HEALTHPRO
CHIROPRACTIC | ACUPUNCTURE

Welcome to the Office!

PATIENT INFORMATION: Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Pfr.

Name: _____ **Suffix:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone: _____ **Mobile Phone:** _____

Email: _____

Contact Method: ☐ Primary Phone ☐ Mobile Phone ☐ Email

Date of Birth: _____ **Age:** _____ **Gender:** (check) ☐ Male ☐ Female

Marital Status (check one): ☐ Single ☐ Married ☐ Other

Employment: ☐ Employed ☐ Student ☐ Self-Employed ☐ Retired

Employer: _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

How did you hear about our office? _____

Personal/Family Medical History (check all that apply, specify *C* = Currently Have, *F* = Family History, *P* =Previously Had)

☐ AIDS/HIV	☐ Allergies	☐ Anemia	☐ Arthritis	☐ Asthma
☐ Bone Fracture	☐ Cancer	☐ Diabetes	☐ Dislocated Joints	☐ Diverticulitis
☐ Hay Fever	☐ Headaches	☐ Thyroid Problems	☐ Sinus Problems	☐ Weight Changes
☐ Venereal Disease	☐ Rheumatic Fever	☐ Pins, Screws, or Plates	☐ Heart Problems	☐High Blood Pressure
☐ Low Blood Pressure	☐ Multiple Sclerosis	☐ Pacemaker	☐ Pain in Limb	☐ Stomach Ulcers
☐ Polio	☐ Prostate Problems	☐ Scoliosis	☐ Sleeping Issues	☐ Epilepsy
☐ Spinal Disc Problems	☐ Stroke	☐ Muscular Dystrophy	☐ Concussion	☐Other Issue

If any options above are selected, please explain: (i.e. Cancer type, Diabetic Type, Date Diagnosed, Previous Treatment)

List all surgeries:

Medications (list all medications and what they are being used for):

Childhood injuries, falls, accidents, traumas, sports:

Do you currently smoke tobacco? ☐ Yes ☐ Former ☐ Never Smoked If yes, how often do you smoke? (packs a day, cigarettes a day):

Are you pregnant? ☐ Yes ☐ No Date of Last Menstrual Cycle:

If yes: _____ **weeks Estimated Due Date**:_____ **Midwife/OBGYN**: _____ **Birthing Location**:_____

Doula: ☐ No ☐ Yes (name)_____ **Birth Classes**: ☐ No ☐ Yes (name of class)_____

Complications trying to conceive:_____ **Complications during pregnancy**:_____

Do you plan on Breastfeeding: ☐ No ☐ Yes **Are you exercising** : ☐ No ☐ Yes: _____

Diet: ☐ Good ☐ Bad ☐ Could be better: _____ **How much water are you drinking a day**: _____ glasses

Describe your birth plan:

Prior Treatments: ☐ Chiropractic ☐ Acupuncture ☐ Massage ☐ Other

For what:

_

CHIEF COMPLAINT:

Please describe your chief complaint/ what brought you in?

When did this condition begin? _____ Was it (gradual/sudden) _____

Is it getting: ☐ Progressively worse ☐ Staying the same ☐ Getting better

Have you had any treatment for this condition? If so, please tell us when, where, with whom, and what were the results:

Does anything aggravate this condition? **YES** or **NO** _____

Does anything make this condition better? **YES** or **NO** _____

How frequent is this condition? How long does it last? _____

Does your pain radiate to other parts of your body: **YES** or **NO**? If so, where to: _____

Do you have any numbness or tingling in your body: **YES** or **NO**? If so, where to: _____

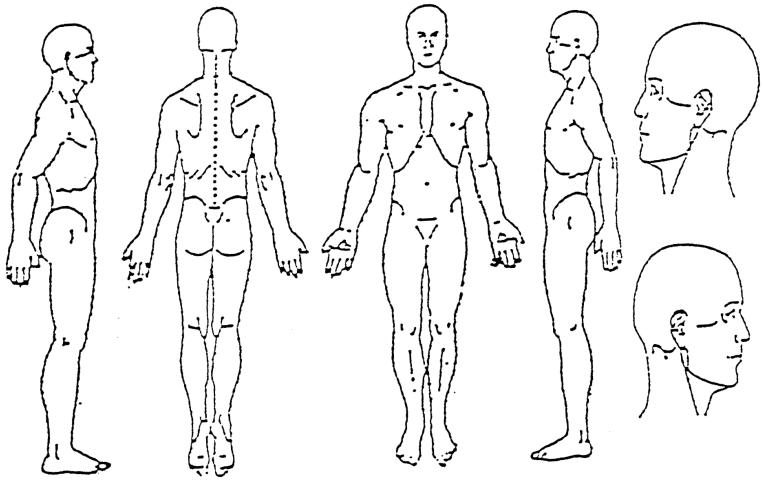
Is your pain (**Improved**, **Worsened**, **Unchanged**) with: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Is this condition interfering with: ☐ Work ☐Sleep ☐Daily Routine

