

# To The New Patient

## ◆ Outline of Procedures for New Patients ◆

1. **STEP ONE:** All new patients are required to fill out a personal health history and insurance questionnaire.
2. **STEP TWO:** Your first consultation with the doctor is to discuss your health problems.
3. **STEP THREE:** Preliminary screening tests help determine whether you are a chiropractic case. If you are not accepted as a chiropractic patient, we will try to assist you in locating the type of physician or specialist which we feel your condition requires.
4. **STEP FOUR:** If preliminary screening tests indicate that you are a chiropractic case, additional diagnostic examinations such as x-rays, laboratory tests, neurological/orthopedic tests, etc., may be required. If so, the necessity and cost of such diagnostic examinations will be thoroughly explained before the examinations are performed.
5. **STEP FIVE:** The doctor(s) will review the diagnostic examinations with you, explain their significance, and make recommendations for treatment. Family members are welcome and may attend this explanation at your request.
6. **STEP SIX:** Treatments will begin and continue as scheduled until your condition has been fully corrected, or until the maximum possible improvement has been obtained. If you do not respond to treatment, or are dissatisfied with your progress, you may stop taking treatment at any time without further financial obligation, except for services previously rendered. In addition, upon request, your case records will be made available for review by the physician of your choice.
7. **STEP SEVEN:** Financial and insurance arrangements are made. Medicare, workers compensations, insurance, automobile med-pay insurance, and most union and company health insurance policies cover chiropractic care up to policy limits. Many group policies only cover a percentage of the expense, and some have a deductible provision. If you wish, our staff will be happy to assist you in determining your policy benefits. Any charges not covered by insurance are the sole responsibility of the patient. Monthly payment plans are available and we accept most credit cards. We also accept insurance assignments on most health insurance policies.

# New Patient Health History Form

In order to provide the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

## Patient Data

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Email \_\_\_\_\_  
Your email will NOT be shared with 3<sup>rd</sup> parties, and is used for general office announcements and promotions.

## Mailing Address

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone: (work) \_\_\_\_\_ (home) \_\_\_\_\_ (cell) \_\_\_\_\_ Referred By \_\_\_\_\_  
Age \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_ Number of Children \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_  
Spouse's employer \_\_\_\_\_ Spouse's Health Status \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

## Current Complaints

Nature of Injury:            Automobile\*            Work            Other  
Please Describe:

\_\_\_\_\_

Date of Injury \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Symptoms Appeared \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever had the same condition?    No    Yes            If yes, when? \_\_\_\_\_

List other practitioners seen for this injury/condition \_\_\_\_\_

Have you ever been under chiropractic care?    No    Yes

If yes, please describe \_\_\_\_\_

## Insurance Information

Name of the Insured \_\_\_\_\_ Name of party responsible for payment \_\_\_\_\_

Phone # \_\_\_\_\_

Do you have health insurance?    No    Yes            Name of Company \_\_\_\_\_

*\*If an auto accident please provide:*

Insurance Company Name \_\_\_\_\_ Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_

Claim # \_\_\_\_\_

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Medical History

Have you been treated for any conditions in the last year?    No        Yes

If yes, please describe \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Is there a chance you may be pregnant?    No        Yes

Have you had x-rays taken?        No        Yes        If yes, where? \_\_\_\_\_

What medication(s) are you taking and for what conditions (please list dosage and amounts, etc.)

\_\_\_\_\_

\_\_\_\_\_

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency)

\_\_\_\_\_

\_\_\_\_\_

### Have you ever:

### Please Circle:

### Briefly Explain

Broken bones?                      No              Yes

Been hospitalized?                No              Yes

Been in an auto accident?        No              Yes

Had sprains/strains?              No              Yes

Been struck unconscious?        No              Yes

Had Surgery?                        No              Yes

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Family History

Family Member	Present and Past Health Conditions (Ex: heart disease, cancer, diabetes, arthritis, etc.)

