergic*: _____

Is there any possibility you could be pregnant? Y / N Date of last menstrual period: _____

Cigarettes/tobacco	Y / N	Quantity per day _____
Alcohol	Y / N	Quantity per day _____
Coffee	Y / N	Quantity per day _____
Do you take vitamins?	Y / N	Please list _____

Do you exercise regularly / participate in sports? Y / N What kind / type? _____

_____

Hobbies:

Review of Symptoms

Below is a list of conditions. Circle conditions you have now and underline conditions you have had previously.

Diseases:
- ☐ *NONE*
- o Pneumonia
- o Asthma
- o Heart Disease
- o High Cholesterol
- o High Blood Pressure
- o Diabetes
- o Cancer/Tumors
- o Thyroid Problems
- o Prostate Problems
- o Arthritis
- o Epilepsy/Seizures
- o Mental Disorders
- o Eczema/Rashes
- o Migraines/HA
- o Hepatitis
- o Anxiety/Depression
- o Other: _____

General Health:
- o *NONE*
- o Allergies
- o Loss of sleep
- o Fever
- o Chills/Night sweats
- o Weight loss/gain without trying
- o Fatigue
- o Infections
- o Dizziness
- o Unusual bleeding
- o Ear aches
- o Ringing in the ears
- o Dental problems
- o Difficulty swallowing
- o Persistent cough
- o Coughing blood
- o Blurred vision
- o Specs of light
- o Chest pain
- o Shortness of breath
- o Palpitations (heart)
- o Swelling in hands/feet
- o Cold hands/feet
- o Nausea/Vomiting
- o Heartburn
- o Abdominal pain
- o Bowel problems
- o Bladder problems
- o Irregular period
- o Forgetfulness
- o Confusion
- o Fainting
- o Tingling / Numb extremities
- o Loss of balance / coordination

Past Medical History

Please answer the following questions. If "Yes," please describe.

- Have you ever had any serious accidents? Y / N _____
- Have you ever broken any bones? Had dislocations? Y / N _____
- Have you ever been hospitalized? Y / N _____

_____

- Have you ever had surgery of any type? Y / N _____

_____

Please fill in the dates (year) that you have ever had any of the following.

Blood test	_____	MRI	_____	Urinalysis	_____
CT scan	_____	Ultrasound	_____	Radiation treatment	_____
X-rays	_____	Other special tests or treatment	_____		

What were the reasons for these tests/treatments? _____

_____

Date of your last physical: _____ Primary care physician's name and phone #: _____

Have you ever been to a chiropractor before? Y / N Chiropractor's name / Date of last visit: _____

_____

Pt. Initials: _____ Date: _____

As we welcome in 2016, we have a few policy changes that we need to share with you.

In order to maintain quality of service, our office is implementing a fee for missed appointments. We ask that you give us 24 hours notice if you will be unable to make your appointment. After the first "no call-no show," we will begin assessing a $25 fee for each subsequent missed appointment. We do this because our schedule stays full, and we routinely have people on the waiting list.

Please be prompt for your appointment times, as we are here to serve you. If you are going to be more than 15 minutes late, please call and let us know so that we can reschedule you.

Dr. Fajardo is the best in the business, and he is often scheduled out weeks in advance. We do not desire to have to impose the above fees, but our time is set aside for you and only you, and it's very important that you be here.

Thank you for continuing to trust us with your care!

_____ _____

Patient Signature Date

HIPAA Notice of Privacy Practices

BestHealth Chiropractic Clinic
6316 Azle Avenue, Suite 600
Fort Worth, TX 76135
817 237-5900

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.