Is this condition a work-related injury or auto-injury? _____

Have you had an X-ray, CT Scan or MRI? ☐ YES ☐ NO Where? _____

Results:



1. Please indicate on the drawing the areas in which you are experiencing pain using the abbreviations that reflect the type of discomfort you have.

N = Numbness T= Tingling P= Pain Sharp D= Dull Ache
S= Stiffness

2. Pain Scale: Please indicate your current pain level

No Pain= 0 1 2 3 4 5 6 7 8 9 10= Worst Pain

Signature: _____

Date:

HealthPro Chiropractic and Acupuncture
9720 Cypresswood Drive, Ste 130
Houston, TX 77070
p: 281.809.0100 f: 281.809.0198

AGREEMENT AND INSTRUCTION FOR DIRECT PAYMENT BY PRIVATE AND GROUP OR ACCIDENT AND HEALTH INSURANCE

RE: Patient: _____ Insured: _____

Employer: _____

Group / Claim #: _____

S.S. or ID#: _____

I hereby instruct and direct the _____
Insurance Company or Law Office to pay by check made out and mailed directly to:

HealthPro Chiropractic and Acupuncture
9720 Cypresswood Drive, Ste 130
Houston, TX 77070

Or, if my current policy prohibits direct payment to the provider, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

HealthPro Chiropractic and Acupuncture
9720 Cypresswood Drive, Ste 130
Houston, TX 77070

The medical expenses benefits allowable under my health or PIP policy, and otherwise payable to me under my current insurance policy as payment toward the total charges for chiropractic services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner any balance for chiropractic service charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL

I authorize the release of any information pertinent to my case to you as the insurance company or attorney.

Dated this _____ day of _____, 20_____

Policyholder _____

Patient Signature _____

Witness _____

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Financial Policy

- Appointments/Cancellations: Please be 5 minutes early for your appointment. Each patient is scheduled an individual time slot. If you are late, or cancel without 24 hours notice this causes other patients to be late or denied an appointment when they might otherwise be seen. You will be financially responsible for all missed appointments or untimely cancellations. ***Initials***_____

- All payments are due at the time that the service is rendered. Patient visits include heat, treatment, rehabilitation (if necessary) & ice. If ancillary services are required (Ultra Sound, Electrical Muscle Stem, Laser or Decompression Therapy) during your visit, there will be an additional fee. We accept cash, checks, MasterCard, Visa, Discover and American Express.

- If you have out-of-network chiropractic benefits, we do accept most health insurance plans. Due to the numerous variations in individual coverage, all acceptances will be on a case-by-case basis. If we do not file your insurance claim, you will be provided an invoice so that you can file any insurance claims and be reimbursed directly.

- 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 or denies a claim based on benefits, you accept responsibility for payment of any outstanding balance. ***Initials***_____

- Personal injury/auto claims may also be handled through your personal injury protection (PIP) insurance.

- MEDICARE/MEDICAID, We do verify that your insurance covers chiropractic, that your deductible has been met and what percentages of payment and coverage will be. You will need to pay in full for the first visit if we cannot verify your insurance.

- MANAGED CARE WAIVER: I understand that in the opinion of the doctor(s) at HealthPro, the services of items, supplies, and durable medical equipment that I have requested to be provided to me may not be covered by my commercial insurance, or my managed health care plan. If my charge(s) is (are) determined by my insurance carrier to be outside of my network or not a covered charge, I understand that I will be responsible for payment for these services because they are reasonably and medically necessary for my care. As per Medicare guidelines, any chronic conditions treated by chiropractic, run a possibility of not being paid for by Medicare. "The manipulation codes 98940, 98941, 98942 may be denied by Medicare if deemed a chronic condition". If treatment is denied, payment is your responsibility or your secondary insurance if applicable.

Patients Name (Printed): _____ Date: _____

Patient/Guardian Signature: _____ Relationship to Patient: _____

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PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____ (Name), hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

_____
Patient's Initials

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Consent To Treatments

By signing this form, I am requesting and consenting to the diagnostic and therapeutic procedures which may include, but are not limited to, physical modalities, x-rays, physical examination and history and chiropractic treatment, acupuncture treatment or massage therapy performed by the doctors of HealthPro Chiropractic and Acupuncture and anyone working in the clinic authorized by the above referenced doctors of chiropractic. I understand that it is my right to determine the extent of my medical care, and I may, at any time, refuse treatment and withdraw my consent for the performance of any procedure or treatment.

