

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Texas Family Chiropractic
Dr. Derrick W. Houghton

Welcome

Patient Information

Date _____ \ SS# _____

Patient Name _____
Last _____
First Name _____ Middle Initial _____

Address _____

City _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Primary Ethnicity
 Native American/Alaska Native Hispanic Asian White
 Black/African American Native Hawaiian/Pacific Island Other

Occupation _____

Patient Employer/School _____

Employer/School Phone _____

Spouse's Name _____

Birthdate _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is Patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, parent, Guardian or Personal Representative

Date

Relationship to Patient

Phone Numbers

Home Phone _____

Cell Phone _____ Cell Carrier _____

How would you like to receive appointment reminders?
 Text Message Email Both

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact # _____

Accident Information

Is condition due to an accident? Yes No

Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
 Auto Insurance Employer Work Comp. Other

Attorney Name (if applicable) _____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

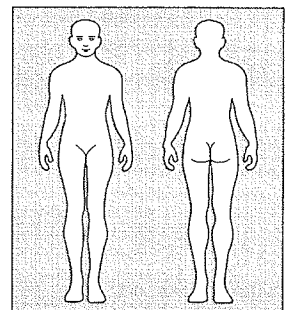
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it consistent or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



Health History

What treatment have you already received for your condition? Medications Surgery Physical Therapy
 Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | | | | | | | |
|---------------------|------------------------------|-----------------------------|------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|
| AIDS/HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Migraine | | | Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergy Shots | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Miscarriage | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Suicide Attempt | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anorexia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Appendicitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Goiter | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gonorrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumors, Growths | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parkinson's Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Typhoid Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vaginal Infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bulimia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herniated Disk | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Polio | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prostate Problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prosthesis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____ | | |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | | |
| Chicken Pox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ | | |
| | | | Measles | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | |

<p>EXERCISE</p> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<p>WORK ACTIVITY</p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<p>HABITS</p> <input type="checkbox"/> Smoking Packs/Day _____ <input type="checkbox"/> Alcohol Drinks/Week _____ <input type="checkbox"/> Coffee/Caffeine Drinks Cups/Day _____ <input type="checkbox"/> High Stress Level Reason _____
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Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (_____) _____	_____	_____

REVISED OSWESTRY DISABILITY

Name _____ Date ____ / ____ / ____ File # _____

(Please Print)

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - 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 is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- I would 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 increase the pain, but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary 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.

SECTION 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives 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, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

SECTION 4 - Walking

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- I can sit in any chair as long as I like without pain.
- I can sit only 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 1/2 hour.
- Pain prevents me from sitting for more than 10 minutes.
- I avoid sitting because it increases pain immediately.

SECTION 6 - Standing

- I can stand as long as I want without pain.
- I have some pain on standing, but it does not, increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing, because it increases the pain immediately.

SECTION 7 - 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 night's sleep is reduced by less than 1/4.
- Because of pain, my normal night's sleep is reduced by less than 1/2.
- Because of pain, my normal nights sleep is reduced by less than 3/4.
- Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of pain.
- Pain has no significant effect 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 the pain.

SECTION 9 - Traveling

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

SECTION 10 - 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 nor getting worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Patient - Doctor Agreement

The purpose of this agreement is to allow us to more completely serve you and for you to get the best results in the shortest amount of time. It is our experience that *those who follow through with these agreements get the best results*

Signing In

When you arrive, please sign in. You will be called and assigned a treatment room in the order you signed in. On each visit, pick up your card at the front desk, go to the assigned treatment room, and lie face down. *Rest and relax*, the doctor will be in as soon as possible.

New Patient Health Talk

We suggest that all our new patients attend our *Health Talk* as soon as possible after starting care. We meet here at the office. The Health Talk explains how the body functions, how Chiropractic works, and how results are produced. Family and friends are always welcome. There is no charge for the talk. While children are welcome in the office during our regular treatment times, childcare is not available during our classes, so please make other arrangements for children under the age of 12.

Missing or Changing Appointments

The doctor will set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required to get the results we both desire. Thus, if you need to change the time of your appointment, plan to come another time the same day, or if the same day is not possible, it is important that you make up the missed appointment within one week. *Schedule your life around your health, not your health around your life.*

Appointment Times

We will set up a specific time for your adjustment. Try to be prompt as the doctor has set this time aside for adjustments and during this time, that is all he will do. If you come at another time, you may have to wait a few minutes, as the doctor also sets aside a specific time to see new patients and conduct extended consultations. *We value your time* and do not want you to wait needlessly. If you wish to sit down with the doctor to discuss your care, a specific Doctor/Patient Conference can be arranged at no additional charge.

