Date:_________________

# PATIENT APPLICATION

Name: _______________________________________________ (Age) ________ Gender: M F
Home Address: ________________________________________ Home Phone: ( )___________________
City, State, Zip: ______________________________________ Cell Phone: ( )___________________
Email Address: _________________________________________ Work Phone: ( )___________________
Birth Date: _____/____/____ Social Security #_________________________ Marital Status: S M D W
Occupation: ____________________________________________________________________________
Spouse's Name: ___________________________________ Cell Phone: ( ) ___________________________
**How were you referred to this office?** __________________________________________________________

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## PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint: _______________________________________________________________
Is this purpose related to an auto accident / work injury? **Yes No If so, when:________________________**
When did this condition begin?_____/_____/_____ Did it begin: **Gradual Sudden Progressive over time**
What activities aggravate your symptoms? __________________________________________________________
Is there anything, which has relieved your symptoms?_________________________________________________
Type of Pain: **Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting**
Does the pain radiate into your: Arm__ Leg__ Does not radiate__ *Is this condition getting worse? **Yes No**
How often do you experience these symptoms throughout the day? **100% 75% 50% 25% Only with activity**
Does complaint(s) interfere with: Work__ Sleep__ Hobbies__ Daily Routine__ Explain:_________________
Have you experience this condition before? **Yes No** If so, explain: ____________________________________
Who have you seen for this? _____________________________ What did they do?________________________
How did you respond?____________________________________________________________________________

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## EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? **Yes No** Who? _______________________ When?______________
Reason for visits: _______________________________________________________________________________
How did you respond?_____________________________________________________________________________
Did your previous chiropractor take before and after x-rays? **Yes No**
Are you aware of any of your poor posture habits? **Yes No**
Explain:__________________________________________________________________________________________

# CURRENT HEALTH LIFESTYLE

Do you exercise? Yes No How often?________________________________________________
Do you smoke: Yes No How much? ________________________________________________
Do you drink alcohol? Yes No How much / week? ______________________________________
Do you drink coffee? Yes No How many cups a day?____________________________________
Do you take supplements (vitamins, minerals, herbs)? ____________________________________

**CERVICAL SPINE (NECK)**

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body.
Do you experience…

- ☐ Neck Pain
- ☐ Pain in your shoulders/arms/hands
- ☐ Numbness/tingling in arms/hands
- ☐ Hearing disturbances
- ☐ Weakness in grip
- ☐ Headaches
- ☐ Dizziness
- ☐ Visual disturbances
- ☐ Coldness in hands
- ☐ Thyroid conditions
- ☐ Sinusitis
- ☐ Allergies/Hay Fever
- ☐ Recurrent colds/Flu
- ☐ Low Energy/Fatigue
- ☐ TMJ/Jaw Pain/Clicking

**THORACIC SPINE (UPPER BACK)**

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body.
Do you experience…

- ☐ Heart Palpitations
- ☐ Heart Murmurs
- ☐ Tachycardia
- ☐ Heart Attacks/Angina
- ☐ Recurrent Lung Infections/Bronchitis
- ☐ Asthma/Wheezing
- ☐ Shortness of Breath
- ☐ Pain on Deep inspiration/Expiration

**THOPRACIC SPINE (MID BACK)**

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves in your ribs/chest and upper digestive tract, and affect these parts of your body.
Do you experience…

- ☐ Mid Back Pain
- ☐ Pain in your Ribs/Chest
- ☐ Indigestion/Heartburn
- ☐ Reflux
- ☐ Nausea
- ☐ Ulcers/Gastritis
- ☐ Hypoglycemia
- ☐ Tired/Irritable after eating or when you haven't eaten in a while

**LUMBAR SPINE (LOW BACK)**

Postural distortions from subluxations (resulting from Forward Head Syndrome) will weaken the nerves in your legs/feet and pelvic organs and affect these parts of your body.
Do you experience…

- ☐ Pain in your hips/legs/feet
- ☐ Numbness/tingling in your legs/feet
- ☐ Coldness in your legs/feet
- ☐ Muscle cramps in your legs/feet
- ☐ Constipations / Diarrhea
- ☐ Weakness/injuries in your hips/knees/ankles
- ☐ Low back pain
- ☐ Frequent/difficulty urinating
- ☐ Menstrual irregularities/cramping (female)
- ☐ Sexual dysfunction

Please list any health conditions not mentioned: ________________________________________

List any medications currently taking: ____________________________________________________________
_______________________________________________________________________________________

List all past surgeries: ______________________________________________________________________
List all previous accidents and falls: ____________________________________________________________

## TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

**Adjustment**: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

**Health**: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation**: A misalignment of one or more the 24 Vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the bodys ability to express its maximum health potential.

