Adams Health Centers, PC
3151 W. 15th St., Plano, TX 75075

Phone: 972-596-1611
Fax: 972-596-9072

www.adamsclinic.com

PATIENT DEMOGRAPHIC INFORMATION

Please Print

Patient's Name: ______________________________ Birthday: ______________

Address: ______________________________ City: ____________ ZIP: __________

Best Contact Phone #: ____________________ Cell / Home / Work - Okay to message? Yes / No

Alt. Contact Phone #: ____________________ Cell / Home / Work - Okay to message? Yes / No

E-Mail: ______________________ Preferred Method of Communication ____________

Who can we thank for referring referring you here today ______________________:

BILLING AND PAYMENT OPTIONS

****If you would like us to submit billed services for payment to your insurance company,, please provide the requested information along with a copy of your drivers license and insurance card. While we file insurance as a courtesy to you, it is ultimately patient responsibility to obtain and provide any needed referrals, co pays, co insurance and estimated out of pocket cost at the time of service ****

INSURANCE OPTION

Patient Relationship to Subscriber ________________ InsurancCo.Name ____________________

Subscribers Name ______________________ Subscribers Birthday ______________

Policy #: ______________________ Group # (if available): ____________________

I understand all copay's, deductibles and coinsurance are due at the time of service. I understand Adams Chiropractic Health Care may bill me for remaining balance insurance left due to eligibility, copay, deductible or non covered services. I give Adams Chiropractic Health care authorization to file claims on my behalf to my insurance company.

__________ *Initial Here*

PRIVATE PAY OPTION

I will not be using an insurance company, claim number or third party to pay for services rendered. I choose to pay with cash, credit card or check . I understand that full payment is due at the time of service.

__________ *Initial Here*

______________________ ______________________ ____/____/____

Print Patient Name *Patient Signature – Responsible Party* *Date*

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SYMPTOM SURVEY

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 problem? ☐ 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	☐ Headaches
☐ Eye Pain-Strain	☐ Dizziness	☐ Seizures	☐ Ringing in Ears	☐ Blurred Vision
☐ Jaw Pain	☐ Bleeding Gums	☐ Neck Pain / Spasms	☐ Chronic Fatigue	☐ Heart Disease
☐ Gall Stones	☐ Swallowing Difficulty	☐ Thyroid Problems	☐ Chest Pain	☐ Chest Congestion
☐ Anemia	☐ Hypertension	☐ Stroke	☐ Kidney Stones	☐ Pancreatitis
☐ Shortness of Breath	☐ Irregular Heart Beat	☐ HIV / AIDS	☐ Asthma / Bronchitis	☐ Mid-Back Pain
☐ Shoulder/Elbow Pain	☐ Wrist or Hand Pain	☐ Low Back Pain	☐ Hip/Knee/Leg Pain	☐ Foot or Ankle Pain
☐ Abdominal Pain	☐ Diabetes	☐ Groin or Rectal Pain	☐ Female Disorders	☐ Urinary Problems
☐ Skin Problems	☐ Broken Bones	☐ Digestive Problems	☐ Nausea - Vomiting	☐ Irregular Bowels

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? ☐ No ☐ Yes Explain: ______

Do you have a history of substance abuse? ☐ No ☐ Yes Explain: ______

List all past Surgeries: ______

Do you have any known drug allergies? ☐ No ☐ Yes, please explain: ______

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	☐ Living	Age: ______	☐ Deceased – cause of death	______
Children	☐ Living	Age: ______	☐ Deceased – cause of death	______

☐ Other problem(s) not listed: ______

Below is for office use only

BP: ______ *PULSE:* ______ *OX:* ______ *HEIGHT:* ______ *WEIGHT:* ______

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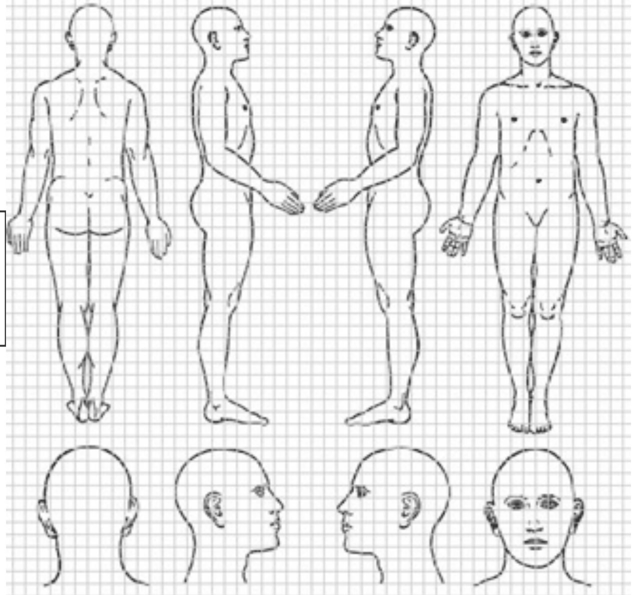
PAIN DRAWING

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

Describe your pain (check all that apply):

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

Pain	•
Numbness	+
Burning	/
Ache	X



Onset of Pain:

- ☐ Sudden
- ☐ Gradual

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

What if anything gives your relief? ____

~IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN ACCIDENT OR INJURY PLEASE COMPLETE BELOW~

☐ NOT APPICABLE
☐ AUTO ACCIDENT   Date ________________   Time ______ (am) (pm)   Location ____

