Amy Akin, D.C.
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Phone: 254-968-2726
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1359 W. South Loop Suite D
Stephenville, TX 76401

Patient Information

Date: _____

Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Birth Date: _____ Gender: M or F

Occupation: _____

Employer: _____

Marital Status: M S W Spouse Name: _____

Referred By: _____

Emergency Contact:

Name: _____

Phone: _____

***Would you like to receive appointment reminders via text message? YES NO**

Text message and call reminders are a courtesy. In the event that you do not get a reminder, it is the patient's responsibility to remember their appointment. Each time a patient misses an appointment without providing proper notice, another patient is kept from receiving care. It is our goal to provide our patients with timely, quality care. In order to do so, we require our patients to understand our policy as it relates to cancellation, no-shows, and late arrivals. **We require an hour advance notice. If you do not show up to the appointment, or notify us, you will be charged a $25.00 fee and it will be your responsibility to pay prior to being rescheduled**. **Three no-shows may result in dismissal. A 5 minute grace period will be allowed, anything past than that may result in your appointment being canceled. If there is any outstanding balance left on your account the card on file will be run for the amount**. Being respectful to staff members is greatly appreciated.

Initial here:_____

Cross Timbers Family Chiropractic

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices(NPP) and agree to its terms.

_____	_____	_____	
Name of Patient	**Date of Birth**	**Signature of Patient/Parent/Guardian**	**Date**

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such a person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____
Print Name:_____
Print Name:_____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:

_____
___OK to leave message with detailed information
___Leave message with call back numbers only

Written Communication Address:

_____
___OK to mail to address listed above
___E-mail me at_____

Work Telephone Number:

_____
___OK to leave message with detailed information
___Leave message with call back numbers only

Fax Communication:

_____
___OK to Fax at the number listed above
___ Email me at_____

Other:_____

_____ _____
Name of Patient (Print) Signature Date

_____ _____
Witness Date

Limited Assignment of Rights and Informed Consent

I _____, hereby assign any and all legal rights required with respect to the enforcement of medical benefit provisions of any insurance policy under which I qualify for benefits, including the right to proceed in AAA arbitration, necessary to collect monies due and owing to *Cross Timbers Family Chiropractic* for medical services which were provided to me.

This is a limited assignment of rights solely for the purpose of collecting fees for outstanding medical services by *Cross Timbers Family Chiropractic*. I specifically do not assign and thereby reserve all other rights and obligations, including the duty to co-operate with the insurance company, with respect to the enforcement of all other medical benefits coverage.

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____**Date:**_____

Witness/Guardian Signature _____**Date:** _____
Dr. Amy Akin / Dr. Joanna Martin

Our office will file your insurance as a courtesy to you. Your insurance policy is a contract between you and your insurance company. We are not responsible for policy limitations. During your first visit our office will make every attempt to verify your policy benefits; however this does ***NOT*** *guarantee your policy or payments. You will be responsible for your deductible and co-insurance.* ***If an insurance payment is anticipated for a service but later denied, you will be responsible for the full amount as soon as our office is notified of the denial.*** *A credit will be added to your account if an insurance payment is received for a service that was already paid for in full by you. You must notify our office of any changes made to your insurance policy or coverage.* ***A fee of $25.00 will be added to your account if your appointment is missed/rescheduled without a 1-hour notice.*** **A 5 minute grace period will be allowed, anything past than that may result in your appointment being canceled.If there is any outstanding balance left on your account the card on file will be run for the amount.** Being respectful to staff members is greatly appreciated

Patient Health Questionnaire

Patient Name_____ **Date**_____

What is your Occupation? _____

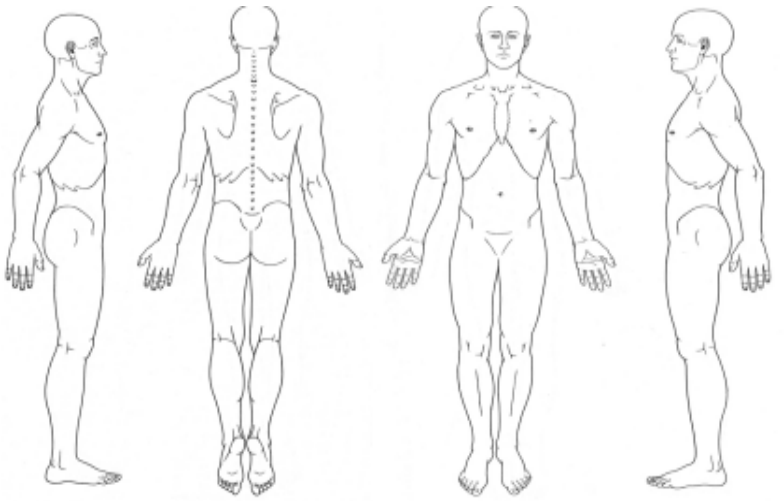
When did your symptoms start?_____

How did your symptoms begin?_____

How often do you experience your symptoms?

