HEAL THY BODY WELLNESS CENTER

2616 South Loop West, Suite 468
Houston, TX 77054
Phone:713-667-4325/Fax: 832-550-8208

NEW PATIENT INFORMATION

Please print all answers

Name_____ Age_____ Sex_____ Date_____

Address_____ City_____ State_____ Zip_____

Phone #_____ Work #_____ Cell #_____

Social Security #_____ Birth date_____ E-mail_____

Referred By: _____ Family Doctor_____

Employer_____ Employer's Phone_____

Employer's Address_____

☐Married ☐Single ☐Separated ☐Divorced ☐Widowed Spouse's Name_____

Spouse's Employer_____ Spouse's Social Security_____ Spouse's Birth date_____

Parent's Employer If Patient Is Minor / Child_____

Parent's Social Security # If Patient Is Child_____

Emergency: Who Do We Call? _____ Relationship_____ Phone_____

Name of Insurance Company_____ Group Number_____

Name of Insured (Policy Holder) _____ Policy Number_____

Heal Thy Body

SYMPTOM SURVEY

What is your chief problem or symptoms? _____

What caused the problem or symptoms to occur? _____

When did the problem or symptoms begin? _____

Have you seen another doctor for this problem? ☐ No, If yes, who_____

What tests/procedures have been performed? ☐ X-Ray ☐ MRI ☐ Surgery ☐ Hospitalization _____

Have you had this problem or symptoms in the past? ☐ No, If yes, explain _____

Have you tried any other treatments for this? ☐ No, If yes, explain _____

Is the problem or symptoms getting worse? ☐ No, If yes, explain _____

√ ALL OF THE ITEMS THAT APPLY TO YOU NOW AND IN THE PAST:

☐ Arthritis / Gout	☐ Depression/Anxiety	☐ Pregnancy	☐ Seasonal Allergies	☐ Urinary Problems
☐ Eye Pain–Strain	☐ Dizziness	☐ Seizures	☐ Ringing in Ears	☐ Blurred Vision
☐ Neck Pain / Spasms	☐ Chronic Fatigue	☐ Thyroid Problems	☐ Shortness of Breath	☐ Anemia
☐ Low Back Pain	☐ Hypertension	☐ Asthma/Bronchitis	☐ Headaches	☐ Heart Disease
☐ Foot or Ankle Pain	☐ Stroke	☐ Irregular Heart Beat	☐ Diabetes	☐ Female Disorders
☐ Shoulder/Elbow Pain	☐ Chest Pain	☐ Abdominal Pain	☐ Broken Bones	☐ Skin Problems
☐ Hip/Knee/Leg	☐ Digestive Problems	☐ Nausea – Vomiting	☐ Other_____	☐ Other_____

PATIENT & FAMILY HISTORY

What is your occupation? _____ ☐Full Time ☐ Part Time

What is your employment status? ☐ Working ☐ Sick Leave ☐ Unemployed ☐ Retired

☐ Temp Disability ☐ Perm Disability Last Day of Work _____

Do you use tobacco? ☐ No ☐ Yes Explain_____
Do you consume alcohol or caffeine? ☐ No ☐ Yes Explain_____
Do you have a history of substance abuse? ☐ No ☐ Yes Explain_____

List all past surgeries_____ List all drug allergies_____

_____ _____

List all current and past medications / drugs

Drug Name: _____ _____

_____ _____

List all physicians you have seen in the past 5 years?

