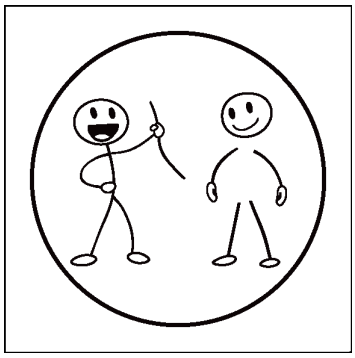

Got UR Back Chiropractic

1625 Williams Drive, Georgetown, TX 78628

512-943-4588

Your Wellness History: Health Profile

Who may we thank for referring you?_____ Date:_____

Name_____ DOB_____ Age:_____

Address_____ City_____ State_____ Zip_____

Home #_____ Work #_____ Cell #_____

Email Address_____ Male_____ Female_____

*you will receive our newsletters via email, you may opt out at any time online

Status: Single Married Divorced Widowed # of Children_____

Your Occupation_____ Employer_____

Spouse's Name_____ Spouse's Employer_____

Reason for visit_____

_____

_____

_____

When did symptoms first appear?_____

How did symptoms occur?_____

Rate the severity of your pain on a scale of 1 (least pain) to 10 (most pain)_____

Does it interfere with (please circle all that apply) work sleep daily routine rec activities

Does anything make the problem better or worse_____

_____

Have you seen any other doctor for this condition? YES / NO

If so, please list their name, specialty, type and length of treatment_____

_____

_____

_____

Are you currently taking any vitamins/herbs/supplements? YES / NO

If so, please list name, amount, frequency of use, and reason for taking_____

_____

_____

Are you currently taking any prescription medications? YES / NO

If so, please list name, amount, frequency of use, and reason for taking_____

_____

_____

If you are female, are you pregnant? YES / NO (x-rays may be taken during your examination)

Please circle to indicate if you are currently having any of the following:

Headaches	Cold Feet	Stomach upset	Constipation/Diarrhea
Nervousness	Neck pain	Sleeping problems	Back pain
Dizziness	Tension	Irritability	Chest pains
Cold hands	Depression	Stiff neck	Menstrual Irregularity
Buzzing in Ears	Ringing in ears	Loss of balance	Light bothers eyes
Numbness in fingers	Numbness in toes	Fatigue	Urinary problem
Sciatica	Loss of taste	Loss of smell	

Other_____

Do you or your family have a history of (please circle all that apply)

Heart disease Arthritis Cancer Diabetes

Injuries/Surgeries:	Description	Date
Auto	_____	_____
Head Injury	_____	_____
Broken Bones	_____	_____
Surgeries	_____	_____
Dislocations	_____	_____

PLEASE RANK YOUR CURRENT ACTIVITIES OF DAILY LIVING

(please circle)

NUTRITION	**EXERCISE**	**WORK ACTIVITY**	**HABITS**	
Excellent	Heavy	Sitting	Smoking	packs/day_____
Good	Daily	Standing	Alcohol	drinks/week_____
Fair	Moderate	Light Labor	Caffeine	cups/day_____
Poor	None	Heavy Labor	High Stress	reason_____

Patient/Guardian Signature _____ Date _____

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, sign in. You will be called and assigned a treatment room in the order you signed in for the doctor. We may maintain a daily sign in register of your visit to our office. This information may be seen by others seeking care or services in this office.

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 is 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. If you want to be here and have your spine corrected, you will be expected to follow the doctor's treatment recommendations. There will be no exceptions on this matter. If you are not ready to make your health a priority by making a commitment to your treatment, then do not waste your time and money now; plan to have your spine corrected at a later date. 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 to detect and correct vertebral subluxations and during this time, that is all he will do. If you come to another time, you may have to wait a few minutes, as the doctor also sets aside specific times 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 case, a specific Doctor/Patient Conference can be arranged at no additional charge.

