

Durbin Chiropractic & Wellness Center

Dr. Misty Durbin D.C.

5022 Holly Rd Ste 104, Corpus Christi, Texas 78411

P: 361-991-8887 F: 361-991-8889

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____

Today's Date: ___/___/___

Social Security Number _____ Birth Date: ___/___/___ Age: ____ Gender: F M

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ___/___/___ Phone: (____) _____

Mother: _____ Date of Birth: ___/___/___ Phone: (____) _____

Guardian: _____ Date of Birth: ___/___/___ Phone: (____) _____

Who do you normally live with? Mother and Father Father Mother Legal Guardian None of these

Marital Status: Married Separated Widowed Single Divorced How many children? _____

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (____) _____

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street _____

City _____ State _____ Zip _____

Phone (____) _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (____) _____

Student at _____ FULL-TIME PART-TIME

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Spouse's Occupation _____ Spouse's Employer _____

Spouse is a student at _____ FULL-TIME PART-TIME

Who should we contact in the event of an emergency? _____ Phone (____) _____

Address of contact person _____

How did you learn about us? _____

Is your condition or injury due to an accident or work-related cause? YES NO Please check ALL that apply.

Did the condition or injury result from *automobile* accident? YES NO

Medical History:

Have you ever been in our office before? Yes No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

- 1) _____ / /
- 2) _____ / /
- 3) _____ / /

What medications or drugs are you taking? _____

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

Date of last physical examination? _____

Serious illnesses or conditions? _____ When? _____

Have you been treated for any health condition by a physician in the last year? YES NO

Describe: _____

Have you ever suffered from:

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Numbness | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Cancer |

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? YES NO UNCERTAIN

Have you missed work or school due to your injuries? Yes No

Do you smoke? Yes No Number of packs: _____

Do you drink alcohol? Yes No Number of Drinks _____

Notes: _____

Patient Questionnaire – Work-Accident

Patient Name: _____ Today's Date: ___/___/___

Date of Exam: ___/___/___ Provider: _____ New Patient Yes No

Basic Information about the Accident:

Date Accident Occurred or Started: ___/___/___ Time of Day when Accident Occurred or Started: ___:___ AM / PM

Describe how the Accident took place: _____

Describe the condition or symptoms caused by the Accident: _____

Describe your pain: Burning Sharp Dull Ache

What aggravates it?

What relieves it?

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/___

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/___

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/___

Please check any of the following symptoms you are now experiencing:

<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Head seems too heavy	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Clumsiness	<input type="checkbox"/> Feet Cold
<input type="checkbox"/> Neck Stiff	<input type="checkbox"/> Tingling in arms/hands	<input type="checkbox"/> Ears Ring/ Buzzing in Ears	<input type="checkbox"/> Sleeping Problems
<input type="checkbox"/> Hands Cold	<input type="checkbox"/> Tingling in legs/feet	<input type="checkbox"/> Face Flushed	<input type="checkbox"/> Nausea
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Numbness in legs/feet	<input type="checkbox"/> Numbness in arms/hands
<input type="checkbox"/> Constipation	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Cold Sweats	<input type="checkbox"/> Tension
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Fainting	<input type="checkbox"/> Fever	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Irritability	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Chest pain/rib pain	<input type="checkbox"/> Pain in arms/hands
<input type="checkbox"/> Pain in legs/feet	<input type="checkbox"/> Jaw pain	<input type="checkbox"/> Burning muscle pain	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Sharp/shooting pain	<input type="checkbox"/> Loss of strength - arms	<input type="checkbox"/> Loss of strength - legs	

Other _____

Have you experienced changes to:

- Eyes (sight) Ears (hearing) Nose (smell) Mouth (taste) Bladder
- Bowels Sleep Emotion Appetite

Please Explain: _____

Work-Accident Specific Information:

Check all that apply:

- Did the accident occur on the premises of the facility where you normally work (i.e., your local work address)?
- Did the accident occur during your normal working hours?
- Did you report the accident to your Employer?
- Is your Employer covered by Workers' Compensation Insurance under state law?
- Has your Employer prepared an initial written report?
- Does the Employer's Report describe the condition or symptoms you are experiencing?
- Has a claim number been issued for this accident?
- Have you received any written denial of liability from either your Employer or Worker's Insurance Comp Payer?

Worker's Insurance Comp Payer: _____

Claim Adjustor Name: _____ Claim Adjuster Phone Number: _____

Claim Number: _____

Do you have health insurance? YES NO Not Sure Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/___

Does the policy holder have the insurance through his/her employer? YES NO

If yes, who is the employer? _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorneys who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/___

Durbin Chiropractic & Wellness Center

Dr. Misty Durbin D.C.

5022 Holly Rd Ste 104, Corpus Christi, Texas 78411

P: 361-991-8887 F: 361-991-8889

Informed Consent -- Chiropractic Care

Dr. Misty Durbin D.C. License #: 10083

Patient's Name: _____

***Instructions: This document relates to your Informed Consent for care.
Please read carefully before signing.***

General. I, the below-signed patient/individuals, have read this document in its entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while the Dr. Misty Durbin D.C. is the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care; Alternatives

Chiropractic manipulation / adjustment. As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

X-Rays. I have been advised that x-rays can be hazardous to an unborn child. To the best of my knowledge. I am not pregnant.

Other Potential Alternatives. I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions. "You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Consent. I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Patient's Name: _____

Patient's Signature: _____

Date of Signature: ___/___/___

Name of Parent / Guardian / Authorized Representative: _____

Signature: _____

Date of Signature: ___/___/___

Durbin Chiropractic & Wellness Center

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: 06/27/2013

Under Federal Law, How Might Your Protected Health Information Need to Be Used / Disclosed by Our Office for Treatment, Payment, or Health Care Operation Purposes?