Name_____ For What? _____

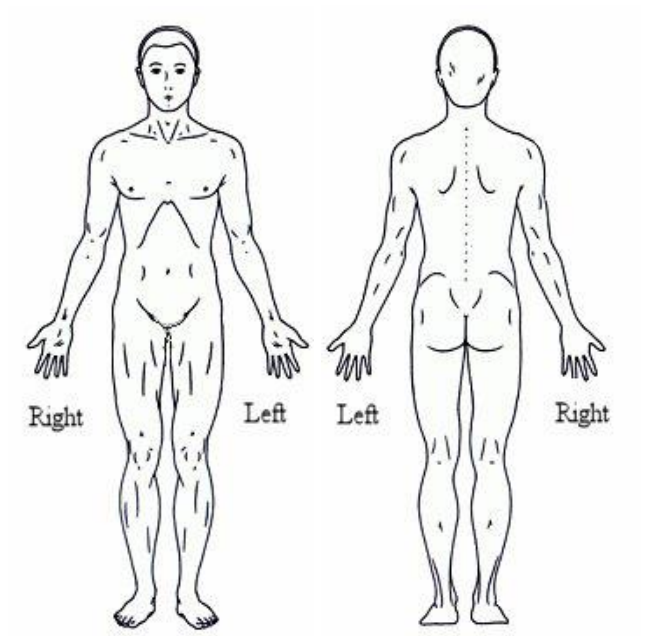
_____ _____

Family History

Father	☐ Living	Age: _____	☐ Deceased – Cause of Death_____
Mother	☐ Living	Age: _____	☐ Deceased – Cause of Death_____
Brother	☐ Living	Age: _____	☐ Deceased – Cause of Death_____
Brother	☐ Living	Age: _____	☐ Deceased – Cause of Death_____
Sister	☐ Living	Age: _____	☐ Deceased – Cause of Death_____
Sister	☐ Living	Age: _____	☐ Deceased – Cause of Death_____
Children	#_____	Age(s): _____	☐ Deceased – Cause of Death_____

PAIN CHART

Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation.



Pain : : : : : : : : : :
Numbness + + + + + +
Burning / / / / / / / / / /
Ache X X X X X X

Describe your pain
(check all that applies)

☐Constant
☐Intermittent
☐Recurring
☐Stabbing
☐Dull Ache
☐Sharp
☐Deep Ache
☐Throbbing
☐Tingling
☐While Resting
☐Daily
☐During Exercise
☐Nightly
☐_____

Onset of pain
☐ Sudden
☐ Gradual

On a scale of 1 to 10 how would you rate your pain level? _____ (1 = Mild, 10 = Intense)

Does anything give you relief? _____

Please provide the receptionist with your driver's license & insurance card to be photocopied for your permanent medical record

Welcome to our multi-specialty practice offering chiropractic, physical therapy, massage therapy, and nutritional counseling. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. **HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice.** This Notice is detailed below. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff.

Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. If you must miss an appointment please notify us. **If you do not show up for your scheduled appointment you will be charged $35.00 as a "missed appointment fee" that you must pay before you are seen or treated again.** We may be available to see new patients the same day. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.

May we contact you by email to schedule appointments and/or send promotions? Check One Box: ☐Yes ☐No

HEALTH CARE PRIVACY NOTICE-INFORMED CONSENT-ASSIGNMENT OF BENEFITS-AUTHORIZATION & LIEN

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to Heal Thy Body.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility.

Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility.

Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility.

I further understand that in the practice chiropractic, massage therapy & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions & reactions and/or other injuries or side effects which cannot be predetermined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

The Facility reserves the right to refuse treatment to any client/ patient for improper conduct or language. Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility.

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to Heal Thy Body, hereinafter referred to as the "Facility" against any & all PIP, insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

_____
Patient Initials

INSURANCE BENEFITS-CREDIT POLICIES-PAYMENT TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers mis-quote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in additional filing medical report charges, which you are responsible to pay.
2. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. All account balances, including automobile claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
5. A non-discriminatory “Time of Service Discount” is offered to anyone who pays for services the day they are rendered. The “TOS” is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, and massage therapy.
6. A service charge is computed by a ‘periodic rate’ of 1½ % per month – 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee’s. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge.
7. For your convenience we accept checks and all major credit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Heal Thy Body

_____ _____

Print Name of Patient Claim # (if applicable)

_____ _____

Signature (if minor, parent must sign) Date

For Office Use Only: **MM** **PI** **WC** **MC** **MT** **SP**