

Harper Wellness and Rehab Center

CONFIDENTIAL PATIENT INFORMATION

Please Print

Date: _____

First Name: _____ Last Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____ Cell Phone: _____

Sex: M F Marital Status: M S W D Birth Date: _____ Age: _____

Social Security #: _____ Spouse's Name: _____

Home Email Address: _____ Work Email Address: _____

Referred By: Patient: _____ Physician: _____

Insurance Co: _____ Staff Health Fair Google Ad/Search Chiro 123 Facebook/Twitter/BlogSpot

Work Status: Employed Full-Time Student Part-Time Student Other: _____

Employer: _____ Occupation: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Race (check one) White Black/African American Hispanic American Indian/Alaskan Native Asian Asian Indian Chinese Filipino Japanese Korean Vietnamese Native Hawaiian or other Pacific Island Guamanian or Chamorro Samoan Other I choose not to specify

Multi-Racial (check one) Yes No Unknown

Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (check one) English Spanish American Sign Language Chinese French German Tagalog Vietnamese Italian Korean Russian Polish Arabic Portuguese Japanese French Creole Greek Hindi Persian Urdu Gujarati Armenian I choose not to specify

Verification Question? (choose only one question, then give the answer to that question)

What is the name of your favorite pet? What city were you born in? What high school did you attend?
 What is your favorite movie? What street did you grow up on? What is your favorite color?

Verification Answer to the chosen question (MUST BE AT LEAST 6 CHARACTERS): _____

Do you currently smoke tobacco of any kind? Yes Never been a smoker Former smoker

If yes, how often do you smoke: Current everyday smoker Current someday smoker

If yes, what is your level of interest in quitting smoking? 0 1 2 3 4 5 6 7 8 9 10

Has any doctor diagnosed you with Hypertension presently? Yes No If yes, describe _____

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type I Type II

If yes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes No Not Sure

Were you involved in an auto accident? Yes No ***If you answered yes to either question, please***

Were you hurt on the job? Yes No ***notify the front desk NOW.***

Do you have Health Insurance? Yes No

POLICY HOLDER INFORMATION: Policy Holder Employer: _____

Name of Insured: _____ Relationship: Self Spouse Parent

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Social Security #: _____ Birth Date: _____

Name of Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Policy #: _____ Group #: _____

Are you covered on an additional Health Insurance Policy? Yes No

Please list any medications including **dosage and frequency**, if known _____

List any allergies that you have to any medication _____

What are your main health problems? Briefly list the name of your problem(s): _____

List any dates you were treated for these symptoms, the type of treatment you received and any residual effects _____

Briefly list your activities at work _____

Briefly list your leisure activities _____

Please list any other symptoms you are experiencing _____

FEMALES ONLY

X-rays may be taken of your spine. When was your last period? _____ Are you pregnant? Yes No Maybe

Family Health History

Relation (father, mother, sibling, child, etc) _____ Past & Present Health Conditions _____

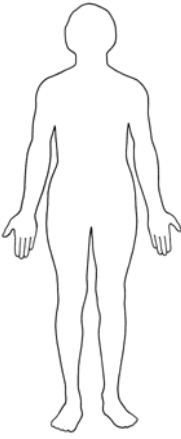
_____/_____

_____/_____

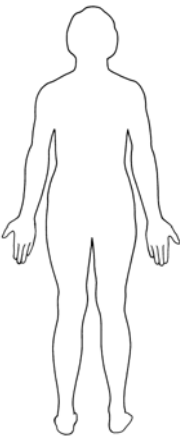
_____/_____

On the diagrams below, please indicate where you are experiencing pain right now. Please mark the exact location of your pain on the diagrams using the following abbreviations:

PAIN = P TINGLING = T NUMBNESS = N BURNING = B STIFFNESS = S



FRONT



BACK

Do you sleep on your Stomach Side Back Toss & Turn Age of Mattress _____ Comfortable Uncomfortable

Do you use a bed board? Yes No

HAVE YOU EVER	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized for other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Taken vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had an allergy to any medication?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you seen a chiropractor in the past?	<input type="checkbox"/>	<input type="checkbox"/>	_____

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal Examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? Yes No

HABITS:	Heavy	Moderate	Light	None	DESCRIBE BRIEFLY
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How many drinks per week? _____
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How many cups per week? _____
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How many glasses per week? _____
Recreational/Illegal Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What kind? _____ How often? _____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How many times per week? _____
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How many hours per night? _____
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How many drinks per week? _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care. Please check the appropriate box if you have been diagnosed with the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Measles | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Venereal Disease/Infection |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cancer | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Influenza |

Please check any conditions you are currently diagnosed with or have been diagnosed with in the past:

MUSCULO-SKELETAL

- Low Back Pain
- Pain between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficulty chewing/ Clicking jaw

NERVOUS SYSTEM

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion
- Depression
- Fainting
- Convulsions
- Cold/Tingling in Extremities
- Changes in Handwriting
- Irritability
- Changes in Personality

GENITO-URINARY

- Bladder Problems
- Painful/Excessive Urination
- Discolored Urine

GASTRO-INTESTINAL

- Poor or Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Problems
- Abdominal Cramps
- Gas or Bloating after meals
- Heartburn
- Black/Bloody Stool
- Colitis

