GOSS CHIROPRACTIC & WELLNESS CONFIDENTIAL PATIENT HEALTH HISTORY

Patient Information

Today's Date: _____

Name: _____ **Preferred Name**: _____

Date of Birth_____/_____/_____ **Gender**: Male /Female **Marital Status:** Married / Single / Other

Address: _____ **City**:_____ **State**: ____ **ZIP**_____

Mobile Phone: _____ **Home Phone:** _____ **Email**: _____

Best way to reach you: Home/Cell/Work/Email Employed? Yes / No Employer: _____

Who may we thank for referring you to our office?_____

CMS requires providers to report both race and ethnicity

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to answer

Race: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian)
Native Hawaiian or Pacific Islander / Other/ Decline to answer

Emergency Contact Information

Name: _____ Primary Care Physician: _____

Mobile Phone: _____ Doctors Phone: _____

Relationship: _____

Financial Information *please allow our staff to make a copy of your insurance card*

Insurance Self Pay (Cash) Other (please explain)

Primary Insurance

Insurance Company: _____

ID Number: _____

Relation to insured: _____

Other than self

Insured's name: _____

Insured's date of birth: ___/____/_____

Secondary Insurance

Insurance Company: _____

ID Number: _____

Relation to insured: _____

Other than self

Insured's name: _____

Insured's date of birth:___/____/_____

List all medications, dosage and frequency (i.e. 5 mg once a day, etc) If you have a list, we can make a copy

_____

_____

Surgeries:

Date:	Procedure:	Description:
___/___ /____	_____	_____
___/___ /____	_____	_____
___/___ /____	_____	_____
___/___ /____	_____	_____

History of Complaint

Please explain the condition(s) that brought you into the office

Primary: _____ **Frequency**: On & Off / Constant

What does your complaint **feel like?** Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Numbness

Does anything make the complaint **better**? Ice / Heat / Rest / Movement / Stretching / OTC / Other:_____

Does anything make the complaint **worse**?: Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Please rate your pain: 10 being the worst pain and zero being no pain: **0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10**

Describe when and how it began: _____

Secondary: _____ **Frequency**: On & Off / Constant

What does your complaint **feel like?:** Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Numbness

Does anything make the complaint **better**? Ice / Heat / Rest / Movement / Stretching / OTC / Other:_____

Does anything make the complaint **worse**?: Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Please rate your pain: 10 being the worst pain and zero being no pain: **0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10**

Describe when and how it began:_____

Have you been under care for the condition(s) previously? Yes / No

If yes, when?: _____ By whom?_____

Name of previous chiropractor: _____ Date of last adjustment: _____

Are you *currently* experiencing any of these symptoms? (Circle all that apply)

General
- Recent Weight Change
- Fever
- Fatigue
- Other: _____

Neurological
- Numbness/tingling
- Loss of feeling
- Dizziness/light headed
- Frequent headaches
- Tremors
- Stroke
- Previous head injury?
- Other: _____

Gastrointestinal
- Loss of appetite
- Nausea or vomiting
- Abdominal pain

Cardiovascular & Heart
- Chest Pains
- Heart Beat changes
- Blood Pressure Problems
- Swelling of Hands/Ankles/Feet
- Heart Problems
- Other: _____

Endocrine, Hematologic,& Lymphatic
- Thyroid
- Diabetes
- Anemia
- Other: _____

Ears, Nose and Throat:
- Ear-ache/drainage/ringing
- Sinus, Allergy problems
- Swollen throat/swollen glands
- Hearing Loss
- Other: _____

Respiratory
- Difficulty Breathing
- Asthma/Wheezing
- Lung problems
- Other: _____

WOMEN ONLY
- Are you pregnant?
- Yes-Due Date_____
- No
- Other: _____

I have read the above information and certify it to be true and correct to the best of my knowledge. I hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I choose to decline a receipt of my clinical summary after every visit. (These summaries are often blank as a result of the frequency of chiropractic care)

Patient/Guardian Signature: _____

Goss Chiropractic & Wellness

2824 Terrell Rd. #204, Greenville, Texas 75402

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Release of Information: Your Protected Health Information (PHI) will be used by this office and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Clinical Summary Report (CCR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Goss Chiropractic & Wellness to save these electronically for me and not print them out after each visit. I understand that, upon my request that those reports are available to be printed or emailed to me for review.

Appointment Reminders: Our office contacts you with appointment reminders via text or voicemail. By signing below, you are giving us authorization to contact you by home/cell phone for appointment reminders.

I,_____**(print)** acknowledge that I have reviewed the above information and

__**DO** (or) **DO NOT** authorize this office to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for the purposes of processing my claim for benefits and payment of services rendered to me. I do understand that if I choose to refuse release of this information, that my PHI will be used **within** the office for purposes of my care, to those individuals designated by the doctor.

Patient or Guardian Signature: X_____Date: _____

Assignment of Benefits / Assignment of Cause of Action / Contractual Lien

Our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Your insurance should pay claims within 30 days from the date in which it was filed. In the event that your insurance company does not pay in a timely manner, you may be asked to contact your insurance carrier.

Irrevocable Assignment of Rights: I hereby assign the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request. To any insurance company providing benefits or settlement of a claim, for any treatment rendered by this facility/physician within 15 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate check to pay in full all services rendered by this office.

I instruct checks to be made payable to Goss Chiropractic & Wellness, and payment to be sent to 2824 Terrell Rd. #204, Greenville, TX 75402

This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account and remit payment of all such sums directly to the above named doctor and/or treating facility upon receipt of my settlement award(s). I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by this facility/physician, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

Limited Power of Attorney: I hereby grant the above named facility/physician the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company for treatment rendered by this office. I agree that any payment in excess of the charges for treatment rendered will be credited to my account or forwarded to my address.

