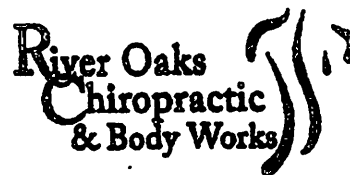


Intake Form

Last name:	First name:	Date:
Email:	Marital status: S M D W	Birth date:
Address: [Address/P.O. Box, Apartment no, City, State, ZIP code]:		
Social Security no.:	Cell phone no.:	
Driver's License no.:	Home phone no.:	
Spouses name:	Referred by:	
Employer:	Occupation:	

Reason for appointment?			
When did this begin?			
Have you had similar problems before?			
How did this occur?			
Date of injury?		Is this condition related to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has this condition?	<input type="checkbox"/> Improved	<input type="checkbox"/> Worsened	<input type="checkbox"/> Remain Unchanged
Please list any X-rays, MRI's or other tests you had for this condition?			

HEALTH QUESTIONNAIRE



Patient: _____ Date: _____

Please check each of the conditions that you are currently experiencing.

Musculoskeletal Systems Low back pain <input type="checkbox"/> Mid back pain <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Neck pain <input type="checkbox"/> Arm problems <input type="checkbox"/> Leg problems <input type="checkbox"/> Swollen joints <input type="checkbox"/> Painful joints <input type="checkbox"/> Stiff joints <input type="checkbox"/> Sore muscles <input type="checkbox"/> Weak muscles <input type="checkbox"/> Walking problems <input type="checkbox"/> Spasms <input type="checkbox"/> Broken bones <input type="checkbox"/>	Gastrointestinal System Poor appetite <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Difficult swallowing <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Black stool <input type="checkbox"/> Bloody stool <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Liver trouble <input type="checkbox"/> Gall bladder problems <input type="checkbox"/> Weight trouble <input type="checkbox"/>	Cardiovascular Respiratory Chest pain <input type="checkbox"/> Pain over heart <input type="checkbox"/> Difficult breathing <input type="checkbox"/> Persistent cough <input type="checkbox"/> Coughing blood <input type="checkbox"/> Rapid heartbeat <input type="checkbox"/> Blood pressure problems <input type="checkbox"/> Heart problems <input type="checkbox"/> Lung problems <input type="checkbox"/> Varicose veins <input type="checkbox"/>
Female Vaginal discharge <input type="checkbox"/> Vaginal bleeding <input type="checkbox"/> Vaginal pain <input type="checkbox"/> Breast pain <input type="checkbox"/> Lumps in breast <input type="checkbox"/> Are You Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	Nervous System Numbness <input type="checkbox"/> Loss of feeling <input type="checkbox"/> Paralysis <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Headaches <input type="checkbox"/> Muscle jerking <input type="checkbox"/> Convulsions <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Confusion <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/>	Eye, Ear, Nose & Throat Eye strain <input type="checkbox"/> Eye inflammation <input type="checkbox"/> Vision problems <input type="checkbox"/> Ear pain <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hearing loss <input type="checkbox"/> Nose pain <input type="checkbox"/> Nose bleeding <input type="checkbox"/> Nose discharge <input type="checkbox"/> Difficulty breathing through nose <input type="checkbox"/> Sore gums <input type="checkbox"/> Dental problems <input type="checkbox"/> Sore mouth <input type="checkbox"/> Sore throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sinus <input type="checkbox"/> Allergy <input type="checkbox"/> Jaw pain <input type="checkbox"/> Difficult speech <input type="checkbox"/>
Genitourinary System Bladder trouble <input type="checkbox"/> Excessive urination <input type="checkbox"/> Scanty urination <input type="checkbox"/> Painful urination <input type="checkbox"/> Discolored urine <input type="checkbox"/>		

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize River Oaks Chiropractic and Body Works to release my medical information to my health, automotive, or any other insurance company providing medical coverage benefits to me for the completion of my insurance form(s).

I hereby authorize and request payment of any medical benefits to which I may be entitled from any insurance policy, including automobile personal injury protection, be made payable to and forwarded to River Oaks Chiropractic and Body Works, 2400 Augusta Dr., Suite 210, Houston, TX 77057.

Patient's Signature

Date

Major Medical for Non-Covered Services

Patient Name: _____ Date: _____

Your insurance does not pay for all healthcare costs. Some items and services are not considered covered benefits under your health insurance plan. As such, your insurance will not pay for these services. Your physician believes that the following services, although not covered by your health insurance, are an important part of your chiropractic care and may be recommended as part of your treatment plan. However, since these services are not considered covered benefits, you will be personally responsible for payment should you choose to receive them. The purpose of this notice is to help you make an informed decision about whether you wish to receive these services.

Below is the price for additional services:

Decompression \$35

Ultrasound \$15

Electrical Stimulation \$15

15 min massage \$25

30 min massage \$50

Cryotherapy \$35

Sonic Wave \$50

Hyperbaric Chamber \$80

Cold Laser \$40

Diode \$40

Infrared Sauna \$30

Acupuncture \$50

I acknowledge that I have been informed in advance of receiving these services that these services are not covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above.

Patient Signature _____ Date _____



Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

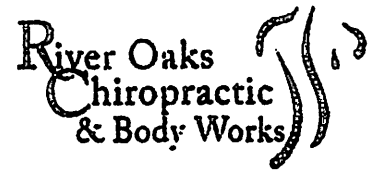
Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Printed Name Signature Date

WITNESS:

Printed Name Signature Date



NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices ("Notice") provides information about: 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients.

Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

By signing this form, you are only acknowledging that you have been provided our Notice.

