BONILLA CHIROPRACTIC

4606 F.M. 1960 W, Ste 110 * Houston, TX 77069
Phone: (832) 573-1133 * Facsimile: (281) 596-7211
Email: bonillachiropractic@aol.com

Confidential Patient Information Form

Today's Date _____

Name _____ Date of Birth _____ Age _____

Social Security **(used for Insurance purposes):** _____

Address _____

City _____ State _____ Zip Code _____

Cell (____) _____ Email Address _____

Marital Status: M S W D Children Y/ N # _____

Occupation _____ Work Phone (____) _____

Work Address _____

Name of spouse _____ Phone (____) _____

Emergency contact _____ Contact Phone (____) _____

***** Relationship of emergency contact (Parent/ Other Relative/Friend) *****

Referred By (circle): Self / Flyer / Other physician / Friend or relative/ Other: _____

Date of last physical examination: _____

Reason for your visit today? _____

Have you seen other doctors or chiropractors for this problem? Y/N

If yes, who: _____

INSURANCE INFORMATION

Name of person responsible for payment (if you hired an attorney provide information)

Attorney Name _____

Attorney Address _____

Phone: _____ Fax: _____

Are you insured? Y/N Company _____

Would you like us to bill your insurance Y/N

If YES, please provide information:

Insurance Name: _____ Policy #/Id #: _____

Phone: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I agree as a patient receiving services from the provider that I am responsible for services that I receive that are not covered by the health insurance Furthermore. I understand that Bonilla Chiropractic 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 will be credited to my account on receipt. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. With my signature I hereby state that all of the above information was truthful and accurate to the best of my knowledge.

Patient's Signature: _____ Date _____

Guardian Signature (minor) _____

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Patient and Family Health History

MAIN HEALTH CONCERNS

My usual health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list, in order of importance, your chief concerns:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

FAMILY & PERSONAL HISTORY

Please list family members (or yourself) who have the following conditions: **M** – Mother **F**-Father **S**- Self

Cancer:	Autoimmune disease:
Eczema:	Arthritis:
Diabetes:	Allergies:
Heart disease:	Asthma:
High blood pressure:	Addictions:
Stroke:	Liver disease:
Thyroid disease:	Mental illness:

Please list hospitalizations, surgeries, major accidents/injuries, x-rays, CAT scans, MRIs, EKGs, etc.

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

List any real or suspected allergies/sensitivities to drugs, food, alcohol, caffeine, chemicals, perfumes, smoke, environment, or other: _____

_____

Read the following questions and fill in the number that applies:

0 (leave blank) = Never consume or use
1 = Consume or use several times per month
2 = Consume or use weekly
3 = Consume or use daily

DIET

_____ Alcohol
_____ Artificial sweeteners
_____ Candy or other sweets
_____ Pop/soda
_____ Chewing tobacco
_____ Cigarettes
_____ Cigars/pipes
8. _____ Coffee
9. _____ Fast food
10. _____ Fried foods
11. _____ Luncheon meats/hot dogs
12. _____ Margarine
13. _____ Milk/cheese/yogurt, etc.
14. _____ Non-herbal tea
15. _____ Refined flour/baked goods
16. _____ Refined sugar
17. _____ Vitamins and minerals
18. _____ Water, distilled
19. _____ Water, tap
20. _____ Water, well
21. _____ Diet often (Y or N)

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INFORMED CONSENT FORM FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient, in accordance with chiropractic exam, test, diagnosis, analysis and treatment. The chiropractor adjustments or other clinical procedures are usually beneficial and seldom cause any problems. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment. In rare cases, underlying physical defects, deformities or pathologies may rendered the patient susceptible to injury . Rare complications that can result, as a result of spinal manipulation include muscle strain, cervical myelopathy, disc or vertebral injury, fractures, strains, dislocations, and stroke. The doctor, of course, will not give any treatment or health care if she is aware that such care may be contraindicated. In order to minimize complications occurrence, a detail clinical history and examination will be done prior to treatment. This examination may include the use of X rays, which pose a risk if you are pregnant. If you are pregnant, please tell the doctor during the clinical history. It is responsibility of the patient to make it known, or to learn through health care procedures whatever the patient is suffering from. The Chiropractor provides specialized a specialized, a non-duplicating health care service. Your doctor of Chiropractic is licensed in a special practiced and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by the chiropractor at **BONILLA CHIROPRACTIC**, I am authorizing **BONILLA CHIROPRACTIC** to precede with any treatment that maybe necessary. Furthermore, any risk involved regarding the chiropractic treatment, will be explained to me upon my request.

