RESOLVE
CHIROPRACTIC AND WELLNESS

Confidential Patient Information

Date: _____
First Name _____ Middle Name _____ Last Name_____ Suffix _____
Address _____ City _____State _____ Zip Code _____
Date of Birth _____ Age _____ Sex: Male Female Marital Status: M S W D
Cell Phone # _____ Social Security Number _____
# of Children _____ Occupation _____ Employer _____
Name of Spouse (or parent if minor) _____ Phone # _____
Emergency Contact _____ Relationship _____ Phone #_____
Whom may we thank for referring you? _____

Purpose of this appointment/ current problem _____
Other doctors seen for this condition _____
Is this condition due to injury arising out of employment or auto accident _____
Date symptoms appeared or accident occurred _____ Days lost from work _____
Do you suffer from:

	(Y/N)		(Y/N)		(Y/N)		(Y/N)
Dizziness		Neck Pain		Shoulder/arm pain		Nervousness	
Back Pain		Arthritis		Hip/leg pain		Sinus Trouble	
Heart Trouble		Headaches		Urinary Problems		Male/Female Trouble	
Diabetes		Numbness		Digestive Disorder		Cancer	

Do you smoke _____ Packs per day _____ Do you have a pacemaker _____
Who is your primary care physician _____ Office Name _____
List of Medications _____
List of Vitamins _____
Do you take birth control _____ Are you pregnant _____

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician, and it is the responsibility of the staff to carry out the instructions of such physician(s).
RELEASE OF INFORMATION: By signing this form, you are granting consent to Resolve Chiropractic and Wellness to use and disclose your protected health information for the purpose of treatment, payment and health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.
Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office. You have the right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or healthcare operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.
You have the right to revoke this consent in writing, except to the extent we have already used or disclosed your protected health information in reliance on your consent.

PATIENT SIGNATURE (or Guardian Signature authorizing care) _____ Date _____

Insurance Company _____ Insured _____ SS# _____

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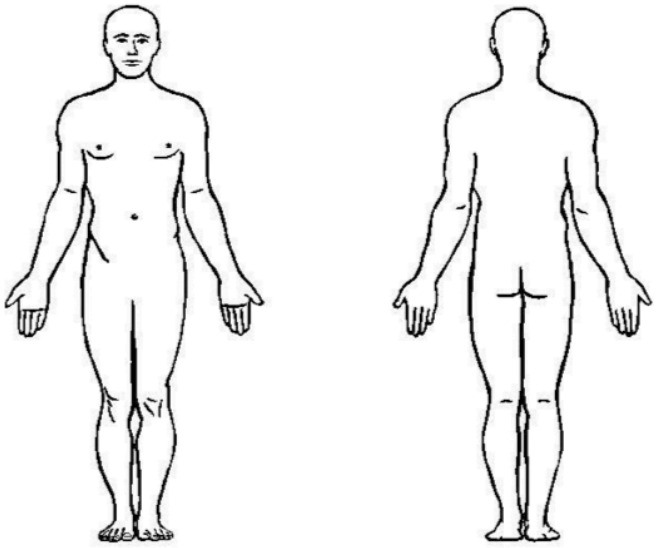
1. What is your major symptom?_____
2. When was the first time you noticed this problem? _____
3. How did it occur? _____
4. Has it become worse recently? _____ If yes, when and how? _____
5. How frequent is the condition? _____ How long does it last? _____
6. Have you ever had the same or similar condition ( ) No ( ) Yes
   If yes, when and describe_____
7. Are there any conditions or symptoms you have that may be related to your major symptom? _____
8. If pain is involved, is it – sharp, dull, throbbing, stabbing, aching, burning, tingling, shooting, (other)? _____
9. Is there anything you can do which seems to provide relief? _____
10. What makes the problem worse? _____
11. List accidents, illness, surgeries, or broken bones _____
12. Rate the severity of your condition (0-10) _____
13. Please mark your symptom areas:



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Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPPA and Consent for Use of Health Information

Name _____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPPA and has been advised that a full copy of this office's HIPPA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPPA, the HIPPA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20____

By _____
Patient's Signature

If the patient is a minor or under a guardianship order as defined by State Law:

By _____
Signature of Parent or Guardian

HIPPA Privacy Authorization Form
Authorization for Use or Disclosure of Protected Health Information

I authorize Dr. Nickesh Mistry DC with Resolve Chiropractic and Wellness to use and disclose the protected health information described below.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Patient's Signature Date

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient: _____ DOB: _____

Claim/Group #: _____Insured SS#: _____

Insured ID #: _____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

Resolve Chiropractic and Wellness
1061 N. Preston Rd.
Celina, TX 75009

as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows: c/o Mistry Chiro, LLC.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjusted or attorney involved in this case.

Dated this _____day of _____, _____

_____ _____

Insured Signature Witness

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Name _____ DOB _____ Date_____

WHAT TO EXPECT AFTER YOUR FIRST ADJUSTMENT

Please read the following information carefully and sign the bottom of the sheet to indicate you understand the instructions and information given.

1. If you have never been adjusted, or if it has been a while since your last adjustment, you may experience soreness or discomfort for a few hours to a few days after your adjustment. This is a normal reaction to chiropractic adjustments.
2. If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20-minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect the skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.
3. Do not use heat except under the doctor's instruction. Heat may aggravate your injury.
4. Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yardwork, raking, digging, lifting heavy groceries, pets, and children, and any other activities that could aggravate or reinjure your condition.
5. Unless indicated by the doctor, you may return to work/school after your appointment.
6. If a sudden movement causes sharp or severe pain, or if you experience swelling, contact the clinic at (972)382-8822. After hours, contact (469)826-7339.

I have read and understand the instructions given for my follow-up care.

_____ _____

Patient's Signature Date

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Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. To provide you and our other patients with optimal spine care, we request you follow our guidelines regarding broken and/or cancelled appointments. Please remember we have reserved appointment times especially for you. Therefore, we request at least 24-hour notice to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor, and the other patients that would like to have utilized your appointment time.

Since our office does not charge for broken or cancelled appointments, please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

_____ _____

Patient's Signature Date

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Financial Policy

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expenses and allows you to place your entire family under care.

If you do not have insurance: all payments are expected at the time of service. A time-of-service discount will be applied when payment is received in full the same date service is rendered instead of prepaying for multiple visits.

If you have insurance: all deductibles and co-pays are expected at the time of service.

You are considered a cash patient until you have completed all insurance forms, and we qualify and accept your insurance coverage.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge and file them with your insurance company to help you collect. If your insurance carrier has not paid a claim within **sixty (60) days** of submission, you agree to take an active part in recovery of your claim. If your insurance carrier has not paid within **ninety (90) days** of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment for any non-covered services, deductibles or co-pays. If your insurance policy requires you to have a referral, it is your responsibility to obtain one.

If you discontinue care for any reason other than being discharged by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Personal injury or automobile accidents: Please present your auto insurance card, your health insurance card and tell us if you have retained an attorney. There are four options available:

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1. Pay at the time of service for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) From the Med Pay or Personal Injury Protection portion of your auto insurance.
3. We will accept a Letter of Protection or a Doctor's Lien from an attorney and await payment at the time of the settlement as long as you remain an active patient.
4. we will build your standard health insurance plan and you will be responsible for all copays and deductibles as they are incurred

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six (6) months after your care is complete. Once the claim is settled or if you suspend care, any fees for services are due immediately.

Flex Plans/Health Saving Accounts: Please inform us if you have a health savings account, sometimes known as “flex plan” or “cafeteria fund.” We will be happy to provide you with a statement of your charges for reimbursement.

A $25 fee will be assessed for returned checks.

There will be a $15 fee for any additional forms that are needed (example: Family Medical Leave of Absence).

I have read and understand the payment policy of Resolve Chiropractic and Wellness. I understand my insurance is an arrangement between myself and my insurance company. I request that Resolve Chiropractic and Wellness prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand if my insurance does not respond within 60 days, or if I suspend or terminate care, my schedule of care as prescribed by the doctor at Resolve Chiropractic and Wellness those fees will be due and payable in full immediately.

_____ _____

Patient’s Signature (or guardian if patient is a minor) Date

_____ _____

Witness Date

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