### Habits:

### Please Circle:

Alcohol        None    Light    Moderate    Heavy

Coffee        None    Light    Moderate    Heavy

Tobacco        None    Light    Moderate    Heavy

Drugs        None    Light    Moderate    Heavy

Exercise        None    Light    Moderate    Heavy

Sleep        None    Light    Moderate    Heavy

Appetite        None    Light    Moderate    Heavy

Soft Drinks        None    Light    Moderate    Heavy

Water        None    Light    Moderate    Heavy

Salty Foods        None    Light    Moderate    Heavy

Sugary Foods        None    Light    Moderate    Heavy

Do you experience pain every day?                      Y        N

Do your symptoms interfere with daily life?            Y        N

Does pain wake you up at night?                        Y        N

Are your symptoms worse during certain times of the day?                      Y        N

Do changes in weather affect your symptoms?                      Y        N

Do you wear orthotics?                                      Y        N

Do you take vitamin supplements?                      Y        N

What activities aggravate your symptoms?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

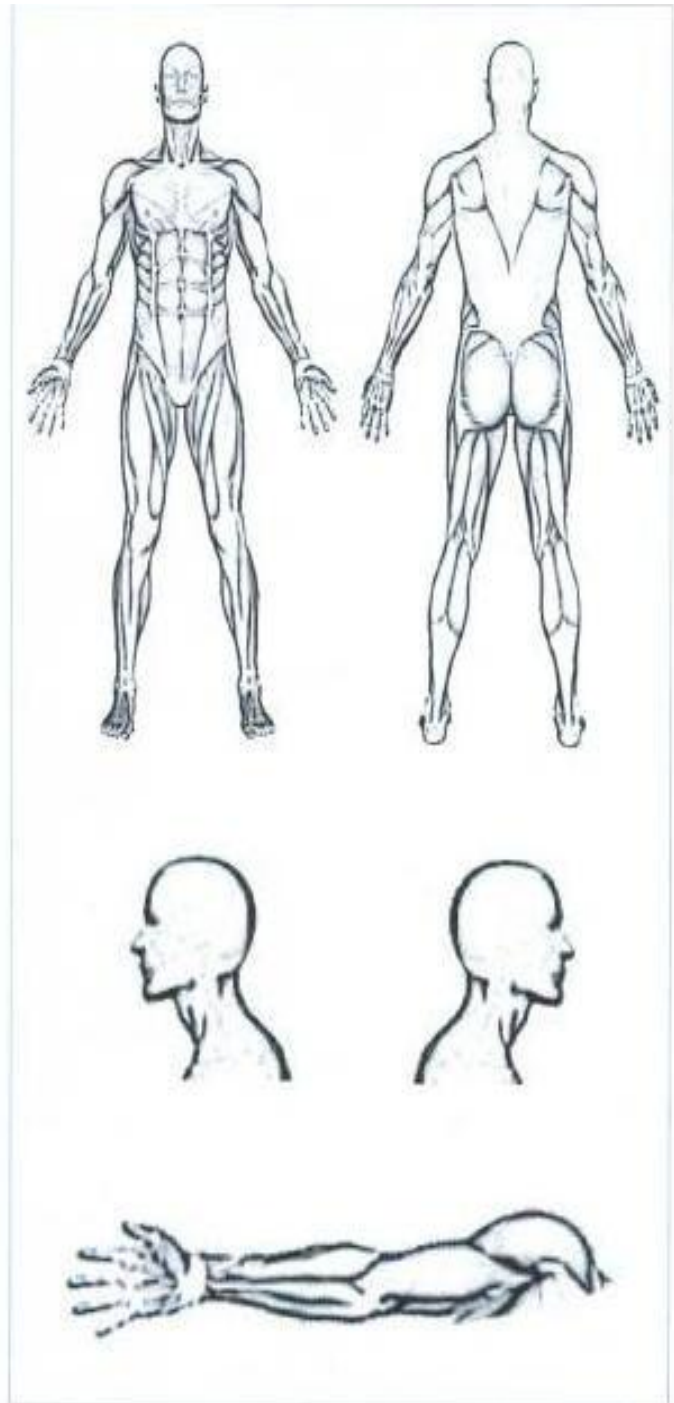
**Have you ever suffered from:**

Alcoholism	<input type="checkbox"/>
Allergies	<input type="checkbox"/>
Anemia	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>
Asthma	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>
Breast Lump	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>
Cancer	<input type="checkbox"/>
Chest Pain/Conditions	<input type="checkbox"/>
Cold Extremities	<input type="checkbox"/>
Constipation	<input type="checkbox"/>
Cramps	<input type="checkbox"/>
Depression	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Digestion Problems	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>
Ears Ring	<input type="checkbox"/>
Excessive Menstruation	<input type="checkbox"/>
Eye Pain/Difficulties	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>
Frequent Urination	<input type="checkbox"/>
Headache	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>
Irregular Cycle	<input type="checkbox"/>
Kidney Infection	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>
Loss of Memory	<input type="checkbox"/>
Loss of Balance	<input type="checkbox"/>
Loss of Smell	<input type="checkbox"/>
Loss of Taste	<input type="checkbox"/>
Lumps in Breast	<input type="checkbox"/>
Neck Pain or Stiffness	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>
Polio	<input type="checkbox"/>
Poor Posture	<input type="checkbox"/>
Prostate Trouble	<input type="checkbox"/>
Sciatica	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>
Sinus Infection	<input type="checkbox"/>
Sleep problems/insomnia	<input type="checkbox"/>
Spinal Curvatures	<input type="checkbox"/>
Stroke	<input type="checkbox"/>
Swelling of ankles	<input type="checkbox"/>
Swollen Joints	<input type="checkbox"/>
Thyroid Condition	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>
Venereal Disease	<input type="checkbox"/>
Other:	<input type="checkbox"/>

**Current Complaints**

Please use the following letter to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

- A=Ache                      B= Burning              N= Numbness  