Re-Examinations

During your treatment series, re-examinations and progress reports will be done on a regular basis.

Communication

Please communicate directly to the doctor any upsetting matter such as waiting too long, rudeness by any staff member, failure to understand treatment, need for extended consultation, etc. *We are here to serve you.* Your constructive criticism will help us to help you as well as others.

Financial Policy

We will expect you to honor the financial agreement you make with our office. For cash patients we request that 100% of the first visit be paid at the time of the first visit. We are happy to accept your check, Master card, Visa, Discover, American Express, or cash. All of your payment options will be discussed with you on your second visit. *We can help you understand your benefits.* If you have suspended or terminated your care without the doctor's approval, payment for services rendered is due immediately. For questions regarding Major Medical/Group Insurance, Auto Accident/Personal Injury, Worker's Compensation, or Medicare, please ask.

I _____ understand the above policy and agree to abide by it
(Print Name)

Signature

Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on 2/28/14 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Dr. Derrick Houghton. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be \$1.00 (max of \$25.00 total) for each page and the staff time charged will be \$25 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)

We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$1.00 (max of \$25.00 total) for each page and the staff time charged will be \$25 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: Texas Family Chiropractic Privacy Officer: Dr. Derrick Houghton

Telephone: 512-252-9444 Fax: 512-252-9341

Email: dwhdcm3@sbcglobal.net

Address: 16301 Yellow Sage St Pflugerville Texas 78660

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 acknowledgement, 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

PARTIAL ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AND TREATMENT AGREEMENT

Consideration: In order to facilitate the ability of Texas Family Chiropractic to collect its Charges directly from various Payers and thereby to enhance the patient-provider relationship, I, the undersigned, as consideration for the Office's services, agree to the following and direct all Payers as follows:

Partial Assignment of the Cause of Action, Assignment of Proceeds, and Contractual Lien: I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Texas Family Chiropractic., as well as any and all causes of action that I might have now or in the future against any Payer to the extent of my Charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as Texas Family Chiropractic sees fit. I further assign my right to receive any proceeds from any Payer to Texas Family Chiropractic and further grant a contractual lien to Texas Family Chiropractic with respect to my charges. I understand that this assignment of rights and contractual lien may effectuate, automatically or otherwise, a secure interest under the applicable Uniform Commercial Code. I intend for this Agreement to effectuate such a lien and hereby authorize Texas Family Chiropractic to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such lien. Except as provided herein, nothing in this agreement shall be construed as an election or waiver by Texas Family Chiropractic to a secured interest under any other statutory lien law. I consistent with these rights, and hereby direct any and all Payers, to pay the Proceeds directly and immediately to, and exclusively in the name of Texas Family Chiropractic in the amount of my charges.

Other Terms: I understand that I remain personally responsible fro my charges. Consistent with law or contract, I agree to pay the full amount of my charges to Texas Family Chiropractic upon demand. Unless mutually agreed to in writing, the receipt and processing of partial payments by the office 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, irrespective of any restrictions indicated on any payments. I understand that at any time, I can request a copy of my total Charges. I hereby waive any statute of limitations which may apply to the collections of my charges.

In the event that I retain one or more attorneys to assist me in collecting any proceeds, I direct each attorney to issue an irrevocable letter of protection to the Office regarding my Charges. I further direct (and the office hereby requests) each attorney to provide immediate notice to the office regarding any proceeds received by the attorney, to promptly pay the Office in full out such proceeds, and to provide a full accounting of such Proceeds to the Office .

I authorize and direct the Office to submit my charges to any and all payers including, without limit, my health benefit plan. I understand, however, that in the event that my Charges are submitted to more than one Payer, I hereby authorize and direct Texas Family Chiropractic to apply any Proceeds received from one Payer to any reduction, write offs, or discounts, issued by another.

I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which 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.

This agreement shall not be modified or revoked without the mutual written consent of the office and myself. I hereby revoke the terms of any previously signed documents to the extent of those terms conflict with the terms of this Agreement.

This agreement shall be governed under the laws of the state where the Office is located and performable in the country where the Office is located. I hereby consent to personal jurisdiction and venue of any court in said country and waive all objections based on improper jurisdiction, venue, or forum non-convenes.

I agree that each and every provisions of this Agreement is reasonably necessary for the protection of the rights and interest of the office and myself. However, should any provisions 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.

