Harper Wellness and Rehab Center

CONFIDENTIAL PATIENT INFORMATION

Please Print

Date:_____

First Name:_____ Last Name:_____ Preferred Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Primary Phone:_____ Secondary Phone:_____ Cell Phone:_____

Sex: ❑ M ❑ F Marital Status: ❑ M ❑ S ❑ W ❑ D Birth Date:_____ Age:_____

Social Security #:_____ Spouse's Name:_____

Home Email Address:_____ Work Email Address_____

Referred By: ❑ Patient:_____ ❑ Physician :_____

❑ Insurance Co:_____ ❑ Staff ❑ Health Fair ❑ Google Ad/Search ❑ Chiro 123 ❑ Facebook/Twitter/BlogSpot

Work Status: ❑ Employed ❑ Full-Time Student ❑ Part-Time Student Other:_____

Employer:_____ Occupation:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Race (check one) ❑White ❑Black/African American ❑Hispanic ❑American Indian/Alaskan Native ❑Asian ❑Asian Indian ❑Chinese ❑Filipino ❑Japanese ❑Korean ❑Vietnamese ❑Native Hawaiian or other Pacific Island ❑Guamanian or Chamorro ❑Samoan ❑Other ❑I choose not to specify

Multi-Racial (check one) ❑Yes ❑No ❑Unknown

Ethnicity (check one) ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language (check one) ❑English ❑ Spanish ❑American Sign Language ❑Chinese ❑ French ❑German ❑Tagalog ❑Vietnamese ❑Italian ❑Korean ❑Russian ❑Polish ❑Arabic ❑Portuguese ❑Japanese ❑French ❑Creole ❑Greek ❑Hindi ❑Persian ❑Urdu ❑Gujarati ❑Armenian ❑I choose not to specify

Verification Question? (choose only one question, then give the answer to that question)

❑ What is the name of your favorite pet? ❑What city were you born in? ❑What high school did you attend?
❑What is your favorite movie? ❑What street did you grow up on? ❑What is your favorite color?

Verification Answer to the chosen question (MUST BE AT LEAST 6 CHARACTERS): _____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Never been a smoker ❑ Former smoker
If yes, how often do you smoke: ❑Current everyday smoker ❑Current someday smoker
If yes, what is your level of interest in quitting smoking? 0 1 2 3 4 5 6 7 8 9 10

Has any doctor diagnosed you with Diabetes presently? ❑Yes ❑No If yes, what kind? ❑Type I ❑Type II
If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑Yes ❑No ❑ Not Sure

Has any doctor diagnosed you with Hypertension presently? ❑Yes ❑No If yes, describe_____

Were you involved in an auto accident? ❑ **Yes** ❑ **No** ***If you answered yes to either question, please***
Were you hurt on the job? ❑ **Yes** ❑ **No** ***notify the front desk NOW.***

Do you have Health Insurance? ❑ Yes ❑ No

POLICY HOLDER INFORMATION: Policy Holder Employer:_____

Name of Insured:_____ Relationship: ❑ Self ❑ Spouse ❑ Parent

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Social Security #:_____ Birth Date:_____

Name of Insurance Company:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Policy #:_____ Group #:_____

Are you covered on an additional Health Insurance Policy? ❑ Yes ❑ No

Back Index

Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain comes and goes and is very severe.
- ❑ The pain is very severe and does not vary much.

Personal Care

- ❑ I do not have to change my way of washing or dressing in order to avoid pain
- ❑ I do not normally change my way of washing or dressing even though it causes some pain
- ❑ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ❑ Because of the pain I am unable to do some washing and dressing without help.
- ❑ Because of the pain I am unable to do any washing and dressing without help.