Were You: ☐ Driver   ☐ Passenger
☐ Unconscious   ☐ Treated in E.R.
☐ Wearing a seat belt   ☐ Yes ☐ No
☐ Transported by ambulance   ☐ Yes ☐ No

Vehicle Damage: ☐ Minimal – Moderate   ☐ Severe – Totaled
Was the vehicle towed away?   ☐ Yes ☐ No

Police Report: ☐ None   ☐ Yes with Police Department ____

Activities: ☐ No Restrictions   ☐ Missed _____ days of work or school
☐ I felt fine before the accident

☐ NOT APPLICABLE
☐ WORK RELATED   Date ________________   Time ______ (am) (pm)   Location ____

or Other Injury   Describe the injury and how it happened:

____
____
____
____
____
____
____
______________________________________.

Accident Reported to ____ on __________________ (date)

☐ No restrictions   ☐ Missed ________ days of work or school
☐ I felt fine before the injury

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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 patients working together as a team to obtain the maximum results. Patient's satisfaction is a vital interest to our staff.

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 the Notice at anytime without additional notice to your except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of the 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/mental health or condition and the care and treatment you receive form 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 concerns to the Compliance Officer of this Facility.

Our Facility may use and 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 be 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 Office 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 and comprehensive Health Care Privacy Notice is available for your review in this Facility.

I understand that this Facility, its Doctors and staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur.

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

I do not expect the doctors/provider to be able to anticipate and explain all risks and/or complications, an 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.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

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 the office named above and listed below, hereinafter referred to as the "Facility" against any and all 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 and staff may deliver medical records, consultants, 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 and/or sign my name on any & all checks for payment of any indebtedness.

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 misquote 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 an additional filing or medical report charges, which you are responsible to pay.
2. Co-Pays, deductible and all non-covered service charges are due the day the service is rendered.
3. Patients are responsible for charges on all services(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 and work injury 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 physical therapy equipment rentals or purchases, vitamins, supplements, ointments, and weight loss programs.
6. A service charge is computed by a 'periodic rate' of 1 ½ % per month – 18% per annum and 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 and filing fee's. Returned checks, debit and credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $25.00 charge.
7. Patients are eligible for a maximum $250 personal credit limit when approved. For your convenience we accept most major credit & debit cards, personal checks, and cash.

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.

____
Print Name of Patient

✗ ____
Signature (if minor, parent or legal guardian must sign)

____
Date

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PATIENT'S PRIVACY AGREEMENT AUTHORIZATION FOR USE AND DISCLOSURE

Patient Name: ____ Date: ____________________________

I, ____, authorize Adams Health Center to use and/or disclose my protected health information (PHI) to family members and/or friends listed below:

☐ Please DO NOT disclose my personal information to anyone at this time!

Family member/friend 1:

Name: ___________________________________ Relationship: ___________________________________

Street Address: ____

City: ___________________________________ State: ____________ Zip Code: ___________________

Phone Number: (______) ______ - ________

Family member/friend 2:

Name: ___________________________________ Relationship: ___________________________________

Street Address: ____

City: ___________________________________ State: ____________ Zip Code: ___________________

Phone Number: (______) ______ - ________

I was advised of the purpose for which my protected health information (PHI) will be used, and authorize the release of medical and billing information to the above-mentioned individual(s).

I understand that I may refuse to sign this authorization, and I will not be denied treatment because of my refusal. The clinic may disclose and use my PHI for all health care delivery purposes (i.e., treatment, payment, and health care operations).

I have the right to revoke this agreement at any time by delivering written notice to the compliance officer.

I fully understand this authorization for use and disclosure of my protected health information, and I agree to this authorization.

___________________________________ ___________________________________
Patient's Signature Date

___________________________________ ___________________________________
Signature of Compliance Officer Date

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PATIENT FINANCIAL RESPONSIBILIY AGREEMENT

Insurance is a way for you to receive repayment for fees you have paid to a physician for services rendered. Having insurance is not a substitute for payment. Even though insurance companies have a fixed allowance or percentage based on your policy with them, your policy is with your insurance company, not with this office. It is your responsibility to provide payment for the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement in any way possible, but you are ultimately responsible for the payment of your bill.

Medicare Patients

I request that payment of authorized Medicare benefits be made to me or on my behalf to Adams Chiro. Health Center, PC for any services furnished me by Homer C. Adams D.C.. I authorize that any holder of medical records about me to release to the Health Care Financing Administration and its agents any information necessary to determine benefits and process the insurance claim. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

Non-Medicare Patients

I authorize the release of all medical records needed to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Adams Chiro. Health Center, PC. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES. I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND IT.

______________________________	______________________________ (responsible party)
-	
______________________________ (witness)	______________________________ (date)

-

AUTHORIZATION
TO KEEP CREDIT CARD ON FILE

You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

Credit Card Information				
Card Type:	☐ MasterCard	☐ Visa	☐ Discover	☐ American Express
Cardholder Name (as shown on card):				
Card Number:				
Expiration Date (mm/yy):				
Cardholder ZIP Code (from credit card billing address):				
CVC Number:				
Email Address to Send Three Day Notice of Intent to Charge:				
Authorized Account Users:				

I, (print name) ____ , authorize **Adams Chiropractic Health Center** to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future payments on my account. I understand I am leaving this card on file as a convenience and it can remove the card on file at anytime per my request.

____ Patient Signature

______________________________ Date

____ Team Member Signature