## CONSENT TO CARE

I do hereby authorize the doctors of North Houston Spine & Sports Medicine to administer such care that is necessary for my particular case. This care may include consultations, examinations, spinal adjustments and other chiropractic/rehab procedures, including various physical therapy & diagnostic x-rays or any other procedures that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor to allow the doctor of chiropractic and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic, including those working at this clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic and/or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. The doctor will not be held responsible for any health conditions or diagnoses which are preexisting, giving by another health care practitioner.

I clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at the time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, ____________________, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the doctors recommended procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

**Signature** ______________________________________ **Date** ______________________ *(If under age 18, Parents signature)*

## PATIENT CONSENT TO X-RAY

**I____________________________________ authorize the performance of diagnostic x-rays examination of myself which the above doctor or his associate may consider necessary of advisable in the course of my examination and treatment.**

**Signed_____________________________________ Date____________________**

## CONSENT TO X-RAY A MINOR CHILD

**I_________________________________________ authorize the performance of diagnostic x-ray examination of my child or ward which the above doctor or his associate may consider necessary or advisable in the course of examination and treatment.**

**Signed_______________________________________ Date_______________________**

## VERFICATION OF NOT PREGNANT

**This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor or his associates have my permission to perform diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child.**

**Signed______________________________________ Date _______________________**

# PRIVACY CONFIDENTIALITY STATEMENT

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information.*

**DISCLOSURE OF INFORMATION**

We may disclose information to other healthcare professionals and/or your insurance carrier for treatment, payment or healthcare operations. Additional disclosure may be necessary to comply with Workers' Compensation and Public Health Laws as well as judicial proceedings. We may contact a family member or other authorized person in the event of an emergency. Be assured that we will not disclose any information without your expressed written consent unless compelled to do so by legal authority. Further you will be contacted by phone or mail in the event a request for information is made.

***Appointment reminder***

It is our policy to call your home or office to remind you of your appointment time. If you are not at home we leave a message on your answering machine or with the person answering the phone. We will not leave any message that discloses confidential information. If you would like to use an alternate contact number, please inform us the number you would prefer.

***Facility set up***

While our examination and treatment rooms are private, this office utilizes an open exercise/rehabilitation setting. Staff and doctors will maintain to ensure privacy, but there may be some inadvertent disclosure to others in the facility at the same time.

***Your Rights***

Send us a written request to see or obtain a copy of the information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as other doctors or hospitals. Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests and in some instance, they may be prohibited by law. Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or health care operations, or the law otherwise restricts the accounting. You have the right to inspect and have a copy of your health information. There is no cost for the first copy. Any copy thereafter will be $20 first 50 pages then .50 cent per page after.

You have the right to amend your information. Please note that we have the right to disagree with your amendments. If there is disagreement, you will be provided with information about our denial of your amendment and how you may appeal the denial of amendment.

***Complaints***

Complaints about your privacy rights or how your privacy is handled at this office can be directed to Dr. Tim Runnels by calling this office or directing a letter to his attention. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to:

DHHS (Office of Civil Rights)
200 Independence Ave. S.W.
Room 509F HHH Building
Washington, D.C. 20201

**Patient Signature ________________________________________ Date ____________________**

**The following names are of people who can have access to my protected health information:**

Name: ______________________________________________________________________

Name: ______________________________________________________________________

# Medical and Automobile Insurance Acceptance

I understand and agree the health and accident insurance policies are an arrangement between the insurance company and me. The Doctors' office will prepare reports and forms necessary to assist me in the filing of my claim with the insurance company (unless you are self-pay or 3rd party claim) but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the Doctor will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payments for these immediately due and payable. Should a third-party collection become necessary, I agree to pay all fees involved in collection of the account.

I authorize Dr. Tim Runnels to examine and treat my condition as deemed appropriate through the use of Chiropractic health care, and I give authority for these procedures to be pre-formed. The amount paid to the Doctors' office for X-rays is for the examination only and will remain on file at the Doctors office as long as I am a patient. I am the responsible party for payment of any treatment received or incurred on the account. Dr. Runnels only provides chiropractic care and/or physical therapy and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

***Please read the following policy regarding assignments***:

1. At the beginning of your treatment our office will attempt to verify your policy benefits, however, this DOES NOT guarantee your insurance policy or payments.
2. You will be responsible for your deductible and co-payment. If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are aware of the denial.
3. Your insurance should pay within 60 days from the date in which it was filed.
4. 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.
5. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to pay.
6. Any overpayments made by your insurance company which credits your account will be refunded to them.
7. If you discontinue care without the doctors' authorization, the balance on your account is due and payable immediately, even if your insurance has been filed. (If your insurance does pay after your account has been paid, refunds will be sent to you.)

**I have read and understand the policy regarding insurance assignments. I realize that I am responsible for all charges incurred by me at this office.**

**Signature: ____________________________________ Date: __________________________**