Sleeping

- ❑ I get no pain in bed
- ❑ I get pain in bed but it does not prevent me from sleeping well
- ❑ Because of pain my normal sleep is reduced by less than 25%
- ❑ Because of pain my normal sleep is reduced by less than 50%
- ❑ Because of pain my normal sleep is reduced by less than 75%
- ❑ Pain prevents me from sleeping at all

Lifting

- ❑ I can lift heavy weights without extra pain
- ❑ I can lift heavy weights but it causes extra pain
- ❑ Pain prevents me from lifting heavy weights off the floor
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table)
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can only lift very light weights

Sitting

- ❑ I can sit in any chair as long as I like
- ❑ I can only sit in my favorite chair as long as I like
- ❑ Pain prevents me from sitting more than 1 hour
- ❑ Pain prevents me from sitting more than ½ hour
- ❑ Pain prevents me from sitting more than 10 minutes
- ❑ I avoid sitting because it increases pain immediately

Traveling

- ❑ I get no pain while traveling
- ❑ I get some pain while traveling but none of my usual forms of travel make it worse.
- ❑ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ❑ I get extra pain while traveling which causes me to seek alternate forms of travel
- ❑ Pain restricts all forms of travel except that done while lying down
- ❑ Pain restricts all forms of travel

Standing

- ❑ I can stand as long as I want without pain
- ❑ I have some pain while standing but it does not increase with time
- ❑ I cannot stand for longer than 1 hour without increasing pain
- ❑ I cannot stand for longer than ½ hour without increasing pain
- ❑ I cannot stand for longer than 10 minutes without increasing pain
- ❑ I avoid standing because it increases pain immediately

Social Life

- ❑ My social life is normal and gives me no extra pain
- ❑ My social life is normal but increases the degree of pain
- ❑ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.)
- ❑ Pain has restricted my social life and I do not go out very often
- ❑ Pain has restricted my social life to my home
- ❑ I have hardly any social life because of pain

Walking

- ❑ I have no pain while walking
- ❑ I have some pain while walking but it doesn't increase with distance
- ❑ I cannot walk more than 1 mile without increasing pain
- ❑ I cannot walk more than ½ mile without increasing pain
- ❑ I cannot walk more than ¼ mile without increasing pain
- ❑ I cannot walk at all without increasing pain

Changing degree of pain

- ❑ My pain is rapidly getting better
- ❑ My pain fluctuates but overall is definitely getting better
- ❑ My pain seems to be getting better but improvement is slow
- ❑ My pain is neither getting better or worse
- ❑ My pain is gradually worsening
- ❑ My pain is rapidly worsening

Neck Index

Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ❑ I have no pain at the moment
- ❑ The pain is very mile at the moment
- ❑ The pain comes and goes and is moderate
- ❑ The pain is fairly severe at the moment
- ❑ The pain is very severe at the moment
- ❑ The pain is the worst imaginable at the moment

Personal Care

- ❑ I can look after myself normally without causing extra pain
- ❑ I can look after myself normally but it causes extra pain
- ❑ It is painful to look after myself and I am slow and careful
- ❑ I need some help but I manage most of my personal care
- ❑ I need help every day in most aspects of self care
- ❑ I do not get dressed, I was with difficulty and stay in bed

Sleeping

- ❑ I have no trouble sleeping
- ❑ My sleep is slightly disturbed (less than 1 hour sleepless)
- ❑ My sleep is mildly disturbed (1-2 hours sleepless)
- ❑ My sleep is moderately disturbed (2-3 hours sleepless)
- ❑ My sleep is greatly disturbed (3-5 hours sleepless)
- ❑ My sleep is completely disturbed (5-7 hours sleepless)

Lifting

- ❑ I can lift heavy weights without extra pain
- ❑ I can lift heavy weights but it causes extra pain
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on the table)
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
- ❑ I can only lift very light weights
- ❑ I cannot lift of carry anything at all

Reading

- ❑ I can read as much as I want with no neck pain
- ❑ I can read as much as I want with slight neck pain
- ❑ I can read as much as I want with moderate neck pain
- ❑ I cannot read as much as I want because of moderate neck pain
- ❑ I can hardly read at all because of severe neck pain
- ❑ I cannot read at all because of neck pain

