PURE HEALTH & WELLNESS

PATIENT INFORMATION AND INTAKE SHEET

CONFIDENTIAL PATIENT INFORMATION **DATE**_____

Name: _____ Home Ph: _____

SSN: _____ Cell Ph: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Age: _____ Date of Birth: _____ Marital Status: M S D W

Occupation: _____ Employer: _____

Employer Address: _____ City: _____

State: _____ Zip: _____ Office Ph: _____

Emergency Contact: _____ Relationship: _____ Ph: _____

How did you hear about our clinic? _____

INSURANCE INFORMATION

Type of insurance: **Health** **Auto** **Work Comp.** **Self/Private** **Other**

Person Responsible for Account & Insurance Information

Insurance CompanyName_____ Ph#_____

Address_____

Policy ID#_____ Group #_____

Policy Holder Relationship to Patient _____

Adjuster Name: _____ Ph: _____

Case Manager/Worker: _____ Ph: _____

Secondary Insurance Information

Ins Company Name_____ Ph:_____

Policy #_____ Group #_____

Policy Holder Relationship to Patient_____

PURE HEALTH & WELLNESS

HIPPA Medical Release Form

I hereby authorize the disclosure of my medical information by Pure Health Chiropractic Center:

Person authorizing release of information:

Name_____

Street address_____

City_____ State_____ Zip_____

Date of Birth_____ Phone #_____

In accordance with the provisions of HIPPA. I, the undersigned, grant permission to Pure Health to disclose protected health information to the following persons: (Please Print)

Name/Relationship_____D.O.B._____

Address_____

_____

Name/Relationship_____D.O.B_____

Address:_____

_____

___ All Records ___Appointments

Any limitations that I impose are declared below:

_____

_____

_____

_____ Release effective until terminated in writing

Name(print)_____

Signed_____Date_____

PURE HEALTH & WELLNESS

CURRENT / PAST MEDICAL HISTORY

Body part(s) injured/hurt (Area of chief complaint) _____
Date of Injury: _____

Where did this occur: **WORK** **HOME** **AUTO** **OTHER** _____

Briefly explain what happened: _____

_____

_____

Has the pain spread to other areas? If yes, what areas?

_____

What treatment (if any) have you received:

_____

Did the treatment help? YES NO

What tests have you had? **X-RAY**_____ **MRI**_____ **CT SCAN**_____ **EMG/NCV**_____ **OTHER**_____

Where were these done at _____

How frequent is this condition? Constant _____ Daily _____ Intermittent _____ Night Only _____

How long does it last? All Day _____ Few Hours _____ Few Minutes _____ Other _____

Is your condition getting worse? Yes _____ No _____ Same _____ Better _____ No Change _____

Describe your pain: Sharp _____ Dull _____ Aching _____ Numbness _____ Tingling _____

Burning _____ Stabbing _____ Throbbing _____ Other: _____

Are you taking any medications for this condition? If yes, please list: _____

What have you done that helps give relief of pain? _____

What do you do that increases your pain? _____

Have you ever had this or similar problems in the past? Yes ____ No ____ If Yes, Please explain:

_____

Date of last menstrual cycle: _____ **Is there any chance that you are pregnant?** Yes No

Do you have any allergies to food or medications? If yes, please list:

_____

Are you currently taking any medications? If so, please list:

_____

Do you: Smoke/Dip _____ Drink alcohol _____ Drink caffeine _____ Exercise _____

Do you have or have you had in the past year:

	YES	No
1. High blood pressure:	____	____
2. Diabetes:	____	____
3. Arthritis:	____	____
4. Sprains/Strains:	____	____
5. Broken bones:	____	____
6 Heart Disease:	____	____
7. Spinal problems:	____	____
8. Cancer:	____	____

Is there any personal or family history of: (please state who)

Kidney disease_____ Heart disease_____ Liver disease_____ Stroke_____

Cancer_____ Diabetes_____ High blood pressure_____

Have you had any surgeries? Please list type and date:

_____

Have you had any injuries or accidents in the past year? Please list:

_____

750 Schneider Rd. #170 Cibolo, TX. 78108 210-566-7873(O) 210-566-8799(F)

FINANCIAL RESPONSIBILITY AGREEMENT

_____I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that PURE HEALTH will prepare any necessary reports and forms to assist me in collecting monies owed by the insurance company, and that any amount authorized to be paid directly to PURE HEALTH will be credited to my account upon receipt. However, I clearly understand, and agree, that all services I receive are charged directly to me and that I am personally responsible for payment, unless those services are administered pursuant to a claim filed which is regulated by the Texas Department of Insurance, Division of Workers Compensation. I also understand that if I suspend or terminate my care and treatment, all fees for professional services I receive will be immediately due and payable, unless those services are administered pursuant to a claim filed which is regulated by the Texas Department of Insurance, Division of Workers Compensation.

