1st Choice Chiropractic

2216 Southgate Street, Suite B
Arlington, Texas 76013
(P) 817 275 9249/ (F) 817 275 9273
www.DFWChiropractor.com

Today's Date: _____

_____ _____ _____ _____ □ Male □ Female
Patient- Last Name Middle Initial First Name Suffix (Jr. /Sr.)

_____ /_____ /_____ _____ - _____ -_____ Marital Status: □ Single □ Married □ Divorced
Date of Birth Social Security Number □ Legally Separated □ Widowed

Ethnicity: □ Hispanic or Latino □ Other Preferred Language: _____

Race: □ Asian □ African American □ American Indian □ Alaskan Native □ White
□ Native Hawaii/ Pacific Island □ Other _____

_____ _____ _____ _____
Home Address City State Zip

_____ _____ _____ _____
Mailing Address (If Different) City State Zip

_____ _____ _____
Home Phone Number Mobile Phone Number Email Address

Preferred Method of Contact: □ Phone □ Email □ U.S.P.S. □ Other _____

Student: □ No □ Yes (Full Time) □ Yes (Part Time) Campus: _____ Level: _____

Work History: □ Not Employed □ Full Time □ Part Time □ Retired □ Disabled (Total) □ Disabled (Partial)

_____ _____ _____
Occupation Employer Work Phone Number

How did you hear about us: □ Walk - In □ Family □ Friend □ Online □ In-Network Provider
□ Referred by another physician □ Groupon / DFW Wellness Promo

In Case of Emergency:

_____ _____ _____
Contact Name Relationship to Patient Phone Number

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Health History:

Smoking Status: □ Every Day □ Some Days □ Former □ Never

Alcohol Status: □ Daily □ 3 per week □ 2 per week □ 1 per week □ 2 per month □ 1 per month □ Never

Allergies: □ None □ Food □ Medicinal □ Seasonal
List Allergies Here: _____

Have you undergone any surgeries: □ No □ Yes
List Surgeries Here: _____

Are you currently on any medications: □ No □ Yes (OTC = Over the Counter)
□ OTC Acetaminophen/ Tylenol □ OTC Ibuprofen / Advil / Motrin □ OTC Naproxen / Aleve

List Other Medications Here: _____

Please check the box if your biological mother, father, or you currently or previously have had trouble with any of the following.

Cardiovascular	Mother	Father	Self
Poor Circulation			
Hypertension			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of legs			

Genitourinary	Mother	Father	Self
Kidney Disease			
Burning Urination			
Frequent Urination			
Blood in Urine			
Kidney Stones			
Lower Side Pain			

Neurologic	Mother	Father	Self
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's			
Carpal Tunnel			
Vertigo			

Constitutional	Mother	Father	Self
Weight Loss/Gain			
Low Energy Level			
Difficulty Sleeping			

Respiratory	Mother	Father	Self
Asthma			
Tuberculosis			
Short Breath			
Emphysema			
Cold/Flu			
Cough			
Wheezing			

Eyes	Mother	Father	Self
Glaucoma			
Double Vision			
Blurred Vision			

Psychiatric	Mother	Father	Self
Depression			
Anxiety			
Stress			

Endocrine	Mother	Father	Self
Thyroid			
Diabetes			
Hair Loss			
Menopausal			
PMS			

Hematologic	Mother	Father	Self
Hepatitis			
Blood Clots			
Cancer			
Bruising			
Bleeding			
Fever, Chills			
Sweating			
Varicose Vein			

Allergic/Immunologic	Mother	Father	Self
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

Ear, Nose and Throat	Mother	Father	Self
Difficulty Swallowing			
Dizziness			
Hearing Loss			
Sore Throat			
Nosebleeds			
Bleeding Gums			
Sinus Infections			

Gastrointestinal	Mother	Father	Self
Gall Bladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal	Mother	Father	Self
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			
Neck Pain			
Low Back Pain			
Upper Back Pain			