P= Pins & Needles        S= Stabbing              O= Other



# Stotts Chiropractic

## INFORMED CONSENT TO CHIROPRACTIC SPINAL MANIPULATION AND SUPPORTIVE CARE

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 team me while employed by, working or associated with or serving as backup for the doctor of chiropractic named below, including those working 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 and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I understand and comprehend all such risks and complications. I, by my signature below, consent to and agree to those treatments deemed by my doctor to be 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.

*To be completed by patient:*

*To be completed by patient's representative, if necessary  
e.g., if a patient is a minor or physically or legally incapacitated:*

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Print Name of Patient's Representative

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date Signed

As: \_\_\_\_\_  
Relationship or authority of Patient's Representative

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date Signed

STOTTS CHIROPRACTIC  
3558 Knickerbocker Rd  
San Angelo, TX 76904  
(325) 949-8688

Doctor(s) treating this patient:

\_\_\_\_\_  
Darci J. Stotts, D.C.

\_\_\_\_\_  
Ed A. Breeding, D.C.

Witness to Patient's Signature: \_\_\_\_\_

# HIPPA Form

## Consent for Purposes of Treatment, Payment, & Healthcare

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to [Stotts Chiropractic].

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restriction that may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may indentify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Chiropractor. The Notice of Privacy Practices of Chiropractor is also posted in the waiting room at [3558 Knickerbocker Rd. San Angelo, TX 76904]. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Printed Name of Patient

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Date of Signing

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Description of Personal Representative's Authority

# **Stotts Chiropractic**

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## **Doctors of Chiropractic**

### **Assignment, Lien, and Authorization Insurance Benefits and Attorney**

I hereby authorize and direct you, my Insurance company, and/or my attorney's, to pay Stotts Chiropractic such sums as may be due and owing this office for services rendered by me, both by reason of accident or illness, and by any other reason or any other bills that are due this office and to withhold such sums from any disability benefits, medical payment benefits, No-fault benefits, health and accident benefits, workman's comp benefits or any other insurance benefits obligated to reimburse me or from any settlement judge or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the offices' services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this office for their services, refuses to make such payments, upon demand by me, or this office, I hereby assign and transfer to this office any and all such causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further I authorize this office to compromise, settle, or otherwise resolve said claim or cause as they see fit.