_____Cancelled appointments need to be made within 24 hours of the appointment. If 24 hour notice is not given a $30 cancellation fee will be assessed per scheduled appointment and that is my responsibility.

AGREEMENT OF COMPLIANCE

_____I understand by choosing PURE HEALTH for care that I am responsible for my appointments as directed by the staff, doctors and therapists. By not complying with the treatment given to me by PURE HEALTH, I understand that I may be negatively impacting my care and ability to recover from an ailment.

_____If I am a workers compensation claimant, I understand that my non-compliance with treatment may also lead to a lack of compliance with the Texas Department of Insurance, Division of Worker's Compensation treatment guidelines. By doing so, I can be released at any time as seen fit by my doctor which will delay treatment progression and could stop financial benefits.

NOTICE OF PRIVACY PRACTICES

_____The complete Privacy Notice is posted in Pure Health and Wellness' facility. In addition, you are entitled to a paper copy of the complete privacy notice upon your request. You may ask the receptionist or your health care provider for your copy. You may also obtain a copy of this notice by emailing us at our listed email address. We reserve the right to change the notice if necessary. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as information we receive in the future.

The privacy notice applies to all of the records of your care generated by Pure Health and Wellness. Other doctors that you consult may have different policies or notices regarding their use and disclosure of your medical information created in their offices or clinics.

The privacy notice will tell you how we use and disclose medical information about you. It also describes your rights and certain obligations regarding the use and disclosure of medical information.

Pure Health and Wellness may share medical information with other medical providers or with insurance carriers (or other third party payers) for treatment or payment,.

AUTHORIZATION FOR RELEASE OF RECORDS AND PROTECTED HEALTH INFORMATION

_____At my request, I hereby authorize Pure Health and Wellness; the staff, employees, or any agents of Pure Health and Wellness, and the Licensed Healthcare Providers at Pure Health and Wellness (hereinafter, collectively, "PURE HEALTH"); to disclose to my attorney, or his/her agent, as well as to any insurance carrier who may be liable for payment of bills and charges for services rendered to me, my individually identifiable health information and any and all information contained in, or documentation constituting or related to, my medical records or other records related to medical services rendered to me, or any information that may be acquired by examination, or other means, of my physical and mental condition (hereinafter, collectively, my "Medical Records"). I hereby release PURE HEALTH from any consequences arising from the provision of said documentation or information. I further understand that I am granting this authorization voluntarily and that I may refuse to sign this authorization.

INFORMED CONSENT

_____It is my desire and intent to receive chiropractic services, medical services, remedies, and therapies; treatment; and other related services (hereinafter, collectively, "Care") from Pure Health and Wellness, the staff at Pure Health and Wellness, and the Licensed Healthcare Providers at Pure Health and Wellness (hereinafter, collectively, "PURE HEALTH"). I understand that PURE HEALTH provides Care in an effort to assist or enable me to remedy, rehabilitate from, or recover from an ailment. I understand, however, that PURE HEALTH cannot guarantee any specific result from the provision of Care. I also understand and agree that my participation in this program – and my receipt of Care - is voluntary and, where PURE HEALTH makes treatment recommendations, I ultimately have the choice over whether or not to accept or participate in the treatment. Accordingly, I understand that I may withdraw from treatment at any time.

_____I therefore give PURE HEALTH the permission and authority to perform - and to care for me in accordance with - assessments, tests, diagnostic impressions, and conclusions. I understand that the clinical procedures employed are usually beneficial and seldom cause any problem. I also understand that, in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. I understand that PURE HEALTH will inform me if they are unable to treat me. I also understand that it is my responsibility to make known any pathological defects, illnesses, or deformities of which I am aware, and of which PURE HEALTH would otherwise be unaware.