Name

Date of Birth

Signature of Patient or Authorized Representative

Date



NOTICE OF PATIENT PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how *River Oaks Chiropractic and Bodyworks* may use and disclose your health information and how you can access this information. This Notice explains how we use and share your health information and describes your rights and our legal duties under federal and state privacy laws.

Who This Notice Applies To

This Notice of Privacy Practices applies to our chiropractic practice and all related services we provide, including those performed by our support staff and business associates who help deliver or manage your care. We follow the requirements of the Health Insurance Portability and Accountability Act (HIPAA). This Notice applies to you as a patient of our practice and to any services we provide in connection with your care.

If you have any questions about this Notice, please contact our Privacy Officer or any staff member in our office.

Privacy Officer: Ryan Shewcraft

*Practice Name: River Oaks Chiropractic and Bodyworks
Address: 2400 Augusta Dr Suite 210, Houston, TX 77057
Phone: 713-953-1356*

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of your protected health information (PHI)
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of the Notice currently in effect

We may change the terms of this Notice from time to time. When we make a significant change, we will post the revised version in our office and, if applicable, on our website. You may obtain the current version at any time by contacting our Privacy Officer or asking at the front desk. You may contact our Privacy Officer in person at our office, by mail at the address above, or by phone.

WHAT IS PROTECTED HEALTH INFORMATION (PHI)?

Protected Health Information (PHI) is information about you that may identify you and relates to your past, present, or future physical or mental health condition, the provision of health care to you, or payment for that care.

USES AND DISCLOSURES PERMITTED WITHOUT AUTHORIZATION

Federal law (HIPAA) permits us to use and disclose your protected health information for treatment, payment, and health care operations without a separate written authorization, as described in this Notice.

Treatment

We may use or disclose your PHI to provide, coordinate, or manage your health care and related services. This includes sharing information with other health care providers involved in your care.

Payment

We may use or disclose your PHI to obtain payment for services provided to you. This may include billing insurance companies, determining eligibility or coverage, utilization review, and related activities.

Health Care Operations

We may use or disclose your PHI to support the business operations of this practice, including quality assessment, employee training, internal audits, and administrative activities.

We may use sign-in sheets or call you by name in the waiting area as part of our normal operations, in a manner consistent with applicable privacy requirements.

BUSINESS ASSOCIATES

We may share your PHI with third-party “business associates” who perform services for us (such as billing, IT support, or transcription). These entities are required by contract to protect the privacy and security of your PHI.

To the extent applicable, we will require, through our agreements with that business associate, that they protect those records in accordance with applicable Part 2 confidentiality requirements.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law. These include:

- Disclosures of psychotherapy notes
- Uses and disclosures for marketing purposes
- Disclosures that constitute a sale of PHI
- Other uses and disclosures not described in this Notice

Substance Use Disorder (SUD) Records – 42 C.F.R. Part 2

Certain records related to Substance Use Disorder (SUD), if present in your record, receive additional confidentiality protections under federal law (42 C.F.R. Part 2).

Our primary services are chiropractic care. We are not a substance use disorder (SUD) treatment program as defined by federal law. However, we may receive or maintain information related to SUD treatment if you or another provider shares that information with us.

If our office maintains such information—such as information received from other providers, hospitals, or patient disclosures—those records generally will not be used or disclosed without your specific written authorization, except as otherwise permitted or required by federal law.

A standard authorization to release medical information may not be sufficient to permit disclosure of SUD-protected records. When required by law, we will obtain an authorization that specifically covers SUD information and complies with 42 C.F.R. Part 2. You may revoke your authorization for us to disclose SUD-protected records at any time by submitting a written request to our Privacy Officer. Revocation will not affect disclosures already made in reliance on your prior authorization.

Most patients seen in our chiropractic practice will not have records covered by these special rules. This section applies only if we receive or maintain information from an SUD treatment program.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES

We may use or disclose your PHI without your authorization in the following situations:

Public Health & Safety - For public health activities, reporting communicable diseases, preventing serious threats to health or safety, and as required by law.

Health Oversight - To health oversight agencies for audits, investigations, inspections, and compliance activities.

Abuse, Neglect, or Domestic Violence - As required or permitted by law to appropriate authorities.

Workers' Compensation - As authorized to comply with workers' compensation laws.

Required by Law - When disclosure is required by federal, state, or local law.

Important Note About SUD Records: Some disclosures described in this section do not apply to records protected by 42 C.F.R. Part 2. Please see the "Substance Use Disorder (SUD) Records – 42 C.F.R. Part 2" section of this Notice for information about how we handle SUD-protected records.

LEGAL PROCEEDINGS & LAW ENFORCEMENT

We may disclose PHI in response to a valid court order, subpoena, discovery request, or other lawful process as permitted by law.

Important: Records protected under federal Substance Use Disorder confidentiality regulations (42 C.F.R. Part 2), if applicable, may only be disclosed pursuant to a court order that specifically authorizes such disclosure or as otherwise permitted by federal law. A subpoena or legal request alone may not be sufficient for disclosure of SUD-protected information.

If we maintain records protected by 42 C.F.R. Part 2, those records are subject to stricter rules than other PHI. Please refer to the "Substance Use Disorder (SUD) Records – 42 C.F.R. Part 2" section of this Notice for details.

YOUR RIGHTS

You have the right to:

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is _____

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website www., calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- o **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

- o **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

Information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.
- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.
- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.
- **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.600 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.

- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. *You have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office.* You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. *You may opt out of fundraising communications in which our office participates.*

Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.
- **You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred