one WELCOME

ABOUT YOU

Today's Date: ____/____/____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age:_____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-Mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

two

INSURANCE INFO

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Please inform front desk of 2nd. Insurance source.

REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): _____

_____

Please describe the pain & its location: _____

_____

When did condition begin? ____/____/____

Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? ❑ Yes ❑ No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No

If so, where? _____

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

If so, whom? _____ Phone#: _____

three

PLEASE CONTINUE ON BACK

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic.

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

Patient Signature _____ Date _____

RELEASE OF INFORMATION

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and hereby release this clinic of any consequence thereof.

Patient Signature _____ Date _____

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, copayment and any services rejected by my insurance company.

Patient Signature _____ Date _____

BENEFITS

I acknowledge that the information given to me by any representative of Memorial Chiropractic Clinic concerning my insurance is only a description of benefits and not a guarantee of payment.

Patient Signature _____ Date _____

NOTICE OF PATIENT RESPONSIBILITY POLICY

SERVICES PROVIDED WITHOUT REFERRAL OR PRE-APPROVAL AUTHORIZATION

As a member of a medical insurance program, I acknowledge for today's visit that I assume full financial responsibility for services rendered to me if my medical insurance carrier denies or does not cover my claim for these chiropractic services.

MEDICAL NECESSITY

If my insurance carrier determines that a medical service and/or material are not covered, I acknowledge that I have been notified and will assume full financial responsibility for the services and/or materials stated in my account.

COPAYS

I understand that I am responsible to pay all co-payments at the time of service, prior to leaving. Copays can NOT be waived at any time by the provider of service or Memorial Chiropractic Clinic.

DEDUCTIBLES

If my insurance carrier determines that I have NOT met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by my insurance carrier and/or provider. Yearly deductibles can NOT be waived at any time by the provider of service or Memorial Chiropractic Clinic.

AGREEMENT TO PAY:

I have received a copy of this form and have been notified of the terms stated above by this provider, Memorial Chiropractic Clinic, that I am fully responsible for all services and/or materials. And if my insurance does not cover or denies payment for a service, material, or both, I understand and agree to be financially responsible for the balance on my account.

PRINT NAME	GUARANTOR/PATIENT SIGNATURE	DATE

Memorial Chiropractic Clinic
12421 Memorial Dr. Houston, TX 77024 713.467.5367
815 Walker St., T-22 Houston, TX 77002 713.222.6000

Authorization to Send and Receive Medical Information by Email/Text

Memorial Chiropractic Clinic (the "Practice") sends patient information by e-mail and/or text messaging.

RISKS: Transmitting information by e-mail/text, however, has a number of risks that patients should consider before using e-mail/text (the "Risks"). These include, but are not limited to, the following Risks:

1. E-mail/text can be circulated, forwarded, and stored in numerous paper and electronic files.
2. E-mail/text can be immediately broadcast worldwide and be received by many intended and unintended recipients.
3. E-mail/text senders can easily misaddress an e-mail or text.
4. E-mail/text is easier to falsify than handwritten or signed documents.
5. Backup copies of e-mail/text may exist even after the sender or the recipient has deleted his or her copy.
6. Employers and on-line services have a right to archive and inspect e-mails/texts transmitted through their systems.
7. E-mail/text can be intercepted, altered, forwarded, or used without authorization or detection.
8. E-mail/text can be used to introduce viruses into computer systems.
9. E-mail/text can be used as evidence in court.

CONDITIONS: Because of the Risks outlined above, the Practice cannot guarantee the security and confidentiality of e-mail/text communication, and will not be liable for improper use and/or disclosure of confidential information that is not caused by the Practice's intentional misconduct. Thus, patients must consent to the use of e-mail/text for patient information. Consent to the use of e-mail/text includes agreement with the following conditions:

1. All e-mails/texts to or from the patient concerning diagnosis or treatment will be saved as part of the medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails/ texts.
2. The Practice may forward e-mails internally to the Practice's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. The Practice will not, however, forward e-mail to independent third parties without the patient's prior written consent, except as authorized or required by law.
3. Although the Practice will endeavor to read and respond promptly to an e-mail/text from the patient, the Practice cannot guarantee that any particular e-mail/text will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail/text for medical emergencies or other time-sensitive matters.
4. If the patient's e-mail/text requires or invites a response from the Practice, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail/text and when the recipient will respond.

5. The patient should not use e-mail/text for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
6. The patient is responsible for informing the Practice of any types of information the patient does not want to be sent by e-mail/text, in addition to those set out in the preceding paragraph.
7. The patient is responsible for protecting his/her password or other means of access to e-mail/text.
8. The Practice is not liable for breaches of confidentiality caused by the patient or any third party.
9. The Practice shall not engage in e-mail/text communication that is unlawful, such as unlawfully practicing medicine across state lines.
10. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

INSTRUCTIONS: To communicate by e-mail/text, the patient shall:

1. Limit or avoid use of his/her employer's computer.
2. Inform the Practice of changes in his/her e-mail address or text number.
3. Put the patient's name in the body of the e-mail/text.
4. Include the category of the communication in the e-mail's subject line or body of a text message, for routing purposes (e.g., billing question).
5. Review the e-mail/text to make sure it is clear and that all relevant information is provided before sending to the Practice.
6. Inform the Practice that the patient received an e-mail/text from the Practice.
7. Take precautions to preserve the confidentiality of e-mails/texts, such as using screen savers and safeguarding his/her computer password.
8. Withdraw consent only by e-mail or written communication to the Practice.
9. Contact the Practice's Privacy Official at (713) 467-5367 with any unanswered questions before communicating with the Practice via e-mail or text message.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand the information the Practice has provided me regarding the Risks of using e-mail and text messaging. I understand the risks associated with the communication of e-mail and text between the Practice and me, and consent to the conditions outlined in this document. In addition, I agree to the instructions outlined above, as well as any other instructions that the Practice may impose regarding e-mail or text message communications.

Signature of patient or personal representative	Date
Printed name of patient or personal representative	Phone number to be used for sending medical records
E-mail address authorized to be used for sending medical records	