Generally, your protected information may be used or disclosed by our clinic for treatment, payment, or specific health care operations. These three words or phrases are defined by Federal Law, 45 CFR s 164.501 and other regulations as follows:

Treatment. *Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.*

Payment. *The activities undertaken by us to obtain or provide reimbursement for the provision of health care. Such activities include without limit determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts); adjudication or subrogation of health benefit claims; billing, claims and practice management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing, analysis and aggregation; provider accreditation; review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and contacting your employer, or you through your employer, for reasons consistent with this paragraph including without limit to obtain current group benefits and effective dates. For the purposes of this Privacy Notice, activities undertaken to properly obtain or provide reimbursement may include without limit disclosures to accountants, attorneys, management consultants, financial consultants, organizations providing data aggregation and other like services, professional associations, and other similar entities, including their agents and subcontractors, where confidentiality is expressly agreed to or normally inferred. Such activities shall also include disclosures to state and federal agencies, officials, and employees for the purposes of enforcement of, and oversight over, payer responsibilities and obligations.*

Other Health Care Operations. 45 CFR s 164.501 and .520(b)(1)(iii) outline several other purposes for which our practice may use or disclose protected information. For example, our practice may use or disclose protected information for the purposes of (1) conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, (2) providing appointment reminders to patients, (3) providing treatment alternatives or other health-related benefits and services that may be of interest to patients, and (4) contacting patients to raise funds.

In addition to those operations listed above, our office may send you welcome cards as well as birthday cards to your attention by mail which may include the actual date of your birthday. Furthermore, for those patients who indicate who referred them to our clinic, our office may send you "Thank You" cards to the referring person. Our office also regularly disburses newsletters, special offers, follow-up surveys and mailings, to our current and past patients.

Disclosures to the Patient by Fax and E-mail; Disclosures Left on Voice Mail.

Periodically, patients request that our clinic transmit protected information to them by means of fax or email, or leave messages on voice mail regarding such information. While we may request specific written authorization from you prior to disclosing protected information through such means, you hereby agree that by providing us with a fax number, email address, or phone number which includes voice mail, you are hereby consenting to disclosures through such means.

Disclosures to "Personal Representatives" at the Patient's Request

Oftentimes, close relatives to our patients will request that we disclose protected health information to them on the patients' behalf or

at our patients' request. You hereby agree that if the person you represent as your spouse contacts our clinic regarding your care, we may disclose protected information to them.

Under Federal Law, How Might Your Protected Health Information Need to Be Used / Disclosed in Ways That Don't Require Written Consent or Authorization?

Under certain circumstances, law may require or permit our practice to make use of or to disclose your protected information without your consent or authorization. Such circumstances include:

- Uses and disclosures required by law.
- Uses and disclosures for public health activities.
- Disclosures about victims of abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities.
- Disclosures for judicial and administrative proceedings.
- Disclosures for law enforcement purposes.
- Uses and disclosures about decedents.
- Uses and disclosures for cadaveric organ, eye or tissue donation purposes.
- Uses and disclosures for research purposes.
- Uses and disclosures to avert a serious threat to health or safety.
- Use and disclosures for specialized government functions.
- Disclosures for workers' compensation.

What Happens If Other Law is More Restrictive Than Federal Law?

In the event other law becomes more restrictive than Federal Law with respect to uses and disclosures of your protected information, our practice will include descriptions of the more stringent requirements in this privacy notice.

All Other Uses / Disclosures Require Your Written Authorization

All other uses and disclosures besides those listed herein and those which require an opportunity to agree or object (see 45 CFR 164.512) will only be made with your written authorization. Once such authorization is granted, you may revoke it at any time as provided by and subject to 45 CFR 164.508(b)(5).

Your Rights and How to Exercise Those Rights

Under Federal Law, you have the following rights. To exercise your rights, you will need to send a written request to the attention of the Privacy Officer of our clinic. You have the right to request restrictions on certain uses and disclosures of protected health information as provided by s 164.522(a). Please note however that under Federal Law, our clinic is not required to agree to a requested restriction. You have the right to receive confidential communications of protected health information as provided by and subject to 45 CFR s 164.522(b). You have the right to inspect and copy protected health information as provided by and subject to 45 CFR s 164.524. You have the right to amend protected health information as provided by and subject to 45 CFR s 164.526. You have the right to receive an accounting of disclosures of protected health information as provided by and subject to 45 CFR s 164.528. You have the right to obtain a copy of this privacy notice.

Duties of Our Clinic

Our clinic is required by law to maintain the privacy of your protected information and to provide you with notice of our legal duties and privacy practices concerning your protected information. Our clinic is required to abide by the terms of this privacy notice currently in effect. Our clinic reserves the right to change the terms of our notice and to make new notice provisions effective for all protected information that our clinic maintains. The revised notice will be made available at the front desk of our clinic for your inspection or copying.

Complaints

Our clinic welcomes any suggestions for amending our privacy practices. If you believe that your privacy rights have been violated, you may file a complaint with the Privacy Officer of our clinic and to the Secretary of Health and Human Services. To file a complaint with our Clinic's Privacy Officer, simply request and complete a copy of our privacy complaint form and submit it to our Privacy Officer. No individual may be retaliated against for filing such a complaint.

Contact Information or Further Information

For more information, call our main office number at **361-991-8887** and ask to speak with our Privacy Officer, Allison Baker.

PATIENT CONSENT FORM
Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: Durbin Chiropractic & Wellness Center.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____

Signature: _____ Date: ___/___/___