Confidential Patient Health Record

Date:	I.D #

PERSONAL HISTORY

Name:____ Address:_______________________________________
City:____ State/Prov:___________ Zip/postal Code:______________
Home Phone:____________________________________ Cell #:____
Date of Birth:_______________________ Age:_______________ Sex: □M □F
Social Security Number:____________________________ Driver's License Number:_________________________________
Social Insurance #:______________________ Circle One: Married Single Widowed Divorced Separated
Business Employer:_____________________________________ Type of Work:______________________________________
Business Phone:__________________________________ Spouse's Social Security #:_________________________________
Name of Spouse:_______________________________________ Spouse's Social insurance:____________________________
Spouse Employer: ____ Business Phone:______________________________
Type of Work:_____________________________ Name and Ages of children:______________________________________
Referred To This Office By:____
Name and Number of Emergency Contact:____ Relationship:______________
Who Is Responsible For Your Bill, You and □Spouse □workers' comp. □ Auto Insurance □Medicare □Medicaid □Personal
Health Insurance(Name)____Health Card#:_______________________
Insured Person's Name:____ Date of Birth:_______________________

CURRENT HEALTH CONDITION

Unwanted Health Condition____
Others Doctors Seen For This Condition: □ Yes □No____ Who?____
Type of Treatment:_________________________________ Results:____
When Did This condition Begin?_____________________________ Has This Condition Occurred Before? □Yes □No
Is Condition: □Job Related □ Auto Accident □ Home Injury □ Fall □ Other____
Date of Accident:___________________________________ Time of Accident:________________________________
Have You Made A Report of Your Accident To Your Employer: □ Yes □ No
Drugs You Now Take: □ Nerve Pills □ Pain Killers/Muscle Relaxers □ Blood Pressure Medicine
□Insulin □ Other____
Do You Wear a Shoe Lift? □ Yes □ No
Do You Suffer From Any Condition Other Than Which You Are Now Consulting
Us?____

PAST HEALTH HISTORY

Please Check and Describe:
Major Surgery/Operations: □ Appendectomy □ Tonsillectomy □ Gall Bladder □ Hernia □ Back Surgery
□ Broken Bones □ Other____
Major Accidents or Falls:____
Hospitalization (other Than
Above):____
____

Confidential Patient Health Record

Below are a list of disease which may seem unrelated to the purpose of your appointment. However, these question must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

□ Pneumonia	□ Mumps	□ Influenza	INTAKE
□ Rheumatic Fever	□ Small Pox	□ Pleurisy	□ Coffee
□ Polio	□ Chicken Pox	□ Arthritis	□ Tea
□ Tuberculosis	□ Diabetes	□ Epilepsy	□ Alcohol
□ Whooping Cough	□ Cancer	□ Mental Disorders	□ Cigarettes
□ Anemia	□ Heart Disease	□ Lumbago	□ White Sugar
□ Measles	□ Thyroid	□ Eczema	

Have you been tested for HIV Positive? □ Yes □ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST SIX MONTHS:

MUSCULO-SKELETAL CODE

□ Low Back Pain
□ Pain Between Shoulders
□ Neck Pain
□ Arm Pain
□ Joint Pain/Stiffness
□ Walking Problems
□ Difficult Chewing/Clicking Jaw
□ General Stiffness

□ Gas/bloating After Meals
□ Heartburn
□ Black/bloody Stool
□ Colitis

GENITO-URINARY CODE

□ Bladder Trouble
□ Painful/Excessive Urination
□ Discolored Urine

NERVOUS SYSTEM CODE

□ Nervous
□ Numbness
□ Paralysis
□ Dizziness
□ Forgetfulness
□ Confusion/Depression
□ Fainting
□ Convulsions
□ Cold/Tingling Extremities
□ Stress

C-V-R CODE

□ Chest Pain
□ Short Breath
□ Blood Pressure Problems
□ Irregular Heartbeat
□ Heart Problems
□ Lung Problems/Congestion
□ Varicose Veins
□ Ankle Swelling
□ Stroke

GENERAL CODE

□ Fatigue
□ Allergies
□ Loss of Sleep
□ Fever
□ Headaches

EENT CODE

□ Vision Problems
□ Dental Problems
□ Sore Throat
□ Ear Aches
□ Hearing Difficulty

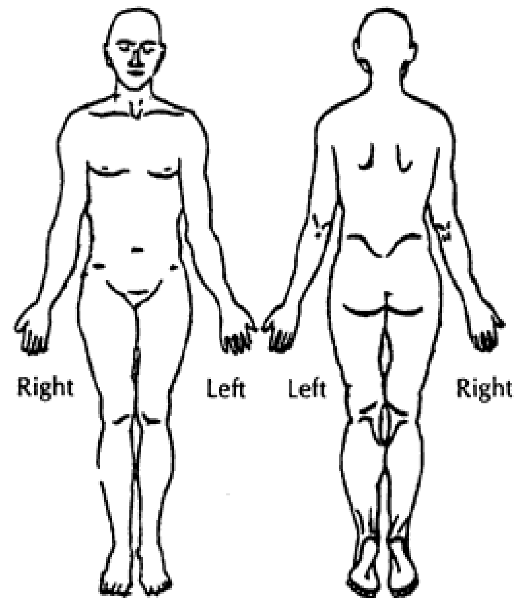
□ Stuffed Nose

<u>FEMALES ONLY:</u>

When was your last period?___________________

Are you Pregnant?