I understand that I remain personally responsible for the total amount due the office for the services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering any services at their option.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien and Authorization; I agree that the above mentioned office be given power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill. I authorize Stotts Chiropractic to release any records including x-rays upon my request whether verbal or in writing.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

**Get Healthy. Stay Healthy**  
**Phone (325) 949-8688 Fax (325) 944-2235**  
**3558 Knickerbocker Road**  
**San Angelo, TX 76904**

# **Stotts Chiropractic**

## **Doctors of Chiropractic**

Date: \_\_\_\_\_

I hereby authorize the office of Stotts Chiropractic to release any medical/billing information regarding me, \_\_\_\_\_, to the person(s) listed below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that this authorization will be valid until a written request is received retracting said authorization. I do not hold Stotts Chiropractic or its agents responsible for any information released before written retraction is received.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Stotts Chiropractic Employee

\_\_\_\_\_  
Date

# Patient Bill of Rights

## **Stotts Chiropractic**

**STOTTS CHIROPRACTIC** endorses a patient bill of rights. It is an expectation that compliance with the patient bill of rights can contribute to an effective program for the patient. A modification of the American Hospital Association's statement on a patient bill of rights has been incorporated as part of the framework of **Stotts Chiropractic**.

The modifications consist of the following:

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from their credentialed practitioner complete and current information concerning the diagnosis, proposed treatment, and expected prognosis in terms that the patient may reasonably be expected to understand. When it is not advisable to give such information to the patient, the information should be made available to an appropriate person (medical proxy) on the patient's behalf.
3. The patient has the right to receive the necessary information for medical decision making and granting of informed consent from the treating credentialed practitioner prior to the start of any procedure or treatment. This information shall include at the minimum: the expected procedure of treatment to be used, who will perform the procedure or treatment, what are the likely benefits from the procedure or treatment, what alternatives exist, if any, what are the likely risks from the procedure or treatment, what may occur if no treatment is undertaken, and length of probable duration of incapacitation if any is expected.
4. The patient has the right to make decisions and participate actively in their own care, consent to or refuse treatment to the extent permitted by law and be informed of the medial consequences of such actions.
5. The patient has the right to have full consideration of security/confidentiality and privacy concerning their records and care plan. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discretely, except in cases such as abuse of public health hazards, which are required by law to be reported. The patient has the right to be advised as to the reason for the presence of any individual.
6. The patient has the right to be advised if the practitioner, agency, or facility propose to engage in any form of human experimentation affecting the care or treatment provided. The patient has the right to refuse to participate in research projects or to withdraw continued consent to participate without repercussions.
7. The patient has the right to information about office policies that relate to their own care. You have the right to express a concern or complaint regarding your care to the practitioner.
8. You have the right to a timely response to your concern or complaint and a resolution when possible. Expression of a concern or complaint will not compromise your care or future access to care.
9. The patient has the right to be cared for by staff who has been educated about patient rights and their role in supporting these rights.
10. The patient has the right to receive care in a safe setting, from of all forms of abuse or harassment and to be free from seclusion or restraints of any form that is not medically necessary.
11. The patient has the right to leave the facility without treatment even against the advice of the practitioner.
12. The patient has the right to examine and receive an explanation of the bill for professional services rendered.
13. The patient has the right to know that some patient claims are filed electronically and the company that Stotts Chiropractic uses for electronic filing has provided us with proof that they are HIPAA (Health Insurance Portability and Accountability Act) compliant.
14. The patient has the right to know the handling of patient claims, checking patient insurance eligibility, checking patient insurance benefits, checking on the status of claim payments, verifying referral authorizations and even communicating via phone or email with HMO's, Medicare, or any healthcare payer will be done with strict patient confidentiality.
15. The patient has the right to sign in on the sign in sheet by using first and last name or first name only.
16. The patient has the right to know that any information that is obtained and not placed in the patient's file will be shredded and disposed of appropriately.

◆ **ALL STOTTS CHIROPRACTIC PATIENTS ARE TO BE TREATED WITH AN OVERRIDING CONCERN FOR THE PATIENT, AND ABOVE ALL, WITH THE RECOGNITION OF THE PATIENT'S DIGNITY AS A HUMAN BEING** ◆