WELCOME TO OUR OFFICE

Confidential Patient Information

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): (_____)_____ (Work): (_____)_____ (Mobile): (_____)_____

Email: _____ Referred By: _____

Age: _____ Birth Date: _____ Sex: M / F Marital Status: S / M / W / D

Occupation: _____ Employer & Address: _____

Spouse's Name: _____ Spouse's Work Phone: (_____) _____Number of Children: _____

Emergency Contact: _____ Contact Phone: (_____) _____

Date of Last Physical Exam: _____ With Whom: _____ Where: _____

Reported Findings: _____

Surgeries, Hospitalizations, Serious Illnesses (List Year in Brackets): _____

Fractures, Dislocations, Major Dental Work (List Year in Brackets): _____

Conditions You Have Had:

_ Allergies	_ Diabetes	_ Neck Pain	_ Sinus Troubles
_ Alcoholism	_ Digestive Disorders	_ Neuritis	_ Stroke
_ Anemia	_ Dizziness	_ Nervousness	_ Tuberculosis
_ Arthritis / Joint Pain	_ Epilepsy	_ Numbness	_ Ulcer
_ Asthma	_ Fatigue	_ Parasites	_ Urinary Trouble
_ Backaches	_ Headaches	_ Poor Appetite	_ Venereal Disease
_ Breathing Problems	_ Heart Trouble	_ Poor Circulation	_ Weight Loss
_ Cancer	_ High Blood Pressure	_ Prostate Problems	_ Yeast / Candida
_ Depression	_ Hypoglycemia	_ Rheumatic Fever	_ _____

Purpose of This Appointment: _____

Other Doctors Seen For This Condition: _____

Have You Been Treated For Any Other Condition in The Past Year? Yes / No (If So, Describe): _____

Medications / Drugs You Are Taking (state reason in brackets following drug): _____

Remarks / Additional Information: _____

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of Person Responsible for Payment: _____

Address & Phone (if different than yours): _____

PATIENT AGREEMENT: I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that I am personally responsible for payment, both for services when rendered and for missed appointments if I fail to give twenty-four hour advance notice of cancellation.

Signature: _____ Parent / Guardian Signature: _____ Date: _____

ADDITIONAL INFORMATION:

Height: _____ Weight: (Now) _____ (One Yr. Ago) _____ (Adult Maximum) _____ Age ____ (Adult Minimum) _____ Age ____
Known Allergies: _____

Blood Type: _____ Have You Ever Had a Blood or Plasma Transfusion? Yes / No

Habits:

Do You Smoke? Y / N What? _____ How Many / Day: _____ Since When? _____
Other Tobacco Products? Y / N What? _____ How Many / Day: _____ Since When? _____
Drink Coffee? Y / N Cups / Day _____ Drink Caffeinated Tea? Y / N Cups / Day _____
Colas / Soft Drinks? Y / N Number / Day _____ Glasses of Water / Day: _____
Alcoholic Beverages? Y / N Avg. No. / Wk _____ Mostly What? _____
Do You Eat Red Meat? Y / N Are You a Vegetarian? Y / N If So, For How Long? _____
Are You Dieting? Y / N If So, Describe: _____
Do You Eat in Fast Food Restaurants? Y / N If So, How Many Times / Week: _____
List Nutritional Supplements You Take: _____

Bowel Movement Frequency: _____ Difficulty? Y / N Approximate Number of Times You Urinate / Day: _____
Do You Sleep Well? Y / N If No, Describe: _____ Average Hours / Night: ____
Do You Have Sufficient Energy For Normal Activities? Y / N If No, Describe: _____

Do You Wear Corrective Lenses? Y / N What Is Your Uncorrected Vision? Right: _____ / 20 Left: _____ / 20
Has Your Vision Changed Recently? Y / N Explain: _____
Do You Wear Heel Lifts or Foot Supports? Y / N Explain: _____

Exercise:

What Sports Have You Played Seriously? _____
What Sports Do You Enjoy Now? _____
Are You In Training For a Particular Sport? Y / N Describe: _____
Do You Use a Heart Rate Monitor? Y / N If So, Target Range: _____
Describe Your Exercise Program: _____

XRAY HISTORY: (Include CAT, MRI, dye studies and dental) When was most recent x-ray / other study performed? _____

Age	Body Area	Type (Normal X-ray, CAT, MRI, etc.)	No. of Studies

FAMILY HISTORY:

	Living?	Age or Age At Death	Allergies	Arthritis	Alcoholism	Cancer	Depression	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Stroke	Other, Description
Father													
Father's Mother													
Father's Father													
Father's Grandparents													
Father's Siblings													
Mother													
Mother's Mother													
Mother's Father													
Mother's Grandparents													
Mother's Siblings													
Your Siblings													
Your Children													

WOMEN ONLY: Menstrual History

Age at Onset: _____ Are Your Periods Regular? Y / N Cycle: _____ days (start to finish) Use Birth Control Pill? Y / N
Your Flow Is: heavy medium light Date of Last Period: _____ Cramping? Y / N
PMS? Y / N If So, What: _____
Other Menstrual / Hormonal Symptoms: _____

Van Pelt Chiropractic, PLLC

Gale Van Pelt, D.C.
3839 Bee Caves Road, Suite 206
Austin, Texas 78746
(512) 902-3029

Patient Name: _____ D.O.B.: _____ Date: _____

Consent for Chiropractic Services

By reading below I have been made aware:

1. The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually, with a table mechanism, or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;

2. As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of electricity, traction, motion, nutritional advice, cold light laser, heat, or cold;

3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;

4. That the chiropractor has made no guarantee of a positive outcome from treatment.

Additionally:

1. I have been afforded ample opportunity for questions and answers.

Therefore by signing below:

I **consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I **consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Client's Printed Name _____

Client's Signature _____

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Statement of Fees

Listed below are some policies and fee information that may be useful.