C-V-R

- Chest Pain
- Shortness of Breath
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling

GENERAL

- Allergies
- Loss of Sleep
- Fever
- HIV Positive

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Earaches
- Hearing Difficulty/Impairment
- Stuffed Nose

MALE / FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain
- Vaginal Infections
- Breast Pain / Lumps
- Prostate Problems / Sexual Dysfunction
- Genital Herpes
- Menopause

Would you like us to send a report of your findings to your physician? YES NO If Yes, please complete the information listed below:

Physician Name: _____ Practice Name: _____
 Address: _____ City/State/Zip: _____
 Phone: _____

THE PURPOSE OF OUR CLINIC IS TO SUPPORT EACH INDIVIDUAL IN ACHIEVING THEIR OPTIMUM HEALTH AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND A MULTIDISCIPLINED APPROACH TO HEALTH AND IN TURN, EDUCATE OTHERS.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's Office 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 Doctor's Office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due.

Patient Signature: _____ **Date:** _____

Guardian or Spouse's
 Signature Authorizing Care: _____ **Date:** _____

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home)

Name: _____
 Address: _____ Phone: _____

PATIENT CONSENT FOR TREATMENT

CONSENT FOR TREATMENT (All Patients):

I voluntarily consent to the rendering of care, including chiropractic, physical therapy and physician treatment, and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and/or physical therapist and it is the responsibility of the staff to carry out the instructions of such clinician(s).

PRINT PATIENT NAME

PATIENT SIGNATURE

IF YOU ARE NOT THE PATIENT, PRINT YOUR NAME AND STATE YOUR RELATIONSHIP TO PATIENT

NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and the methods you can use to request access to this information. Please review this notice carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, personal research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on disclosure on this information. By law, we are not required to grant your request. However, if we decide to grant your request, we are bound by our agreement.

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Harper Wellness & Rehab to use and disclose your protected health information for the purposes of treatment, payment and healthcare operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected 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 telephoning our office at (713) 622-3456. You have a right to request a restriction on how we use and disclose your private health information for the purposes of treatment, payment or health care operations. By law, we are not required to grant your request. However, if we 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 that we have already used or disclosed your protected health information in reliance on your consent.

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or any other related Medicare or Medicaid claim.

- √ Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.
- √ You may inspect and receive copies of you records within 30 days of your request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation of your medical records.
- √ You may request changes to your records. Our practice has the right to accept or deny your request.
- √ We maintain a history of protected health information disclosures that is accessible to you.
- √ In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.
- √ Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.
- √ For your convenience, you may obtain an Authorization for Release of Records form on our website at www.harperwellness.com or by calling (713) 622-3456.
- √ You may file a complaint about privacy violations by contacting our Office Manager at (713) 622-3456.

PATIENT SIGNATURE

DATE

OFFICE FINANCIAL POLICY

Our policy is to extend 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 family under our care.

1. If You Do Not Have Insurance: All payments are due at the time of service or by an authorized payment plan. For bookkeeping purposes, we suggest that you prepay for your scheduled appointments with the doctor. This will greatly reduce your time at the front desk and help us minimize our bookkeeping expenses.

2. If You Have Insurance: All deductibles and co-payments are due at the time of service or by an authorized payment plan. For bookkeeping purposes, we suggest that you prepay for your scheduled appointments with the doctor. This will greatly reduce your time at the front desk and help us minimize our bookkeeping expenses.

- √ You are considered a cash patient until you bring in your completed insurance forms and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but we will be happy to provide you with a claim for your secondary carrier.
- √ Our fees are considered usual, customary and reasonable by most insurance companies and are therefore covered up to the maximum allowance determined by each carrier. This statement does not apply to insurance companies that reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.
- √ If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active role in the recovery of your claim. If your 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.
- √ When your treatment plan is once per month or less in frequency, your insurance carrier may deem your treatment as maintenance and not cover the visit. Charges for services rendered will be due as they are performed or by an authorized payment plan. We will happily provide you with an insurance claim form for these visits.
- √ If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claims already submitted.

Patient's Printed Name: _____

Signature: _____ Date: _____

Finance Counselor: _____ Date: _____

For your convenience, you may retain your credit card number on file with us.

Credit Card #: _____ Exp Date: _____

Your name as it appears on the card: _____

Driving Directions

COMING FROM 290/Katy Freeway

Take 610 and travel south toward the Galleria
 Exit San Felipe then turn LEFT under the freeway
 Go to the 2nd light which is Briar Oaks, turn LEFT
 Briar Oaks dead-ends into Post Oak Place Drive, turn RIGHT
 There will be a cul-de-sac in front of you
 We're in the last building on the left in the cul-de-sac
 Our building # is 4544 and our suite # is 287

COMING FROM 59

Take 610 and travel north toward the Galleria
 Exit San Felipe, then turn RIGHT
 Go to the 2nd light which is Briar Oaks, turn left
 Briar Oaks dead-ends into Post Oak Place Drive, turn RIGHT
 There will be a cul-de-sac in front of you
 We're in the last building on the left in the cul-de-sac
 Our building # is 4544 and our suite # is 287