I recognize that no guarantees have been or can be made regarding the likelihood of success of the outcome of any evaluation, treatment, test, procedure, or therapy performed by HealthPro Chiropractic and Acupuncture doctors of chiropractic or staff.

_____INTIAL I understand that there are risks associated with any treatment. Chiropractic and acupuncture are very low risk procures. Potential risks include slight pain, discomfort or soreness in the area treated. Associated risk factors for acupuncture include but are not limited to the following: bruising, blistering, bleeding, redness around the site where the needle was inserted, weakness, fainting, nausea, temporary discoloration of the skin, possible aggravation of the symptoms existing prior to treatment, skin infection or broken needle.

**Patients with bleeding disorders, pacemakers, seizure disorders, local infections, Hepatitis, HIV positive or have AIDS, on any anticoagulant medications or pregnant must disclose this information to the doctor.*

Verification of Pregnancy:

_____INTIAL By signing this form, I certify that, to the best of my knowledge, **I am not pregnant** and the above doctor(s) and/or associates have my permission to perform diagnostic X-ray examination. I have been advised that X-rays can be hazardous to an unborn child.

_____INTIAL By signing this form, I am affirming that **I am pregnant** and my due date is _____. I consent the above doctor(s) and/or associate to perform the necessary chiropractic manipulative therapy and/or adjunctive therapy.

NOTE: There has been a risk factor documented in the medical literature of 1:600,000 to 1:6 million (the greater risk depending in whether you are a woman that smokes and is on birth control pills) of a stroke type accident due to neck manipulation. There also might be some discomfort in areas that have never been treated chiropractically after your first adjustment. By signing this form, I understand this and will talk to the doctor(s) regarding any concerns I may have regarding this.

With this knowledge, I voluntarily consent to the procedures realizing that no guarantees have been given to me by any doctor or staff member at HealthPro Chiropractic & Acupuncture regarding cure or improvement of my condition. I herby release the doctors and staff from HealthPro Chiropractic & Acupuncture from any and all liability which may occur in connection with the procedures, except failure to preform the procedures with appropriate care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual Signature of Individual

_____ _____
Signature of Legal Representative Relationship to Patient
(e.g. Attorney-In-Fact, Guardian, Parent if a minor)

DATE:

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Patient Provider Email Agreement

Name:

Email offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has the advantages over office visits or telephone calls. But remember, there are also important differences. Email is not the same as calling our office, there is no person at the other end of the call – just a computer. You can't tell for certain when your messages will be read, or even if your doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication that email affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us via email.

- Email is never, ever, appropriate for urgent or emergency problems. Please use the telephone or go to the Emergency Department for emergencies.
- Email is great for asking those little questions that don't require a lot of discussion. Appropriate uses of email also include referral letters, excuse notes needed for work/school after an appointment, and billing/insurance questions.
- Emails should not be used to communicate sensitive information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- Email is not confidential. It is like sending a postcard through the mail. Our staff may read your emails to handle routine, non-emergency matters. You should also know that if sending emails from work, your employer has a legal right to read your email if he or she chooses.
- Email may become a part of the medical record when we use it, a copy may be printed and put in your chart.
- Email is not a substitute to seeing a doctor at HealthPro. If you think that you may need to be seen, please call and schedule an appointment.
- Emails may be forwarded to our staff for handling, if appropriate.

Finally, HealthPro reserves the right to revoke permission of the email system at any time.

☐ **I DO** want to communicate with my doctor electronically. I have read the above information and understand the limitations of security of information transmitted. I understand that my doctor may not be able to communicate with me electronically about my specific condition if I live outside of the state of which my doctor is licensed.

PATIENT:

Patient Name: _____

Patient Signature: _____

E-Mail Address: _____

Date: _____

TESTIMONIAL RELEASE

NAME: _____

I hereby grant permission for my picture or video(s) to be used by *HealthPro Chiropractic & Acupuncture* for educational purposes of the practice, on the website or via social media and internet forums. I understand that this agreement releases *Dr. Alayna Pagnani-Gendron & Dr. Daniel Dannug with HealthPro Chiropractic & Acupuncture* and the producer of his/her/their educational materials from any legal responsibilities arising from the use of said pictures or video(s) in the aforementioned capacity.

Signature: _____

Printed Name: _____

Date: _____

Witness: _____