PAYMENT OF BILLS--We will expect you to honor the financial agreement you make with our office. In order to serve you better, please plan to make any payments at the front desk before you go to the back office for your adjustment. Upon being released from care, a three-month period is allowed for settlement of your account. If a settlement has not been reached within this period, or if you have suspended or terminated your care without your doctor's approval, payment for services is due immediately.

PROGRESS EVALUATIONS AND 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 criticism will help us to help you as well as others.

CASH PATIENT FINANCIAL POLICY--We request that 100% of the first visit be paid at the time of the first visit. For your convenience, future payments may be arranged at the first visit of each week. We are happy to accept your check, MasterCard, Visa, Discover, or cash.

MAJOR MEDICAL/GROUP INSURANCE--You are expected to make a payment toward your services on the first day in this office. Complete the information regarding your insurance policy and make sure the Front Desk Assistant has a copy of your insurance card. Also, any checks sent to your home by the insurance company must be brought or sent to our office within three days.

AUTO ACCIDENT/PERSONAL INJURY--You are usually covered 100% for these injuries. You are responsible for obtaining the Personal Injury Protection forms and address from your insurance company to which we send statements for your care. You are also responsible for reporting your accident to the insurance company and your insurance agent.

WORKER'S COMPENSATION--Our office does not accept workers compensation cases.

I understand the above policy and agree to abide by it.

SIGNATURE_____DATE _____

HIPAA HAPPENINGS

This notice describes how your health information may be used and how you can gain access to this information. Please review it carefully.

Our Promise to You our Valued Patient…

This is not meant to alarm you. Quite the opposite. We want to assure you that we take the new Federal HIPPA (Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our offices because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why a Privacy Policy Now?--The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review not only how your information is used within our computers but also with the Internet, phones, fax machines and any device used to copy or transfer that data.

We want to advise you that we have developed policies and procedures for our practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information. We will assure our adherence to those laws and we want you to understand our procedures and your rights as a valued patient.

Your health information will be communicated only for the purpose of conducting health care business and obtaining payment for services. Be assured that without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used To Provide Treatment--Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health professionals providing you treatment.

To Obtain Payment--Your health information may be included with an invoice for the purpose of collecting payment for services provided to you in this office. We may do this with insurance forms filed for you by mail or electronically. We will make every effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations--Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, and associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

In Patient Reminders--Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or members of your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care chiropractic can provide. They may include postcards, newsletters, flyers, and telephone or electronic reminders such as e-mail (unless you tell us that you prefer not to receive reminders.)

Public Health and National Security--We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health and or national security.

For Law Enforcement--As permitted or required by state or Federal law, we may disclose your health information to proper authorities for the purpose of law enforcement including, under certain circumstances, if you are a victim of a crime or in order to report a suspected crime.

Family, Friends and Care givers--We may share your health information with those you tell us will be assisting you with your home hygiene, care, treatment or payment. We will be certain to obtain your permission prior to sharing you information. In the event of an emergency, if you are unable to tell us what you want, we will use our very best judgment when sharing your health information with anyone participating in your care.

Medical Research--Advancing health care knowledge often involves learning from the careful study of health histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements, and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information--Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time.

Patient Rights--This law is careful to describe that you have the following rights related to your health information. Be assured that our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications--You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately with or without other family members present or through sealed mail communications. We will make all reasonable effort to honor your request.

Inspect and Copy Your Health Information--You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information--You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request. Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested sealed and or delivered to any authority for review.

Documentation of Health Information--You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment, or health care operations. Our documentation procedures will enable us to provide information on your health information usage from July 22, 2013 and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice--You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes. A printed copy of our notice of privacy practices is located on our reception table in a red binder for your reference.

You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing, any concerns you may have regarding the privacy of your health information.

Thank you very much for taking time to review how we are carefully using your health information. If you have questions, please let us know. If not, we would appreciate your acknowledging by signature that you have received, thoroughly reviewed and understand this policy.

_____ Date _____/_____/_____

Patient Signature

Thank You For Your Trust and Confidence