Driving

- ❑ I can drive my car without any neck pain
- ❑ I can drive my car as long as I want with slight neck pain
- ❑ I can drive my car as long as I want with moderate neck pain
- ❑ I cannot drive my car as long as I want because of moderate neck pain
- ❑ I can hardly drive at all because of severe neck pain
- ❑ I cannot drive my car at all because of neck pain

Concentration

- ❑ I can concentrate fully when I want with no difficulty
- ❑ I can concentrate fully when I want with slight difficulty
- ❑ I have a fair degree of difficulty concentrating when I want
- ❑ I have a lot of difficulty concentrating when I want
- ❑ I have a great deal of difficulty concentrating when I want
- ❑ I cannot concentrate at all

Recreation

- ❑ I am able to engage in all my recreation activities without neck pain
- ❑ I am able to engage in all my usual recreation activities with some neck pain
- ❑ I am able to engage in most but not all my usual recreation activities because of neck pain
- ❑ I am only able to engage in a few of my usual recreation activities because of neck pain
- ❑ I can hardly do any recreation activities because of neck pain
- ❑ I cannot do any recreation activities at all

Work

- ❑ I can do as much work as I want
- ❑ I can only do my usual work but no more
- ❑ I can only do most of my usual work but no more
- ❑ I cannot do my usual work
- ❑ I can hardly do any work at all
- ❑ I cannot do any work at all

Headaches

- ❑ I have no headaches at all
- ❑ I have slight headaches which come infrequently
- ❑ I have moderate headaches which come infrequently
- ❑ I have moderate headaches which come frequently
- ❑ I have severe headaches which come frequently
- ❑ I have headaches almost all the time

Complaint #1:_____

How long have you had this condition?_____ Most recent date of onset for this episode:_____

Is Condition: ❑ Constant (76-100% of time) ❑ Frequently (51-75% of time) ❑ Occasionally (26-50% of time) ❑ Intermittently (0-25% of time)

Please indicate the character of your pain below:

A. ❑ Dull or ❑ Sharp B. ❑ Deep or ❑ Surface C. ❑ Aching or ❑ Knife-like D. ❑ Burning or ❑ Pins & Needles E. ❑ Tingling or ❑ Numbness

Please indicate the onset of your condition: ❑ Immediate ❑ Gradual

Average pain intensity:

Last 24 hours: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Past Week: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

In general, is your pain worse when you are moving about or when you are not moving?_____

Please indicate what helps you to relieve the pain: ❑ Lying ❑ Sitting ❑ Walking ❑ Hot Packs ❑ Standing ❑ Rest ❑ Cold Packs

❑ NOTHING ❑ Other:_____ ❑ Medication (Please List):_____

Is your condition ***better*** in the ❑ morning or ❑ at night? Is your condition ***worse*** in the ❑ morning or ❑ at night?

How much have your symptoms interfered with your usual daily activities? ❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

What other doctors have you seen for this condition? Give type of treatment and dates:_____

Complaint #2:_____

How long have you had this condition?_____ Most recent date of onset for this episode:_____

Is Condition: ❑ Constant (76-100% of time) ❑ Frequently (51-75% of time) ❑ Occasionally (26-50% of time) ❑ Intermittently (0-25% of time)

Please indicate the character of your pain below:

A. ❑ Dull or ❑ Sharp B. ❑ Deep or ❑ Surface C. ❑ Aching or ❑ Knife-like D. ❑ Burning or ❑ Pins & Needles E. ❑ Tingling or ❑ Numbness

Average pain intensity:

Last 24 hours: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Past Week: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

In general, is your pain worse when you are moving about or when you are not moving?_____

Please indicate what helps you to relieve the pain: ❑ Lying ❑ Sitting ❑ Walking ❑ Hot Packs ❑ Standing ❑ Rest ❑ Cold Packs

❑ NOTHING ❑ Other:_____ ❑ Medication (Please List):_____

Is your condition ***better*** in the ❑ morning or ❑ at night? Is your condition ***worse*** in the ❑ morning or ❑ at night?