□Yes □No □Not Sure



Please outline on the diagram the area of your discomfort.

GASTRO-INTESTINAL CODE
- ◻ Poor/Excessive Appetite
- ◻ Excessive Thirst
- ◻ Frequent Nausea
- ◻ Vomiting
- ◻ Diarrhea
- ◻ Constipation
- ◻ Hemorrhoids
- ◻ Liver Problems
- ◻ Gall Bladder Problems
- ◻ Weight Trouble
- ◻ Abdominal Cramps

MALE/FEMALE CODE
- ◻ Menstrual Irregularity
- ◻ Menstrual Cramps
- ◻ Vaginal Pain/Infection
- ◻ Breast Pain/Lumps
- ◻ Prostate/sexual Dysfunction
- ◻ Other Problems
- ◻___________________________
- ◻____________________________
- ◻_____________________________

FAMILY HISTORY

The following members have a same or similar problem as I do:
- ◻ Mother
- ◻ Father
- ◻ Brother
- ◻ Sister
- ◻ Spouse
- ◻ Child

Confidential Patient Health Record

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will Weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

□ Relief care □Corrective Care □ Check here if you want the Doctor to select the type of care appropriate for your condition

____________________________ ____

Date Patients Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!

<u>RELIEF CARE</u>: Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as dying a floor that was getting wet from a leak, but not fixing the leak.

<u>CORRECTIVE CARE</u>: Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

*Patient's Signature*____ *Date*________________________

*Consent to Treat a Minor*____ *Date*________________________

*Guardian or Spouse's Signature of Authorizing Care*________________________ *Date*________________________

ASSIGMENT OF BENEFITS AND THRID PARTY AGREEMENT

Zero Pain Clinic PC
2301 S Hampton Rd#800
Dallas, TX 75224
P: 214 339 3333 F: 214 333 3334

Records

I authorize the above name office to furnish all information provided by or pertaining to me, including all records relating to examination, diagnosis, treatment and prognosis, to any third party against which I may have a claim for benefits, insurance or reimbursement.

Assignment of Benefits

I hereby instruct and direct you, my insurance company, and/or my attorney, to pay by check made out and mailed to:

Zero Pain Clinic PC- P.O Box 571458 Dallas, TX 75357
OR:

If my current policy prohibits direct payment to the above named office, I hereby also instruct and direct you to make out
The check to me and mail it as follows:

Zero Pain Clinic PC-P.O Box 571458 Dallas, TX 75357
For such sums as may be due and owing this office for services rendered me by reason of accident or illness that are due this office and to withhold such sums from my disability, medical payments benefits. No-fault benefits, health and accident benefits, workers compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may necessary to adequately protect said office. I hereby further give an assignment to said office against any and all insurance benefits named herein, and any and all proceeds of any Settlement, judgment or verdict, which may be paid to me as a result of the injuries of illness for which I have been treated by said office. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS TO THE EXTENT OF THE OFFICE'S SERVICES PROVIDED .

Responsibility for payment: (Excludes patients under Texas Workers Compensation)

I agree that I am personally responsible 100% of the payment to the above named office of all amounts that may be and owing for treatment and services rendered to me, and that payment of such amount shall not be contingent upon receipt of any benefit, insurance or reimbursement from any other party.

Termination of care: (excludes patients under Texas Workers Compensation)

Further, in the event that I terminate my care, without my Doctor's approval or release, I agree to pay the entire outstanding balance of my account upon request. It is understood that the total outstanding balance includes any amounts already filed with my insurance carrier which have not yet had payment received on. Should my carrier pay those amounts, I will receive a refund equal to the amount that my bill has be overpaid.

Cost of Collection: (excludes patients under Workers Compensation)

I agree that if any amount due and owing to the above named office for treatment or services is not paid when due, collection costs, including attorney's fees, will be added to the amount due.

Authorization to the Doctor

I authorize the Doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.
Date: _____/_______/______
Insured Signature:____ Printed Name:____
Claimant's Signature: (if other than policyholder):____

Attorney Acknowledgement

The undersigned attorney acknowledges receipt notice of assignment of the above named office, and agrees to withhold from any payment of benefits, insurance or reimbursement, and pay to the above named office, for treatment or services to the patient, first, from any settlement, the entire bill in full.

Attorney: Please date, sign, copy this for your records and mail original back:

ZERO PAIN CLINIC PC
DORIT SAR- SHALOM, D .C

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATEINTS

To our valued patients:

The misuse of the personal health information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training t understand and comply with government rules and regulations regarding Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve very highest standards of ethics in performing services for our patients.

It is our Policy to properly determine appropriate use of PHI in accordance with the government al rules, laws and regulations, we want to ensure you our practices never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem, so that may remedy the situation promptly.

Thank you for being one of our highly valued patients.

_____________________________/____/______

Patient signature & Date

PERSONALIZED HEALTH CARE FOR:

- Stress & Tension
- Auto Accidents
- Work injuries
- Sport injuries

COMPREHENSIVE TREATMENT OF:

*Headaches
*Carpal Tunnel(wrist)
*Shoulder & Arm Pain
*Low Back & Leg Pain

CONSENT TO TREATMENT

I Hereby authorize the Doctor to treat my condition as he or she deems appropriate. This treatment may include, but is not limited to chiropractic, Acupuncture, and massage therapy. These treatments may be to get rid of my symptoms, but also to correct the cause of my condition.

____
Patient Signature

____
Date