○ Constantly (75-100% of the day)
○ Frequently (51-75% of the day)
○ Occasionally (16-50% of the day)
○ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms:



What describes the nature of your symptoms?

○ Sharp ○ Shooting
○ Dull Ache ○ Burning
○ Numb ○ Tingling

How are your symptoms changing?

○ Getting better
○ Not Changing
○ GettingWorse

How bad are your symptoms at their:

a. worst: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

b. best: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

How do your symptoms affect your ability to perform daily activities?

○	○	○	○	○	○
No Complaints	Mild. Forgotten with activity	Moderate. Interferes with activity	Limiting. Prevents full activity	Intense. Preoccupied with seeking relief	Severe. No activity possible

What activities make your symptoms worse? _____

What activities make your symptoms better? _____

Who have you seen for your symptoms?

○ No one ○ Medical Doctor ○ Other Chiropractor ○ Physical Therapist ○ Other_____

a. What treatment? _____ Date:_____

What tests have you had for your symptoms?

○ X-rays Date:_____ ○ CT Scan Date:_____ ○ MRI Date:_____ ○ Other Date:_____

Have you had similar symptoms in the past? ○ Yes ○ No

If you received treatments for the symptoms, who did you see?

○ Other Chiropractor ○Medical Doctor ○ Physical Therapist ○ Other_____

Bloodwork:

Last time you had bloodwork done? _____ Results: ○ Normal ○ Abnormal

If Diabetic, last Hemoglobin A1C _____ Results: ○ Normal ○ Abnormal

Last Mammogram? _____ Results: ○ Normal ○ Abnormal

What do you hope to get from your visit? *(select all that apply)*

○ Reduce symptoms ○ Explanation of condition/treatment
○ How to prevent this ○ Learn how to take care of this on my own.
○ Resume/increase activity

Patient Signature_____ ***Date*** _____

Patient Health Questionnaire

What type of regular exercise do you perform? ○ None ○ Light ○ Moderate ○ Strenuous

What is your height and weight? Height: _____ Weight:_____

Place a check in the PAST column if you have had the condition in the past. If you presently have a condition listed below, place a check in the PRESENT column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke	○	○	Chronic Sinusitis
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Tobacco Products
○	○	Shoulder Pain	○	○	Kidney Stones	○	○	Drug/Alcohol Dependence
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infections	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
○	○	Hip/Upper Leg Pain	○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Knee/Lower Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain	○	○	HIVS/AIDS
○	○	Jaw Pain	○	○	Loss of Appetite	○	○	Birth Control Pills
○	○	Joint Swelling/Stiffness	○	○	Abdominal Pain	○	○	Hormonal Replacement
○	○	Arthritis	○	○	Abnormal Weight Loss	○	○	Pregnancy
○	○	Rheumatoid Arthritis	○	○	Hepatitis	○	○	Ulcer
○	○	General Fatigue	○	○	Liver Disorder	○	○	Muscular Incoordination
○	○	Cancer	○	○	Gallbladder Disorder			
○	○	Visual Disturbances	○	○	Tumor			
○	○	Dizziness	○	○	Asthma			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus

List all Prescriptions, Over-the-Counter Medications and Nutritional/Herbal Supplements you are taking:

_____

_____

List all Surgical Procedures you have had and all the times you have been hospitalized:

_____

_____

Patient Name_____

Patient Signature_____ **Date** _____

Doctor's Additional Comments:

_____

_____

Doctor's Signature_____ ***Date***_____

Cross Timbers Family Chiropractic
Amy Akin DC / Joanna Martin DC
1359 W South Loop Suite B
Stephenville, Texas 76401-5173

Electronic Health Records Intake Form

In compliance with Medicare requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ **Date:**_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____