MOORE
Family Chiropractic
A Gentle, Moore Natural Approach To Health Care.

Patient History Form

Confidential

6302 Broadway
Ste 230
Pearland, TX 77581
Ph. : 281-997-0157
Fax: 281-997-5510

Date ____________________ Dr. License #____________________
Name ____________________ SS#____________________
Address____________________ City __________ St. ____ Zip__________
Home Phone ____________________ Cell Phone ____________________
Insurance Co. ____________________ Ins. Phone ____________________
Sex: M F Age___ DOB:________ Single Married Widowed Divorced
Occupation:____________________ Employer: ____________________
Work Phone ____________________ Years Worked: ____________________
Spouse ____________________ SS# ____________________
Employer ____________________ Work Phone ____________________
List Children ____
Last Doctor: ____________________ List Medications ____________________
Care Received ____________________ List Surgeries ____________________
How did you find out about us? ____________________

Please circle correct response.

Are your present problems due to an injury? Y N Job Auto Personal Injury Other
Have you reported it: Y N to employer Auto Carrier other __________
Are you or have you ever been disabled/impaired? (service /work) Y N when ________
Have you retained an attorney? Y N Name and address ____________________

Chief Complaint/ Regions of Pain		Habits	Exercise
1) ____________________	Smoking	Packs/ D___	None
2) ____________________	Alcohol	Cups/D___	Moderate
3) ____________________	Coffee	Cups/D___	Daily
4) ____________________	Soda	Cups/ D___	Type________

Have you had any of these diseases? (Please circle)

303.9 Alcoholism	345 Epilepsy	280 Anemia	240 Goiter
239 Cancer	487 Influenza	052 Chicken Pox	250 Diabetes
541 Appendicitis	042 HIV	690 Eczema	045 Polio
319 Mental Disorder	072 Mumps	511 Pleurisy	055 Measles
390 Rheumatic Fever	847. Whiplash	716 Arthritis	429.9 Heart Disease
724.2 Low Back Pn.	480 Pneumonia	737.3 Scoliosis	846 Sprain/Strain S/I

Family History

	Diabetes	Heart	Kidney	Cancer
Mother-Living Y N	☐	☐	☐	☐
Father-Living Y N	☐	☐	☐	☐
Brother # ___	☐	☐	☐	☐
Sisters # ___	☐	☐	☐	☐
Adoption History	☐	☐	☐	☐

When was your last Physical? __________ Spinal Exam?__________
Last lab?__________ Spinal X-ray? __________
Prostate exam?__________ Pap Smear?__________
Breast exam?__________ MRI? __________

Please enter "X" for present and ✓ for previously, in front of all of the following signs and symptoms. Leave blank if not applicable. A complete history and understanding of your health will facilitate care.

General Symptoms

__784.0 Headache
__780.6 Fever
__780.99 Chills
__780.8 Night Sweats
__780.2 Fainting
__780.4 Dizziness
__780.3 Convulsions
__780.52 Loss of Sleep
__780.7 Fatigue
__799.2 Nervousness
__783.0 Loss of Weight
__782.0 Numbness or pain
__995.3 Allergy (What)
__786.07 Wheezing
__729.2 Neuralgia

Muscles and Joints

__728.9 Weakness
__781.0 Twitching
__723.5 Stiff Neck
__724.5 Backache
__719.0 Swollen Joints
__781.0 Tremors
__729.5 Foot Trouble
__724.79 Painful Tailbone
__724.5 Pain b/w Shoulders
__737.3 Spinal Curvature

Gastro-Intestinal

__783. Poor appetite
__536.8 Poor Digestion
__994.2 Starvation
__787.3 Belching/gas
__787.0 Nausea/Vomiting
__578.0 Vomiting Blood
__536.8 Pain over Stomach
__564.0 Constipation
__787.91 Diarrhea
__562.1 Colon Trouble
__455.6 Hemorrhoids
__776.7 Fluid Retention
__873.9 Liver Trouble
__274.0 Gout
__782.4 Jaundice
__575.9 Gall Bladder Trouble

Cardio-Vascular

__785.0 Rapid Heart
__427.89 Slow Heart
__401.9 High Blood Pressure
__458.9 Low Blood Pressure
__786.51 Pain over Heart
__429.9 Heart Trouble
__719.07 Swelling ankles
__459.9 Poor Circulation
__454.9 Varicose Veins
__436.0 Strokes
__785.1 Palpitations

Eye/Ear/Nose/Throat

__368.9 Poor Vision
__378.0 Crossed Eyes
__379.91 Pain in Eyes
__389.9 Deafness
__388.70 Earache
__388.30 Ear Noises
__388.60 Ear Discharges
__478.1 Nasal Obstruction
__784.7 Nose Bleeds
__462.0 Sore Throats
__784.49 Hoarseness
__477.9 Hay Fever
__493.9 Asthma
__460.0 Frequent Colds
__240.9 Enlarged Thyroid
__463.0 Tonsillitis
__473.0 Sinus Trouble

Skin or Allergies

__680. Skin Eruptions
__698.9 Itching
__924.9 Bruising Easily
__701.1 Dryness
__680.9 Boils
__782. Sensitive Skin
__708.9 Hives or Allergy
__692.9 Eczema

Medications: ____________
____

Respiratory

__786.2 Chronic Cough
__786.3 Spitting Blood
__786.4 Spitting Phlem
__786.50 Chest Pain
__786.09 Difficulty Breathing

Genito-Urinary

__788.4 Frequent Urination
__788.1 Painful Urination
__599.7 Blood in Urine
__590.0 Kidney Infection
__788.3 Inability to control
__601.9 Prostate Trouble

For Women Only

__625.3 Painful Periods
__626.2 Excessive Flow
__626.4 Irregular Cycle
__627.2 Hot Flashes
__625.3 Cramps or Backache
__623.5 Vaginal Discharge
___ Currently Pregnant
___Last Pap/ By whom:
____

Do Not Fill out beyond this point.

In Patient/ Out Patient Operations and Procedures — Hospitalizations

Date		Date		Date		Date	
_______	Vaccinations	_______	Other	_______	Rectal Surgery	_______	Thyroid
_______	Tonsillectomy	_______	Tubes/ Ears	_______	Other	_______	Stomach
_______	Gall Bladder	_______	Appendectomy	_______	Sinus	_______	Other
_______	Back Operation	_______	Female Organs	_______	Hernia		

Hospital Stays: ____________________

Other Surgeries: ____________________

Accidents or Falls: Car ____________ Other ____________

Broken Bones/ Dislocation: ____________ Crutches ____________

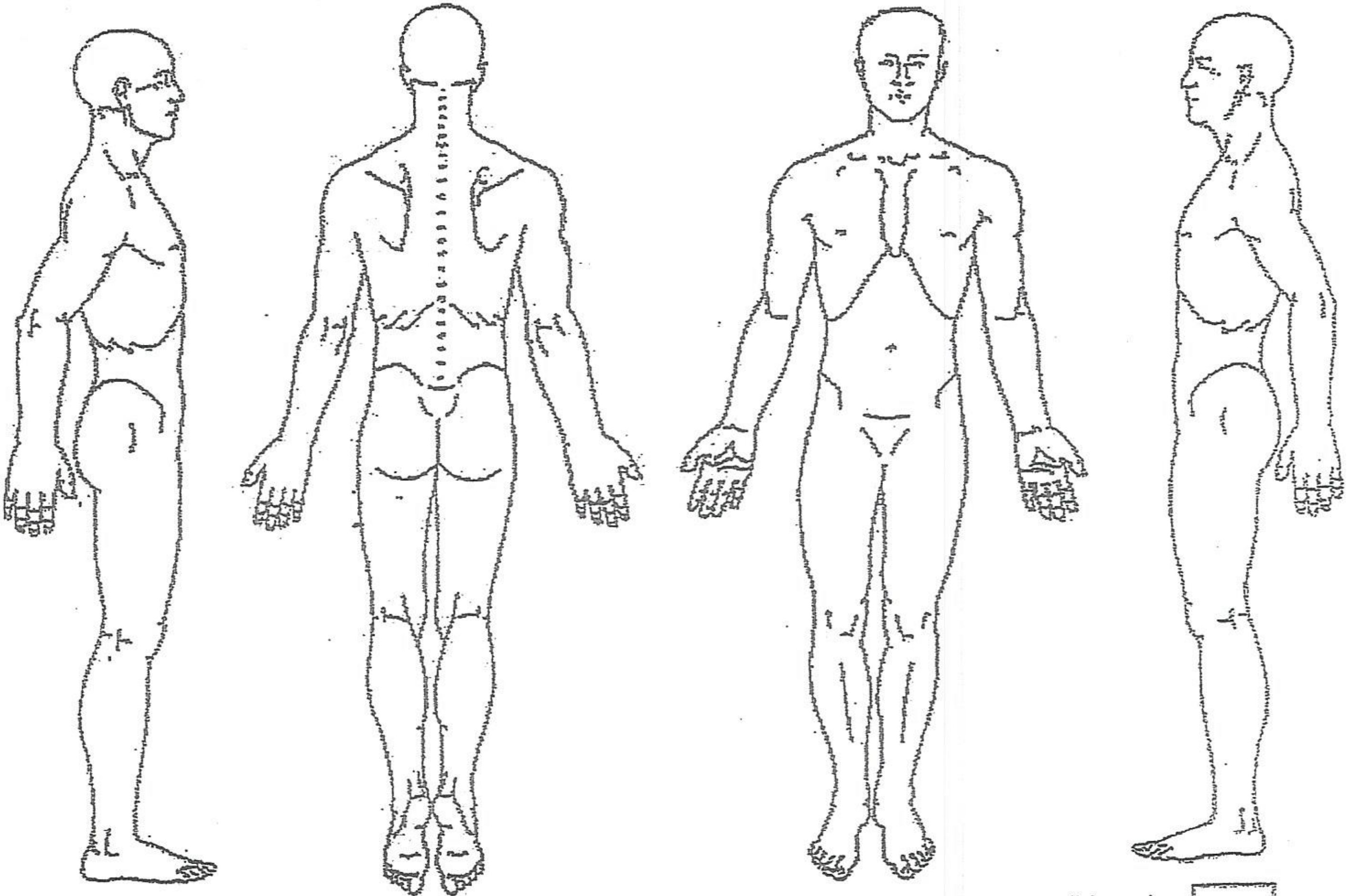
Do you suffer from any condition other than what you are now consulting us? ____________

Doctor's Signature: ____________________

Patient Name: ______________________ Date: ____________________

Please use the following key to accurately mark the area in which you feel the described sensation. Use the appropriate symbols and include all affected areas. ☐ Please check here for wellness visit.

Dull: NNN   Stabbing/ Cutting: /// ///   Burning: XXX   Numb: ===   Tingling :::   Tight: TTT   Cramping: SSS



Please note a number from 0 - 10 that best describes your pain. 0 = no pain; 10 = worst possible pain. ☐

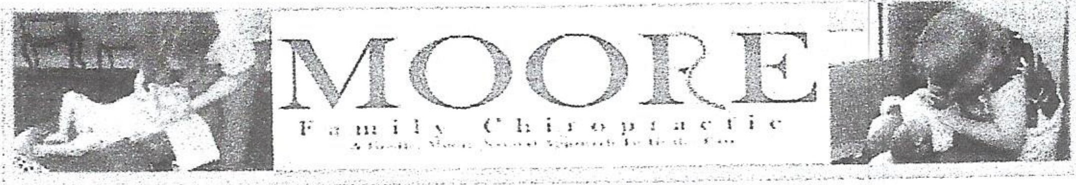
How have you felt since your last visit: much better   better   same   worse   much worse

Please note any changes in your condition:

Patient Signature: Date:

Doctor's Notes:

Doctor's Signature:



More Family Chiropractic Physician Organization and its Physicians
Notice of Privacy Practices Acknowledgement

You have been given the Notice of Privacy Practices for MFC Physician Organization and its Physicians. This notice describes your legal rights regarding your health information and will inform you of the legal duties and privacy practices of MFC Physician Organization and its Physicians with respect to health information created for services generated by MFC Physician Organization and its Physicians. If you receive services by your physician or other health care providers at a different location, you may want to ask about that office or clinic's health care information privacy policies and notices because they could be different.

Your name and signature below indicate that you have been provided with a copy of this Notice of Privacy Practices.

If you have a question regarding any of the information set forth in this Notice of Privacy Practices, please do not hesitate to call us at (281)-997-0157

Patient Name: ______________________________

Signature of Patient or
Patient's Qualified Representative: ______________________________
Date: ______________

Printed Name of Qualified Personal Representative: ______________________________

Legal Authority of Act on Behalf of the Patient: ______________________________

Note: In the case of an Obstetrical patient, this signed acknowledgment for receipt of the Notice of Privacy Practices also serves as receipt of the Notice of Privacy Practices on behalf of the newborn(s).

For Staff Use Only:

Date Acknowledgement noted in HIS/Patient management system: ______________

Comments if Notice not provided or Acknowledgement not obtained: ______________________

____

Processed by: ______________________

Informed Consent to Chiropractic Treatment

The nature of Chiropractic treatment: The doctor will use his/her hands or mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, and therapeutic ultra sound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon serve injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- ***Over-the-counter analgesics*** – The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- ***Medical care*** - Typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- ***Hospitalization*** – In conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- ***Surgery*** – In conjunction with medical care adds risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes these changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

______________________ ______________________ ______________________

Printed Name **Signature** **Date**

WITNESS:

______________________ ______________________ ______________________

Printed Name **Signature** **Date**

Office Policy Regarding insurance Assignment & Payment

Our office will accept your insurance assignment and submit to your insurance on a weekly basis. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. We will not enter into a dispute with your insurance company over policy limitations or issues. As such you will be responsible to clear these issues up with your insurance company; this is your responsibility and obligation. All charges incurred are your responsibility. Our office will file your claims for you and assist in every way possible to ensure benefit recovery as a courtesy to you the patient.

Please read the following and sign:

1. Prior to your treatment we will make every attempt to verify your policy benefits, however this DOES NOT guarantee your insurance policy or payments. If something on your policy should change it is YOUR responsibility to let us know.
2. You are required to sign an "Assignment of Benefits" form and any other forms required by your insurance company on your first visit.
3. If your insurance requires their own claim form, you are required to bring in the completed forms by your second visit and then as needed.
4. You will be responsible for your deductible and co-payment. If your insurance does not pay something that *was anticipated*, you will be responsible for the amount as soon as we/you are aware of the denial.
5. Your insurance should pay within 60 days from the date in which it was filed. By taking your insurance assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance does not pay on a timely basis YOU will be asked to pay after 60 days.
6. If your insurance mails a check directly to you for our services, you must bring in the misdirected check to our office within 48 hours.
7. Any overpayments made by your insurance company which credits your account will be refunded to them. However, any errors which do not credit your account will be your responsibility. Anything that is not paid within 90 days will be sent immediately to our collection agency and you will be responsible for the amount owed PLUS a 30% fee from our collection agency.
8. If you discontinue care without the doctor's authorization, the balance on your account is due and payable immediately, even if your insurance has been filed. (If your insurance does pay, after your account has been paid, refunds will be sent to you.)

I have read and understand the policy regarding insurance assignment and payment; I realize that I am responsible for all charges incurred by me at this office regardless of the reason for non-payment.

____

Signature | Printed Name | Date

FINANCIAL POLICY

Thank you for selecting Moore Family Chiropractic for your medical needs. We look forward to working with you to provide the highest quality of care possible. As one of our patients we would like to keep you informed of our current office and financial policies. We require that you read and sign this document prior to any further treatment/services rendered. We recommend that you keep a copy of this document for your records.

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

We ask that you please bring your insurance card with you at the time of your appointment. If your insurance plan has changed from your last visit we ask that you please notify us so that the information can be updated in our system. With insurance plans where we have agreed to participate in the network as a provider, your carrier requires that all co-pays be collected for any services being rendered. The co-pay requirement cannot be waived by our practice as it is a requirement placed on you by your insurance carrier.

PATIENTS WITHOUT INSURANCE

We request that payment be made at time services are rendered unless previous arrangements have been made.

GROUP OR INDIVIDUAL INSURANCE

Plans that are HMO or POS where we participate, and require a referral, obtaining the referral will be the **patient's responsibility.** We ask that you please keep track of the referrals on file allowed by your primary care provider. If for any reason there is no current referral on file for the particular date of service and the insurance carrier denies payment for no referral a bill will be generated to you for full payment of services. We suggest that the patient always be aware of their insurance benefits and requirements to reduce any further out of pocket expenses not necessary if taken care of prior to your visits. When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays. Please be aware that you, the patient, are ultimately responsible for any services rendered that the insurance did not cover.

ON THE JOB INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, you will be responsible for the payment of services rendered. We will not treat a work injury until all questions are answered concerning payment of services.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

You are considered a cash patient. Therefore you must make payment arrangements and you must facilitate our business office in communications with any responsible insurance companies. Please notify your auto insurance carrier of your visit to our office immediately. Notify us immediately if an attorney is representing you.

MEDICARE

Medicare only covers manual manipulation of the spine for chiropractors. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

I have read and understand the payment policy of Moore Family Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Moore Family Chiropractic and my insurance company. I request that Moore Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days that fees will be due and payable immediately.

____________________________________ _______________

atient's signature (or guardian if patient is a minor) Date

____________ (Employee Initials)

Moore Family Chiropractic
6302 Broadway Ste. 230
Pearland, Tx 77581
Ph. 281-997-0157
Fax 281-997-5510

Semi- Private Room Waiver

Moore Family Chiropractic has semi-private adjusting and exam rooms. Personal and medical histories will be conducted in Dr. Moore's private office. Please note if at any time you need to speak privately with the Doctor about your condition or another matter you must let the CA know ahead of time so that you may be placed in the Doctor's office to discuss the private matter.

I ________________________ have read and acknowledge the semi-private room waiver and agree to the terms listed above.

Patient Signature ________________________________

Date ______________________

Moore Family Chiropractic Patient Provider E-Mail Agreement

E-mail offers an easy and convenient way for patients and physicians to communicate. However, there are distinct differences between communicating via e-mail as opposed to calling or coming in to the office. Remember: there is no person on the other side of the e-mail – just a computer. You cannot tell when your message will be read, or even if your doctor is in the office or on vacation. Nevertheless, we believe that the ease of communication e-mail affords is a benefit affords is to patient care. Below are our rules for contacting us using e-mail.

- Email is **NEVER** appropriate for urgent or emergency problems. if you have an urgent or emergent problem, please call 911 or go to the closest Emergency Department for Immediate treatment.
- E-mail is NOT confidential. My staff may read your emails to handle routine matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail.
- E-mail is NOT a substitute for seeing the doctor. However, you may use it to make an appointment.
- E-mail will become a part of your medical record; a copy will be placed in your chart.
- E-mail is great for asking those straight forward questions that do not require in depth discussion. Appropriate uses of e-mail include referral and appointment scheduling requests and billing/insurance questions,
- E-mails should NOT be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- Please identify the nature of your request in the subject line of your message.

Finally, either one of us can revoke permission to use the e-mail system at any time.

☐ I DO want to communicate with my physician electronically. I have read the above information and understand the limitations of security on information transmitted. I understand that my physicians may not be able to communicate with me electronically about my specific condition if I live outside of the state in which my doctor is licensed.

PATIENT:

Patient Name: ______________________________

Patient Signature:___________________________

E-mail Address:_____________________________

Date: ______________________________________

Appointment Reminder Permission

I ___________________ grant my permission to Moore Family Chiropractic to call or sent me a text prior to an appointment to remind me of the appointment date and time. For voice calls I understand that a message may be left regarding to me appointment at the number provided below.

I would prefer to be of my scheduled appointments by:

(**Check ONE that applies and provide correct information**):

Voice___-Phone Number:_______________ and/or;

Text Message___–Mobile Number:_______________.

Cell Phone carrier:____________________.

I understand that I can unsubscribe by replying "STOP" to any message received.

I also understand that standard text message rates apply.

_________________________ _____________

Patient Signature Date

Assignment of Benefits

Moore Family Chiropractic Courtney L. Moore, DC

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in onsideration of treatment rendered assigns to the physicians or facility named above the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster, for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owned by an insurance company, in accordance with Article 21.55 of the Texas Insurance Code or other applicable insurance or state statue. I as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 21/45 days (electronic/paper) following your receipt of such bill for services to the extent such bills are payable under the terms of demand specifically conforms with Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court costs, and interest from judgement upon violation.

THIRD PARTY LIABILITY: If my injuries are the results of negligence from a third party, then I instruct the liability rrier to cut a separate draft to pay in full all the services rendered, payable directly to the physician/facility named above.

STATUE OF LIMATATIONS; I waiver my right to claim any Statue of Limitations regarding claims for services rendered or to be rendered by the physicians/facility named above, in addition to reasonable costs of collection, including *attorney fees and court costs if incurred.*

LIMITED PWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable insurance representing payment from any insurance company representing payment for treatment and health care rendered by the physician/facility named above. I agree that any insurance payment representing an amount excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in noting to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this chiropractic office, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of my care, my insurance company requires me to take examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

A photo copy of this instrument shall serve as original.

Signature of Patients and/or responsible parties:

1. ______________________ Date__________