PATIENT NAME (PRINT) _____

_____ _____

PATIENT SIGNATURE DATE

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Payment Policy Thank you for choosing Bonilla Chiropractic as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below.

1. INSURANCE. We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.

2. CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.

3. PROOF OF INSURANCE. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

4. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.

5. COVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.

6. **MISSED APPOINTMENT. Our policy is to charge $35.00 after one missed appointment not cancelled 24 hours in advance. The charges will be your responsibility in which we will billed directly to you and expect to pay that fee at your following appointment. Please help us to serve you better by keeping your regular scheduled appointment.**

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines.

Patient Signature _____ Date_____

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Notice of Privacy Practice for Protected Health Information

We are required by law to maintain the privacy for your health information. We are also required to provide you with this notice for our legal duties and our privacy practices with respect to your health information. Other than the uses and disclosures we described below, we will not sell or provide any of your health information to any outside marketing organization.

We must abide by the terms or this notice while it is in effect, but we reserve the right to change the terms of our privacy notices. If we make a change, it will apply for all of your health information in our files, and we will notify you in writing if/when you come in for treatment.

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health information:

i. We may have to disclose your health information to another health care provider, or a hospital, etc., if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
ii. We may have to disclose your examination and treatment records and your billing records to another party (i.e. your insurance company), if they are potentially responsible for the payment of your services.
iii. We may need to use any information in your file for quality control purposed or any other administrative purposes to run our practice.
iv. We may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you (i.e. tests results). 164.520 (b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine and/or mailed.

You have the right to refuse to give us authorization to contact you regarding your case at this office. If you do not give us authorization, it will not affect the treatment we provide to you, or the methods we use to obtain reimbursement for your care including billing you by mail or collection proceedings. You may inspect or copy the information that we use to contact you regarding your care at any time (i.e. appointment reminders, care alternatives, etc.)

Your right to limit uses or disclosers

You have the right to request that we do not disclose your health information to specific individual, companies, or organizations. Any restriction should be requested in writing. We are not required to honor these requests. However, if we agree with your restrictions, the restriction is binging on us.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances.

i. We are providing health care services to you based on the orders (referral) of another health care provider.
ii. We provide health care services to you in any emergency and we are able to obtain your consent after attempting to do so.
iii. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Revoking your authorization

You may revoke your authorization to us at any time in writing. There are two circumstances under which we will not be able to honor your revocation requests:

i. If we have already released your health information before we receive your request to revoke your authorization. 164.508(b)(5)(I)
ii. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information of the decide to contest any of your claims.

Confidential Communication
We will attempt to accommodate any reasonable written request regarding how/where (i.e. mailing address or contact number) you would like to receive information about your health or the services that we provide.

Inspecting/Copying your Health Information
You have the right to inspect the health information contained in your files while in our office and/or have a copy made for you. The health information is available up to seven years from the date that the record was created or as long as the information remains in our files. Your request must be in writing to inspect the records and/or have them copied. There will be a change of $.50 per page copied.

Accounting of Disclosures of your Records
You have the right to request an accounting of any disclosures (not listed below) made of your health information for six years prior to the date of your request. The request must be in writing. The accounting will exclude the following disclosures:

- Required for your treatment, to obtain payment for services, to run our practice, and/or made to you.
- Necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- For national security, intelligence purposes, or law enforcement officers.
- That were made prior to the effective date of the HIPPA privacy law (April 14, 2003).

We will provide the first accounting within a 12-month period without any charge, but any additional requests will be charged a fee. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw of modify your request.

Re-Disclosure
We cannot control the actions of others to whom we have released your information for treatment. Information that we use or disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by the federal privacy rules.

Complaints
You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. Written comments would be addressed to our office address or Secretary for Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Bldg, Washington, D.C. 20201.

Patient Name Printed _____ Date _____

Patient Signature _____ Authorized Staff Person _____