WELCOME TO BACK 'N PLACE CHIROPRACTIC

NAME:_____

ADDRESS:_____

CITY/STATE/ZIP:_____

E-MAIL:_____

BEST CONTACT #:_____ WORK:_____

BIRTHDAY_____/_____/_____ Marital Status: M W D S P

PRIMARY INSURED'S NAME
IF OTHER THAN THE ABOVE_____

PRIMARY INSURED'S D.O.B.___/____/_____

RELATIONSHIP TO PRIMARY INSURED_____

YOUR EMPLOYER_____
OCCUPATION_____

HEALTH REASONS FOR CONSULTING OUR OFFICE

_____

IS THIS AN AUTO OR WORK INJURY?_____

ANY SURGERIES RELATED TO YOUR NECK OR BACK:

_____

ARE YOU PREGNANT? Y/N * Please tell the Doctor in person , if pregnant.*
DO YOU HAVE HEALTH INSURANCE? Y/N
NAME OF COMPANY_____
HOW DID YOU HEAR ABOUT US?_____

INITIAL_____

Please check any of the following that gives you difficulty or you have had recently.

General

☐Headaches
☐Shooting head pain
☐Fatigue
☐Jaw pain*TMJ
☐Loss of balance
☐Cancer
☐Chest pain

Neck

☐Neck pain
☐Grinding/popping in neck
☐Neck stiffness
☐Pinched nerve in back
☐Neck feels out of place
☐Muscle spasm in neck

Shoulders

☐Shoulder/arm tightness
☐Shoulder/arm pain
☐Pain in shoulder joint
☐Pain across shoulders
☐Can't raise arms
☐Tension in shoulders
☐Pinched nerve in shoulders
☐Pain between shoulder blades
☐Pain from front to back
☐Muscle spasms in mid-back

Mid Back

☐Mid-back pain
☐Mid-back stiff

Low Back

☐Low back pain
☐Low back stiff
☐Low back weak
☐Feels out
☐Muscles spasm

Arms & Hands

☐Rash
☐Pins & needles
☐Numbness hand
☐Pain in upper arm
☐Pain in elbow
☐Pain in forearm
☐Pain in hand
☐Pain in fingers
☐Weakness
☐Cold hands

Hips, Legs & Feet

☐Cold Feet
☐Pain in glute
☐Pain in hip joint
☐Pain down leg
☐Pain in knee
☐Pain in ankle
☐Pain in foot
☐Weakness of leg
☐Weakness of knee
☐Leg cramps
☐Pins & needles in legs
☐Numbness in legs/feet

Other Symptoms:_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ **Date**:_____

Nick Fourie, DC
1000 East 41st Street, Suite 915
Austin, Texas 78751

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

THIS NOTICE DESCRIBES HOW RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION.

In the course of your care as a patient at our office, we may use or disclose personal and health related information about you in the following ways: 1.) Your personal health information including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. 2.) Your health records as well as your billing records may be disclosed to another party, such as insurance carrier (HMO, PPO, etc.) or your employer (if they are responsible for payment). 3.) Your name, address, phone number, and your health records may be used to contact you regarding appointment reminder, a message may be left on your answering machine, you also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you should not provide us with this authorization, it will not affect the care provided to you. Under federal law, we are also permitted to use or disclose your health information without your consent or authorization in the following circumstance:

* If we are providing health care services to you based on the orders of another health care provider.
* If we provide health care services to you in an emergency.
* If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
* If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account.

By signing below, I, acknowledge that I have read the above information, been offered a copy of this offices HIPAA policy and give full disclosure of my information.

Patient
Signature:_____Date:_____

Informed Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he may designate as his assistant to administer treatment, physical examination, x-ray studies, laboratory procedure, chiropractic care or any clinic services that he deems necessary in my case; and I further authorize him to disclose all or any clinic services that he deems necessary in my case; and I further authorize him to disclose all or any part of my (patient's) records to any person or corporation which is or may be liable under a contract to the clinic or the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services, companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer.

It is not enough that you understand the benefits of chiropractic care in restoring normal joint motion and nervous system health. Every type of treatment (medical, chiropractic or otherwise) carries some form of potential risk associated with it. Risks associated with some forms of chiropractic care include muscular sprain/strain, neurological deficit, osseous fracture and vertebral artery dissection (stroke). While the incidence of injury from chiropractic care is extremely low, and only seldom are the risks great enough to contraindicated care, these facts should be considered in making the decision the receive chiropractic care.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the potential risks of chiropractic care, including the risk that care I receive in this office may not accomplish the desired clinical objective. I have been advised of reasonable alternative treatments, including known risks, consequences, and probable effectiveness of each, and I have been advised of the possible consequences if no care is provided. I acknowledge the effectiveness of each, and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been provided to me concerning the results of the care I will receive. I knowingly authorize Nick Fourie, DC to proceed with chiropractic care and treatment. By signing below I state that I have weighed the risks involved in undergoing treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. 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:_____