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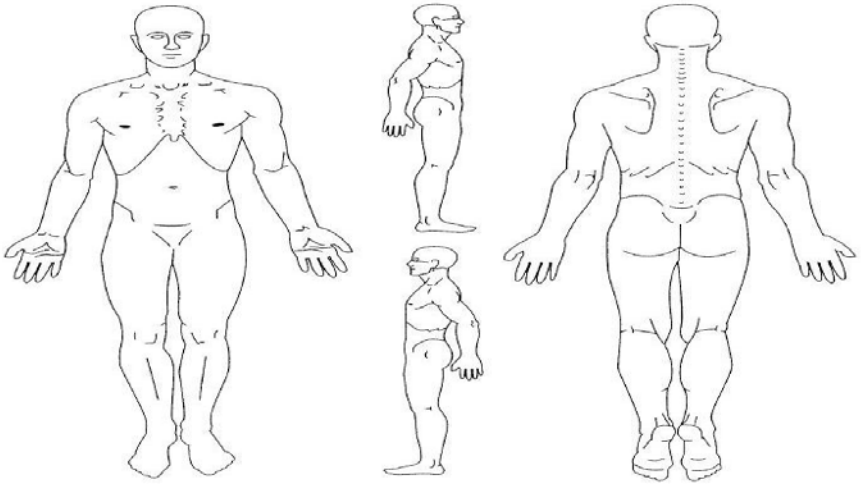
Complaints/ Problem Areas:
Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness *B=Burning* *S=Sharp/ Shooting Pain* *T=Tingling* *A=Dull Ache*



Average Pain Intensity:

Last 24 hours:	(No Pain)	0	1	2	3	4	5	6	7	8	9	10 (Excruciating Pain)
Past week:	(No Pain)	0	1	2	3	4	5	6	7	8	9	10 (Excruciating Pain)

Does anything improve your pain/ discomfort? □ No □ Yes If Yes, what: _____

_____

Does anything worsen your pain/ discomfort? □ No □ Yes If Yes, what: _____

_____

Are your symptoms a result of: □ Motor Vehicle Accident □ Work Related Accident □ Other _____

Have you had any X- rays for this injury/ illness? □ No □ Yes

If Yes: _____ _____ _____
Name/ Phone Number of Facility Date of Study What Area Body

Approximately when did your symptoms begin: _____ Is your condition getting: □ Better □ Worse

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

□ Constantly	□ Frequently	□ Occasionally	□ Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

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Have you been treated for this illness/injury before? ☐ No ☐ Yes

If Yes by whom: _____ _____ _____
Physician Name | Date Last Seen | Phone Number

Have you ever been treated/ seen by a chiropractor? ☐ No ☐ Yes

If Yes by whom: _____ _____ _____
Physician Name | Date Last Seen | Phone Number

For Medical Office Use Only:
Height: _____ (inches) Weight: _____ (lbs.) Temperature: _____ (°F)
Blood Pressure: _____ (Systolic mmHg/Diastolic mmHg) Pulse: _____ (times/minutes)
Respiratory Rate: _____ (breaths/minutes) BMI: _____

PREGNANCY WAIVER

Are you currently or do you believe you are pregnant? ☐ No ☐ Yes

If No – Date of last menstrual cycle: _____ If Yes – Due Date: _____

I hereby acknowledge that 1st Choice Chiropractic has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own volition that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

_____ _____ _____
Print Name / Relationship to Patient | Patient / Representative Signature | Date

Notice of Privacy Practices

Signature below is acknowledgement that you have received our Notice of Privacy Practices. If you require an additional copy should you misplace the one you received today one may be requested from the front desk.