_____I understand that PURE HEALTH may prescribe or recommend exercise, physical training, massage therapy, nutritional supplements, and/or lifestyle adjustments. I am aware and understand that these recommendations or prescriptions have the potential for side effects. Though typically safe, it is possible to injury myself while performing exercise, physical training, and/or lifestyle adjustments. Regardless, I am willing to accept these risks and perform any such exercises, physical training, and/or lifestyle changes. Though some research has been performed on nutritional supplements, they remain experimental remedies and most supplements have not been certified as treatment for any particular ailment. Regardless of the generally untested nature of supplements, nutritional or otherwise, I understand and agree that my use of any supplements recommended or prescribed by PURE HEALTH is entirely voluntarily and done regardless of the possible risks associate with the use of such supplements.

IRREVOCABLE ASSIGNMENT OF PROCEEDS/BENEFITS AND CONVEYANCE OF NON-STATUTORY LIEN INTEREST

_____I hereby execute and provide this Irrevocable Assignment of Proceeds/Benefits and Conveyance of Non-Statutory Lien Interest ("Assignment and Interest") in favor of Pure Health and Wellness, which is my treating facility and the facility at which my Providers (including my treating doctor) are employed (hereinafter, collectively, "PURE HEALTH"). This Assignment and Interest shall apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/ medical payment insurance policy to which I am entitled, and from which I am to paid in the form of an insurance settlement(s), claim(s), judgment(s), or verdict(s) resulting from the above identified incident/ accident (collectively the "insurance proceeds").

_____Pursuant to this Assignment and Interest, the Insurance Carrier is hereby instructed and authorized to directly pay PURE HEALTH the total dollar amount of all sums which I owe on account to PURE HEALTH, as evidenced by the medical bills submitted by PURE HEALTH, out of those settlement proceeds to which I am entitled. Alternatively, said amounts owed shall be withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to PURE HEALTH as compensation for their professional services provided to me.

_____In the event that 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 PURE HEALTH upon demand by PURE HEALTH.

_____I fully understand and stipulate that I am ultimately and directly responsible to PURE HEALTH for all medical bills incurred by me for those services rendered to me, or on my behalf or request, and that this Assignment and Interest is made solely for the benefit of PURE HEALTH as additional protection and in consideration of PURE HEALTH'S agreement or forgo immediate collection of payment for such services rendered.

SIGNATURE PAGE

By placing my signature in the appropriate space below, I hereby:

Certify, represent, and agree that the information that I have provided to Pure Health and Wellness regarding my background, past medical history, and other details is true, accurate, and correct;
Represent and agree that I have read and understand the information contained in the foregoing paragraphs, and have resolved any questions that I may have had about this form by discussing my questions with Pure Health and Wellness and its staff.
Represent and agree that I have read, understand, and received a copy of the foregoing Notice of Privacy practices(Upon request)
Represent that I have read, understand, accept, and agree to the foregoing Informed Consent, Financial Responsibility Agreement, and Agreement of Compliance, (the "Agreements"); have received a copy thereof; and am personally empowered, or am duly authorized by the patient as the patient's general agent, to execute the Agreements.

_____ _____

Patient (or Parent/Guardian/Representative) Signature Witness Signature

_____ _____

Patient Name (Please Print) Witness Name (Please Print)

_____ _____

Date Signed Date Signed

_____

Parent/Guardian/Representative Name (Please Print)

_____

Relationship to Patient (for Guardian or Representative)

CONSENT TO TREAT A MINOR CHILD

I hereby authorize PURE HEALTH & WELLNESS and whomever they may designate as their Doctors or assistants to administer treatment as they deems necessary to my minor child._____.

Dated at the office of Pure Health and Wellness on this _____day of _____, 20_____.

Signature:_____ Date:_____

CONSENT TO TREAT AN EMANCIPATED MINOR

By my signature, I warrant that I am over the age of 16 years, and that I reside separate and apart from my parents and/or Guardian. I further warrant that I am managing my own financial affairs, and hereby consent to treatment by Pure Health and Wellness.

Signature:_____ Date: _____

Pure Health & Wellness **Patient Communication Consent Form**

TEXT MESSAGE/EMAIL APPOINTMENT REMINDER

I authorize Pure Health & Wellness to send text message/ email appointment reminders to me on my provided cell phone number/email. I understand that I may call the number provided on the message to cancel and/or change my appointment. By accepting these terms, I agree that I will be receiving alerts referencing my appointment. Text message charges from my cell phone provider may apply.

Patient's Name:_____ Account Number:_____

Patient's Cell Phone Number: (___)_____

Patient's Email:_____

My Signature below indicates that I represent and warrant that I am the person legally responsible for all use of the accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging and/or email services. I understand that this authorization can only be revoked in writing.

Signature: _____ Date: _____