Definitions: For the purpose of this Agreement, the following terms shall have the following meaning: "Office" shall refer to: Texas Family Chiropractic located at 15803 Windermere Dr. suite # 420, Pflugerville, TX 78660. "Payer" shall refer to , without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for my reason; "Proceeds" shall include, without limit the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits. Plans, coverage: individual and group health benefits. Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; "Charges" shall include, without limit, the full fees for the "Offices" services (including., without limit, treatment, medical equipment, supplies., supplements, narrative reports, depositions, and testimony), any Collection Costs incurred by the Office, 18% interest on outstanding Charges, and any other charges incurred by me at the Office; "Collections Costs" shall include, without limit any pre-and post judgment court costs, filing fees, service of process charges, attorney fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or any payer.

Patient Name (please print): _____

Patient Signature _____ Date: _____

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

Patient/Guardian Signature: _____

Personal Injury Questionnaire

Name: _____ Date: _____

Nature of accident:

1. Date of accident _____ Time of Day _____
2. Were you: ___ Driver ___ Passenger ___ Front Seat ___ Back Seat
3. Number of people in vehicle _____ Were you wearing seatbelts? _____
4. Were you struck from: ___ behind ___ front ___ left side ___ right side
5. Approximate speed of you car _____ mph Other car _____ mph
6. Were you knocked unconscious? _____ If so, how long? _____
7. Were police notified? _____
8. In your own words, describe the accident: _____

9. Did you have any physical complaints before the accident? _____ If yes, describe in detail: _____

10. Describe how you felt:
 - a. DURING the accident: _____
 - b. IMMEDIATELY AFTER: _____
 - c. LATER THAT DAY: _____
 - d. THE NEXT DAY: _____
11. What are your present complaints and symptoms? _____

12. Do you have any congenital (from birth) factors which relate to this problem?

13. Do you have any previous illnesses which relate to this case? _____ Please describe: _____

14. Have you ever been involved in an accident before? _____ If yes, please describe including dates, type, as well as injuries received. _____

15. Where were you taken after the accident? _____
16. Have you been treated by another doctor since your accident? _____ If yes, please list type of doctor and name _____
17. What type of treatment did you receive? _____

18. Circle any symptoms you have noticed since the accident:

headache	irritability	numbness in toes	flushed face	cold feet
neck pain	chest pain	shortness of breath	buzzing in ears	cold hands
stiff neck	dizziness	fatigue	loss of balance	upset stomach
sleeping problems	constipation	head seems heavy	depression	fainting
back pain	pins, needles in arms	light bothers eyes	loss of smell	cold sweats
nervousness	pins, needles in legs	loss of memory	loss of taste	fever
tension	numbness in fingers	ringing in ears	diarrhea	

other _____

19. Since this injury occurred, are your symptoms:

Improving

Getting Worse

Same

20. Have you lost time from work as a result of the accident? _____

- Last day worked: _____

- type of employment _____

21. Do you notice any activity restrictions as a result of this injury? _____

Please describe: _____

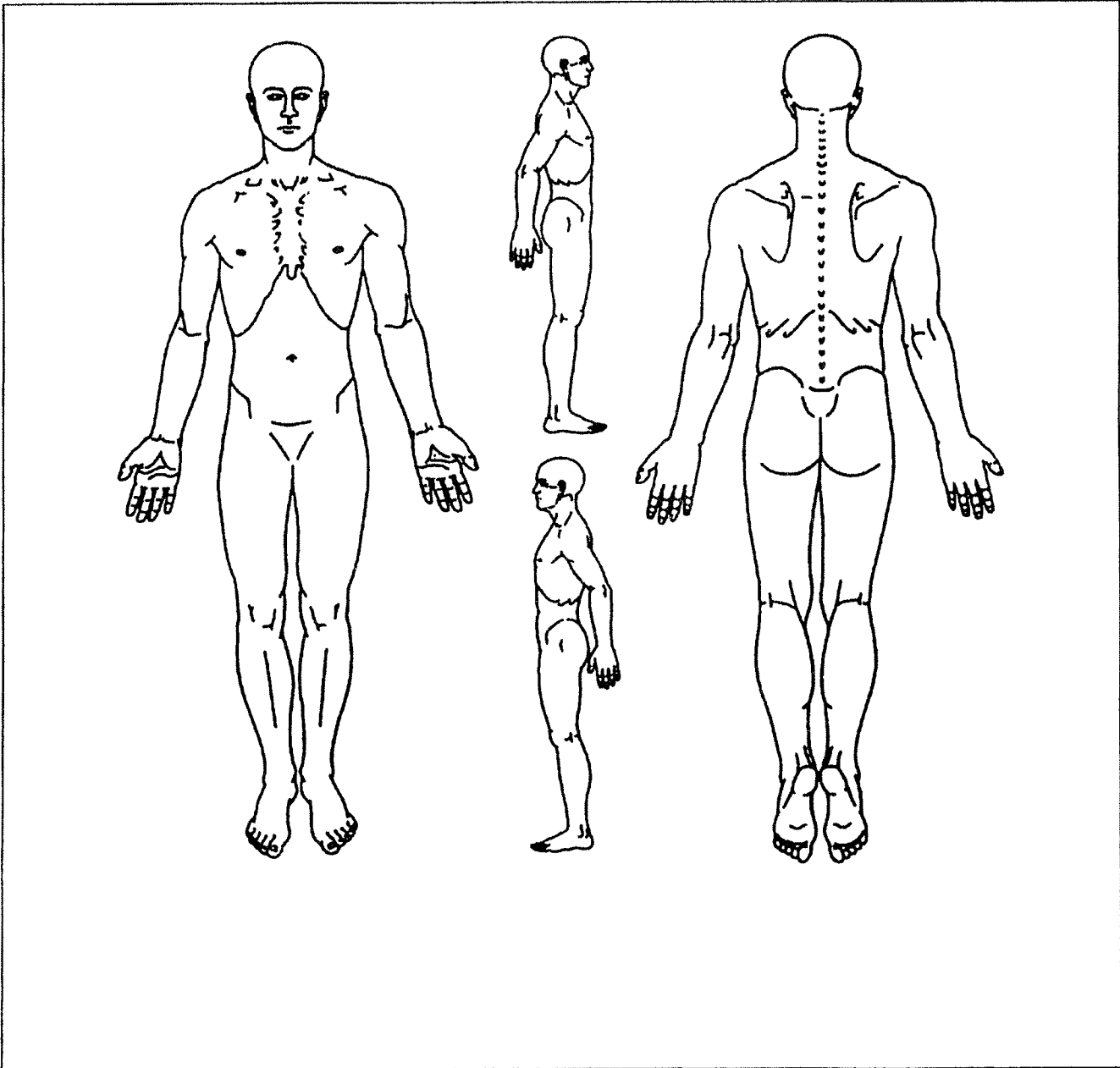
22. Other pertinent information: _____

Patient signature _____ Date _____

Name _____

Date _____

A = ACHE	B = BURNING	N = NUMBNESS
P = PINS & NEEDLES	S = STABBING	O = OTHER



ROLAND MORRIS DISABILITY INDEX

Name _____ Date ____/____/____ File# _____
(Please Print)

When your back hurts, you may find it difficult to do some of the things you normally do. Check the box before each sentence that describes you today. Leave the box blank if the sentence does not describe you.

- I stay home most of the time because of my back.
- I change positions frequently to try and get my back comfortable.
- I walk more slowly than usual because of my back.
- Because of my back , I am not doing any of the jobs that I usually do around the house.
- Because of my back, I use a handrail to get upstairs.
- Because of my back, I lie down to rest more.
- Because of my back , I have to hold on to something to get out of an easy chair.
- Because of my back, I try to get other people to do things for me.
- I get dressed more slowly because of my back.
- I only stand up for short periods of time because of my back.
- Because of my back, I try not to bend or kneel.
- I find it difficult to get out of a chair because of my back.
- My back is painful almost all of the time.
- I find it difficult to turn over in bed because of my back.
- My appetite is not very good because of my back.
- I have trouble putting on my socks (stockings) because of my back.
- I only walk short distances because of my back pain.
- I sleep less well because of my back pain.
- Because of my back pain, I get dressed with help from someone else.
- I sit down for most of the day because of my back.
- I avoid heavy jobs around the house because of my back.
- Because of my back pain, I am more irritable and bad tempered with people than usual.
- Because of my back, I go upstairs more slowly than usual.
- I stay in bed most of the time because of my back.

NECK DISABILITY INDEX

Name _____ Date ____/____/____ File # _____

(Please Print)

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- 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.

SECTION 2 - Personal Care (Washing, Dressing etc.)

- 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 manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4 - Reading

- I can read as much as I want to with no pain in my neck
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

SECTION 5 - 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.

SECTION 6 - Concentration

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

SECTION 7- Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can 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.

SECTION 8 - Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

SECTION 9 - Sleeping

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

SECTION 10 - Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.