How much have your symptoms interfered with your usual daily activities? ❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

What other doctors have you seen for this condition? Give type of treatment and dates:_____

_____

Past Medical History

*Please list any conditions you have been treated for prior to this occurrence. List the **dates,** the type of **treatment** received along with **who performed the treatment**, and any **residual effects** you are still experiencing.*

Surgeries ❑ _____

Fractures ❑ _____

Serious Injuries ❑ _____

Work Injuries ❑ _____

Personal Injuries or Motor Vehicle Injuries ❑ _____

What are your main health problems? Briefly list the name of your problem(s):

_____

List any dates you were treated for these symptoms, the type of treatment you received and any residual effects

_____

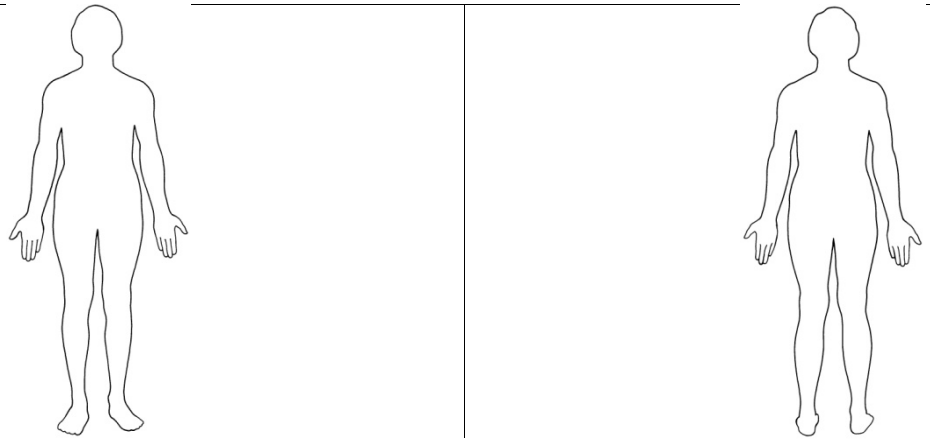
Briefly list your activities at work_____

Briefly list your leisure activities_____

Please list any other symptoms you are experiencing _____

On the diagrams below, please indicate where you are experiencing pain right now. Please mark the exact location of your pain on the diagrams using the following abbreviations:

PAIN = P **TINGLING = T** **NUMBNESS = N** **BURNING = B** **STIFFNESS = S**



FRONT **BACK**

FEMALES ONLY

X-rays may be taken of your spine. When was your last period? _____ Are you pregnant? ☐ Yes ☐ No ☐ Maybe

Family Health History

Relation (father, mother, sibling, child, etc) Past & Present Health Conditions

_____ / _____

_____ / _____

_____ / _____

_____ / _____

Do you sleep on your ❑ Stomach ❑ Side ❑ Back ❑ Toss & Turn Age of Mattress _____ ❑ Comfortable ❑ Uncomfortable

Do you use a bed board? ❑ Yes ❑ No

HAVE YOU EVER	***YES***	***NO***	***DESCRIBE BRIEFLY***
Been knocked unconscious?	❑	❑	
Been treated for a spine or nerve disorder?	❑	❑	
Been hospitalized for other than surgery?	❑	❑	
Taken vitamins or minerals?	❑	❑	
Had an allergy to any medication?	❑	❑	
Have you seen a chiropractor in the past?	❑	❑	DC Name:

Reason for treatment: Date of Treatment:

DATE OF LAST:	***Less than 6 months***	***6-18 months***	***Over 18 months***	***Never***
Spinal Examination	❑	❑	❑	❑
Physical Examination	❑	❑	❑	❑
Blood test	❑	❑	❑	❑
Chest X-Ray	❑	❑	❑	❑
Spinal X-Ray	❑	❑	❑	❑

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑Yes ❑No

HABITS:	***Heavy***	***Moderate***	***Light***	***None***	***DESCRIBE BRIEFLY***
Alcohol	❑	❑	❑	❑	How many drinks per week?
Coffee	❑	❑	❑	❑	How many cups per week?
Water	❑	❑	❑	❑	How many glasses per week?
Recreational/Illegal Drugs	❑	❑	❑	❑	What kind? How often?
Exercise	❑	❑	❑	❑	How many times per week?
Sleep	❑	❑	❑	❑	How many hours per night?
Appetite	❑	❑	❑	❑	
Soft Drinks	❑	❑	❑	❑	How many drinks per week?

Please list any medications including dosage and frequency, if known_____

_____

List any allergies that you have to any medication_____

_____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care. Please check the appropriate box if you have been diagnosed with the follwing:

- ❑ Hepatitis
- ❑ Appendicitis
- ❑ Scarlet Fever
- ❑ Diphtheria
- ❑ Typhoid Fever
- ❑ Pneumonia
- ❑ Rheumatic Fever
- ❑ Polio
- ❑ Tuberculosis
- ❑ Anemia
- ❑ Measles
- ❑ Mumps
- ❑ Small Pox
- ❑ Chicken Pox
- ❑ Eczema
- ❑ Cancer
- ❑ Heart Disease
- ❑ Goiter
- ❑ Pleurisy
- ❑ Alcoholism
- ❑ Venereal Disease/Infection
- ❑ Arthritis
- ❑ Epilepsy
- ❑ Mental Disorder
- ❑ Lumbago
- ❑ Influenza
- ❑ Whooping Cough

Please check any conditions you are currently diagnosed with or have been diagnosed with in the past:

MUSCULO-SKELETAL
- ❑ Low Back Pain
- ❑ Pain between Shoulders
- ❑ Neck Pain
- ❑ Arm Pain
- ❑ Joint Pain/Stiffness
- ❑ Walking Problems
- ❑ Difficulty chewing/ Clicking jaw

NERVOUS SYSTEM
- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Fainting
- ❑ Convulsions
- ❑ Cold/Tingling in Extremities
- ❑ Changes in Handwriting
- ❑ Irritability
- ❑ Changes in Personality

GENERAL
- ❑ Allergies
- ❑ Loss of Sleep
- ❑ Fever
- ❑ Headaches/Migraines
- ❑ HIV Positive

GASTRO-INTESTINAL
- ❑ Poor or Excessive Appetite
- ❑ Excessive Thirst
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver Problems
- ❑ Gall Bladder Problems
- ❑ Weight Problems
- ❑ Abdominal Cramps
- ❑ Gas or Bloating after meals
- ❑ Heartburn
- ❑ Black/Bloody Stool
- ❑ Colitis

GENITO-URINARY
- ❑ Bladder Problems
- ❑ Painful/Excessive Urination
- ❑ Discolored Urine

C-V-R
- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ Irregular Heartbeat
- ❑ Heart Problems
- ❑ Lung Problems/Congestion
- ❑ Varicose Veins
- ❑ Ankle Swelling

EENT
- ❑ Vision Problems
- ❑ Dental Problems
- ❑ Sore Throat
- ❑ Earaches
- ❑ Hearing Difficulty/Impairment
- ❑ Stuffed Nose

MALE / FEMALE CODE
- ❑ Menstrual Irregularity
- ❑ Menstrual Cramping
- ❑ Vaginal Pain
- ❑ Vaginal Infections
- ❑ Breast Pain / Lumps
- ❑ Prostate Problems / Sexual Dysfunction
- ❑ Genital Herpes
- ❑ Menopause

Would you like us to send a report of your findings to your physician? ❑ YES ❑ NO If Yes, please complete the information listed below:

Physician Name:_____ Practice Name:_____

Address:_____ City/State/Zip:_____

Phone:_____

THE PURPOSE OF OUR CLINIC IS TO SUPPORT EACH INDIVIDUAL IN ACHIEVING THEIR OPTIMUM HEALTH AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND A MUILTIDISIPLINED APPROACH TO HEALTH AND IN TURN, EDUCATE OTHERS.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due.

Patient Signature:_____ **Date:**_____

Guardian or Spouse's
Signature Authorizing Care:_____ Date:_____

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home)

Name:_____

Address:_____ Phone:_____

PATIENT CONSENT FOR TREATMENT

CONSENT FOR TREATMENT (All Patients):

I voluntarily consent to the rendering of care, including chiropractic, physical therapy and physician treatment, and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and/or physical therapist and it is the responsibility of the staff to carry out the instructions of such clinician(s).

PRINT PATIENT NAME

PATIENT SIGNATURE

IF YOU ARE NOT THE PATIENT, PRINT YOUR NAME AND STATE YOUR RELATIONSHIP TO PATIENT

NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and the methods you can use to request access to this information. Please review this notice carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, personal research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on disclosure on this information. By law, we are not required to grant your request. However, if we decide to grant your request, we are bound by our agreement.

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Harper Wellness & Rehab to use and disclose your protected health information for the purposes of treatment, payment and healthcare operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at (713) 622-3456. You have a right to request a restriction on how we use and disclose your private health information for the purposes of treatment, payment or health care operations. By law, we are not required to grant your request. However, if we decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent that we have already used or disclosed your protected health information in reliance on your consent.

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or any other related Medicare or Medicaid claim.

- √ Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.
- √ You may inspect and receive copies of you records within 30 days of your request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation of your medical records.
- √ You may request changes to your records. Our practice has the right to accept or deny your request.
- √ We maintain a history of protected health information disclosures that is accessible to you.
- √ In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.
- √ Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.
- √ For your convenience, you may obtain an Authorization for Release of Records form on our website at www.harperwellness.com or by calling (713) 622-3456.
- √ You may file a complaint about privacy violations by contacting our Office Manager at (713) 622-3456.

PATIENT SIGNATURE **DATE**

OFFICE FINANCIAL POLICY

Our policy is to extend you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expenses and allows you to place your family under our care.

1. If You Do Not Have Insurance: All payments are due at the time of service or by an authorized payment plan. For bookkeeping purposes, we suggest that you prepay for your scheduled appointments with the doctor. This will greatly reduce your time at the front desk and help us minimize our bookkeeping expenses.

2. If You Have Insurance: All deductibles and co-payments are due at the time of service or by an authorized payment plan. For bookkeeping purposes, we suggest that you prepay for your scheduled appointments with the doctor. This will greatly reduce your time at the front desk and help us minimize our bookkeeping expenses.

√ You are considered a cash patient until you bring in your completed insurance forms and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but we will be happy to provide you with a claim for your secondary carrier.

√ Our fees are considered usual, customary and reasonable by most insurance companies and are therefore covered up to the maximum allowance determined by each carrier. This statement does not apply to insurance companies that reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

√ If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active role in the recovery of your claim. If your carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

√ When your treatment plan is once per month or less in frequency, you insurance carrier may deem your treatment as maintenance and not cover the visit. Charges for services rendered will be due as they are performed or by an authorized payment plan. We will happily provide you with an insurance claim form for these visits.

√ If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claims already submitted.

Patient's Printed Name:_____

Signature:_____ Date:_____

Finance Counselor:_____ Date:_____

For your convenience, you may retain your credit card number on file with us.

Credit Card #:_____ Exp Date:_____

Your name as it appears on the card:_____

Driving Directions

COMING FROM 290/Katy Freeway
Take 610 and travel south toward the Galleria
Exit San Felipe then turn LEFT under the freeway
Go to the 2nd light which is Briar Oaks, turn LEFT
Briar Oaks dead-ends into Post Oak Place Drive, turn RIGHT
There will be a cul-de-sac in front of you
We're in the last building on the left in the cul-de-sac
Our building # is 4544 and our suite # is 287

COMING FROM 59
Take 610 and travel north toward the Galleria
Exit San Felipe, then turn RIGHT
Go to the 2nd light which is Briar Oaks, turn left
Briar Oaks dead-ends into Post Oak Place Drive, turn RIGHT
There will be a cul-de-sac in front of you
We're in the last building on the left in the cul-de-sac
Our building # is 4544 and our suite # is 287