_____ _____ _____
Print Name / Relationship to Patient | Patient / Representative Signature | Date

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Informed Consent for Chiropractic Treatments & Care

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest. I have had an opportunity to discuss with the doctor(s) named above and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments. By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Print Name / Relationship to Patient	Patient / Representative Signature	Date
Witness to Patient/ Representative Signature	Staff Signature	Date

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PARTIAL ASSIGNMENT OF THE CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION
("Agreement")

I hereby direct any and all insurance carriers, attorneys, governmental agencies, companies, individuals, and/or legal entities ("payers"), which may elect, or be obligated, to pay proceeds to me for any reason, to pay directly to , and exclusively in the name of, **1st Choice Chiropractic** ("office") in the amount of the full charges incurred by me at the office, past or future, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the Office ("my charges"). I further grant a contractual lien to **1st Choice Chiropractic** with respect to my charges, however, I understand that nothing in this Agreement shall be construed as an election by **1st Choice Chiropractic** to claim protection under any statutory lien law. For the purposes of this Agreement, proceeds shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as proceeds relating to the following insurance coverages: individual/group health, disability, worker's compensation, medical payments benefits, personal injury protection, lost wages, lost services, no-fault benefits, uninsured and underinsured motorist coverage, liability coverage, and malpractice coverages.

I further agree that, in the event a payer refuses to pay **1st Choice Chiropractic**, I hereby assign to the Office, insofar as permitted by law the following: all of my rights, remedies, and benefits to **1st Choice Chiropractic**, as well as any and all causes of action that I might have against such payer to the extent of my charges, the right prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I direct each attorney to issue a letter of protection to the **1st Choice Chiropractic** regarding my charges. Upon issuance, I agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of the Office. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the office regarding any funds received by the attorney relating to my accident, to promptly pay the Office out of such funds, and to provide a full accounting of such funds to the Office upon request.

In consideration of medical expenses incurred, I, the undersigned, have insurance and/or employee health-care benefits coverage with the above caption, and hereby have assigned and conveyed directly to **1st Choice Chiropractic** all medical benefits and/or insurance reimbursement, if any, otherwise payable to be for services rendered from such doctor and clinic. I understand that I'm financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process claims. I hereby authorize any plan administrator or fiduciary, insurer and/or attorney to release to such doctor and clinic any and all plan documents insurance policies and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement and/or any applicable remedies. I hereby authorize the use of the signature on all of my insurance and/or employee health benefits claims submissions. I hereby convey to the above named Dr. and clinic to the full extent permissible under the law and under the applicable insurance policies and/or employee health-care plan in a claim, chosen in action, or other right I may have two such assurance and/or employee health-care benefits coverage under any applicable insurance policies and/or employee health-care plan with respect to medical expenses incurred as a result of medical services are received from the above named Dr. and clinic and the extent permissible under the law to claim such medical benefits, insurance reimbursement in any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claims, chose in action or against such insurers and/or employee health-care plans in my name, but at such doctor's expense.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policies/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon written receipt of any assignment, otherwise this agreement should be reasonably expected to be effective and such antiassignment is waived. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

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24 Hour Appointment Cancellation Policy Effective 04/30/2015

1st Choice Chiropractic has a 24 hour cancellation / rescheduling policy;

- If you miss or cancel your CHIROPRACTIC appointment within 24 hours of your set appointment there will be a charge of $25 towards your account that must be paid prior to or on your next visit.
- If you reschedule your CHIROPRACTIC appointment TWICE in a row you will also be charged a single fee of $25 that must be paid prior to or on your next visit.
- If you miss your MASSAGE appointment, cancel, or choose to reschedule it within 24 hours of your set appointment there will be a charge of $30 towards your account that must be paid prior to or on your next visit.
- Please make note if you are late to your massage appointment those minutes will be deducted from your reserved time and you will still be charged the full price of your scheduled massage.

This policy is in place out of respect to our other chiropractic patients as well as massage clients. Appointment slots with less than 24 hour notice are difficult to fill. By giving last minute notice or no notice at all, you prevent a fellow patient/client from being seen.

By signing below you acknowledge that you have read and understand this policy as described above. Thank you for your understanding and cooperation.

Print Name / Relationship to Patient	Patient / Representative Signature	Date

1st Choice Chiropractic
Nader Awwad, D.C.

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Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

August 18, 2015

This Notice of Privacy Practices applies to the following organizations.

Back and Neck Care of Arlington LLC dba 1st Choice Chiropractic
Reese Medical Consulting

Nader Awwad, D.C. *1stChoiceChiropracticArlington@gmail.com* *(817) 275 - 9249*