Dallas Spinal Care
Paul E. Collett, D.C.
1200 Coit Road #101A
Plano, TX 75075

CHIROPRACTIC HEALTH HISTORY

Name_____ Sex: M F Date of Birth:_____
Address_____ City_____ State_____ Zip Code_____
Cell Phone:_____ Home Phone:_____ Email:_____
Occupation/Employer:_____ Marital Status:_____

What are your reasons for seeking chiropractic care?

1)_____

2)_____

3)_____

What have you already tried to help?_____

_____

Do you take any medicines?_____

Please list any accidents/traumas in your past, including car accidents, childhood/teen incidents, etc.:

_____

_____

Have you had any broken bones, surgeries/operations, concussions, or hospitalizations?_____

_____

What occupations have you held, and how long for each one?_____

_____

What sports have you participated in?_____

Please list your hobbies/recreational activities:_____

_____

Family Health: Please note any health problems YOU, your parents, siblings, spouse, or children have or had:

High Blood Pressure **Asthma/Cough** **Allergies** **Arthritis** **Anemia/Bruising**

Diabetes **Ringing Ears** **Headache/Dizziness** **Skin Rash/Itching** **Painful Urination** **Pain in Bowels**

I understand and agree:

- A history, consultation, exam, and x-rays are conducted for diagnostic & informational purposes. I am requesting these services.
- It is my responsibility to complete the clinic's forms accurately. It is my responsibility to notify the doctor if any of my information has changed or needs updating. Original x-rays are the clinic's property and copies of the original film(s) and/or report(s) will be released to me upon written request.
- **I am fully and solely responsible for any & all fees at the time services are rendered, regardless of whether or not my insurance will cover or reimburse me for these services & fees.**

Patient (or Guardian) Signature_____ Date_____

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TERMS OF ACCEPTANCE/INFORMED CONSENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art that concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation (misalignment)**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed using an instrument. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. **The costs of the services I will need have been explained to me to my satisfaction.** I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____
(signature) (date)

Consent to evaluate and adjust a minor child

I, _____, being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

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CONSENT TO X-RAY

The doctor has explained that the purpose of the x-rays about to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing this x-ray, I will be informed. I then must determine if I should seek the services of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation corrective care provided by this office.

- I fully understand the above and consent to chiropractic spinal x-rays.
- I hereby authorize Dallas Spinal Care to take x-rays of me (or said minor).
- ****Pregnancy Release** -** I hereby release Dallas Spinal Care and Dr. Paul Collett from any and all liability. I hereby affirm that I am not pregnant, nor am I attempting to get pregnant as of this date. I have been advised that x-ray can be hazardous to an unborn child.

Date _____ Patient Name (print) _____

Patient/Guardian Signature _____

Dallas Spinal Care Privacy Policy

The Health Insurance Portability and Accountability Act of 1996 was designed to protect your rights to privacy of your protected health information. This act was passed with the intent to provide security of the electronic transmission of your individual health information.

At Dallas Spinal Care your personal health information (i.e. x-rays, initial medical history, progress record, etc.) and your public or nonpublic personal information (i.e. your Social Security Number, your name, address, and phone number, your date of birth, marital status, etc.) are **never shared with any outside sources** unless you personally request and authorize us to do so. **We are not contracted with any insurance company or their affiliates.**

Is your Personal Information Shared with Others?

We have no affiliates or non-affiliates or third parties with whom we share or sell your private, public or nonpublic information. In other words, YOUR PERSONAL INFORMATION IS NEVER DISCLOSED OUTSIDE THIS OFFICE WITHOUT YOUR REQUEST AND AUTHORIZATION.

- Do we share your patient records with insurance companies when they request it? We are not providers for any insurance network nor do we contract with any insurance company to provide care to you. If your insurance company requires additional information about your care, we forward copies of your records, if you have authorized us to do so. On your first visit to the office we ask you to authorize us to release information for insurance purposes.
- What other means do we use to protect your private health information? Some of the following points offer the general means we use to protect your private health information and public and non-public information:
    - **We secure the premises when the office is closed.**
      Security measures are in place to protect electronic and hard copy data.
      We permanently dispose of your paper and electronic records when required.
      We randomly audit patient records to eliminate or detect errors and/or omissions of information.
      What rights do I have to protect the privacy of my health information?

As a new patient, we will ask your permission to release information to insurance companies, to take photographs for personal identification, to include your name on our mailing list to receive our quarterly newsletter, or for any other administrative use of your health information we deem necessary. You have the right to refuse our requests.
You have the right to revoke any authorization that you may have previously given us.
Your records are available for your review or copies can be made for you at a small administrative fee. The first page is $1.00 and the subsequent pages are $.50 including any postage required. If you request a copy of a film, you will be charged the actual cost for reproduction not to exceed $5.00 per film.

Please be aware that the doctors may review and discuss your x-rays in a public area of this office unless you make a special request to the contrary. If so, we will be glad to evaluate your films in a private area. **If you have any comments, questions, requests or complaints regarding our Privacy Policy, please feel free to contact Dr. Paul Collett 214-669-0623.**

Acknowledged and Accepted:

Date _____ Patient Name (print) _____

Patient/Guardian Signature _____