Rejection in Writing: I hereby authorize the above facility/physician to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request of the provider, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. If my carrier is unable to provide said rejections in a timely manner, I acknowledge that I am entitled to minimum levels of coverage, as per section 1952.152 of the Texas Insurance Code, and further instruct my carrier to pay up to available limits directly to the facility named above.

If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

I,_____**(print)**, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to **Goss Chiropractic & Wellness**, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the above rights, power and authority.

Patient or Guardian Signature: X_____Date: _____

Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic procedures, various forms of physical therapy, physical examination, x-ray studies, and/or any clinical services that are deemed necessary in my case to be administered by the doctor and/or any support staff employed or contracted by this office or clinic. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and include, but are not limited to, muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fracture, disc injury, stroke, dislocations and sprains.

I understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also be used to alleviate other symptoms through a conservative approach with hopes to avoid more invasive procedures. I further understand that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has the right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I further understand that there are other treatment options available for my condition, and that I have the right to a second opinion should I have concerns as to the nature of my symptoms and/or treatment options. If during the course of my care my insurance company requires me to take an examination from any other doctor, I will notify this facility/physician immediately. I understand that failure to do so may jeopardize my case.

I,_____**(print)** have read the above consent and I have had an opportunity to ask questions regarding its content. By signing below, I agree to the above-named procedures and intend this consent to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with this office.

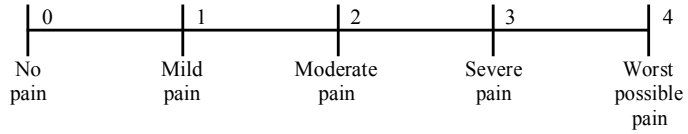
Patient or Guardian Signature: X_____Date: _____

Functional Rating Index

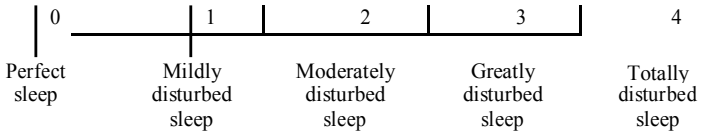
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

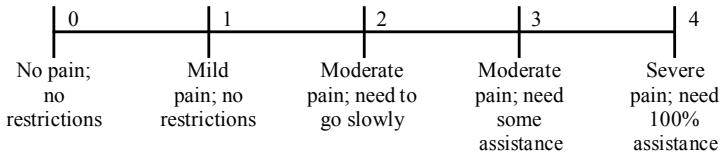
1. Pain Intensity



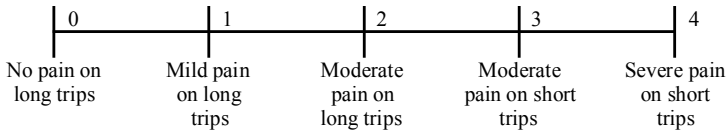
2. Sleeping



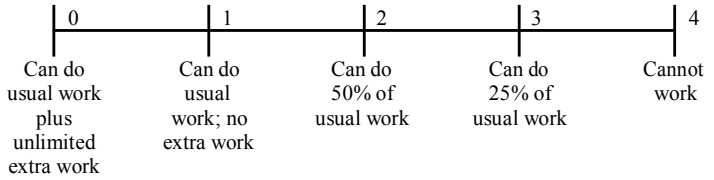
3. Personal Care (washing, dressing, etc.)



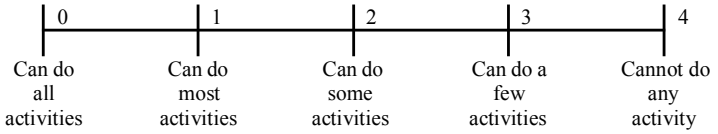
4. Travelling (driving, etc.)



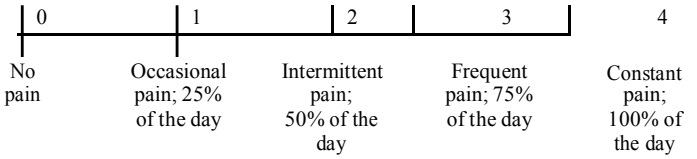
5. Work



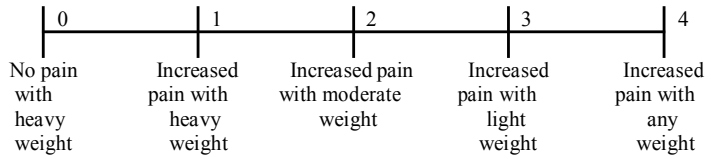
6. Recreation



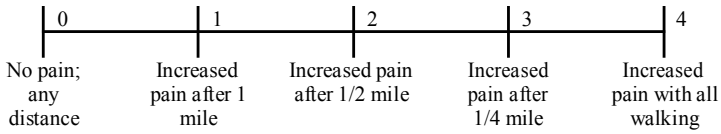
7. Frequency of Pain



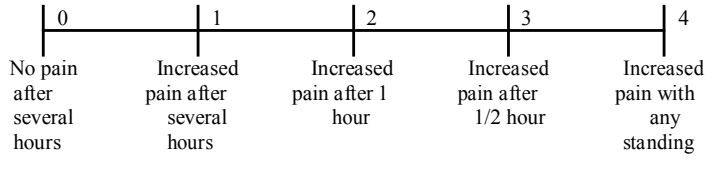
8. Lifting



9. Walking



10. Standing



Patient's Signature _____ **Date** _____

For Office Use Only:

Practitioner ID#: _____

Total Score _____ **/ 40**

Clinical Diagnosis Codes:

Patient ID#: _____