Neuro Emotional Technique / Congruent Consulting Information
It is greatly encouraged that you visit the website www.netmindbody.com prior to your initial visit. If you have any questions or concerns, Dr. Van Pelt will gladly address them before your first session. Here is a link to a video explaining the new NET research study. https://youtu.be/EhOXXoLf7bo

Session Rate
$150 per hour with Dr. Van Pelt
Fees are due immediately following the session.
*Rates for sessions outside of the office may be obtained by written request.

Introductory Fee Policy / No Risk Satisfaction Guarantee
If either the client or Dr. Van Pelt decides to end the session at the end of one half hour, there will be ***no charge*** to the client.

After the first half hour, if the consulting process is deemed valuable by both the client and Dr. Van Pelt, the first half hour will be charged for *plus* any additional time following the first half hour. Either Dr. Van Pelt or the client may also terminate the session at any point thereafter. The additional time will be charged by prorating the regular hourly fee quoted above. Regarding follow-up appointments, prorating only applies to appointments that are one hour or longer. The set rate on my scheduling page will apply for appointments less than one hour.

Disclaimers
I understand that Dr. Van Pelt's attempts to coordinate my body and nervous system are not the practice of psychology or psychiatry. If any other medical specialist or specialized form of consulting is indicated at any time in my case, it is understood that a proper referral will be made.

Dr. Van Pelt cannot guarantee results due to the fact that results vary from person to person. Insurance companies do NOT consider this "elective" procedure as "medically necessary" and will not reimburse you for services rendered.

I have read and agree with the above and acknowledge doing so by my signature.

Client's Printed Name _____ **Date** _____

Client's Signature _____

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CHIROPRACTIC CONSULTING DISCLAIMER

The Congruent Chiropractic Consulting technology is a system of health-success methodologies which includes the finding and removing of neurological aberrations called Neuro Emotional Complexes (N.E.C.'s) in the human organism. N.E.C.'s have, as a component part, a spinal subluxation. These aberrations have, as a component part, specific emotional neurophysiological patterns. The technology ultimately is a methodology of making rational and physiologically emotional functions congruent via spinal adjustments.

Emotions are physiologically based functions which normally do not present any neurophysiological problems. Occasionally, emotional trauma in the presence of neurological deficit (lowered resistance) causes a neurological pattern (N.E.C.) in the body which does not resolve itself. The result is an embodied non-extinguished conditioned response. These old, unresolved responses interfere with the central nervous system's ability to function properly in various everyday recreational and workplace situations.

The Congruent Chiropractic Consulting technology seeks to normalize this pattern by spinal adjustments which in turn affect a physiological change, resulting in a new ability to utilize your own success concepts.

Emotions also have a psychological aspect; however, this technology is not psychology or psychiatry. It does not involve any type of psychotherapy or a "talk-it-out" approach to emotions. Psychological aspects of emotional health will be referred out to appropriate health care professionals, such as a psychologist or psychiatrist.

Additionally, this technology does not deal with the spiritual realm. It does not exorcise demons or entities. It does not predict the future or deal in any way with the occult or parapsychology. It does not make claims as to what events may have historically happened in the past. It does not tell people what their psychological plan of action may, must or should be for the future.

In addition, the services provided by the attending doctor are considered "elective" procedures and are not reimbursed by insurance companies. Should an insurance company be mistakenly billed for these services, it is likely a letter will be sent to the doctor requesting a report of service. The doctor will reply that the services rendered were elective in nature and attach a copy of this disclaimer.

I have read this and consent to the concepts and disclaimers presented above.

Client's Printed Name _____ **Date** _____

Client's Signature _____

HIPAA Notice of Privacy Practices

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

If you have any questions about the above notice, please contact our Privacy Officer, Dr. Gale Van Pelt, D.C. at (512) 902-3029.

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us and to send birthday/holiday cards. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or

local law.

To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Patient Signature _____ **Date** _____

Client Questionnaire

Please feel free to use the back of this sheet or attach extra papers, if necessary, to answer these important questions.

1. What do you see as symptoms (physical complaints, things going wrong, not going right) which suggests to you a problem exists?

2. Who is being most burdened or hampered by these symptoms?
   Is anyone else being directly or indirectly impacted by these symptoms?

3. What underlying problem do you think is actually causing these symptoms?

4. If possible, state the problem mentioned above in a different way.

5. What have you done so far to solve this problem?

6. Have you considered the possibility that technical “know how” or “how to” consulting from your specific field may help this problem? If so, who is (are) your consultant(s)?

7. What, exactly, do you want as the ultimate result when this problem is fixed?

8. What is your ultimate long range desired circumstance?

9. When did this problem start?

10. Please list any new circumstances which were occurring at about the same time the problem started.

11. Has this or a similar problem occurred before? If so, please explain.