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| --- |
| **PATIENT HISTORY FORM**DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ LAST FIRST MIAGE: \_\_\_\_\_\_\_\_SEX: F M MARITAL STATUS: ❑SINGLE ❑MARRIED ❑DIVORCED ❑WIDOWEDHOW DID YOU HEAR ABOUT US? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HEALTH INSURANCE INFORMATION:INSURANCE TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY HOLDER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_IDENTIFICATION NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHYSICIAN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LAST VISIT: \_\_\_\_/\_\_\_\_/\_\_\_\_EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FOOD/DRUG ALLERGIES:BRIEFLY DESCRIBE YOUR SYMPTOMS: |
| **CURRENT MEDICATIONS** |
|  |  |
| Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements: |
| **Name of drug** | **Dose (include strength & number of pills per day) What are you taking this for?** |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |
| 6. |  |
| 7. |  |
| 8. |  |
| 9. |  |
| 10. |  |
| 11. |  |
| 12. |  |

|  |  |
| --- | --- |
| **Date (approx)** | **Surgical History** |
|  |  |
|  |  |
|  |  |
|  |  |

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| **PAST MEDICAL HISTORY** |
| Do you now or have you ever had: |  |  |
|  |  |  |
| * Diabetes
 | ❑ Heart murmur | ❑ Crohn’s disease |
| ❑ High blood pressure | ❑ Pneumonia | ❑ Colitis |
| ❑ High cholesterol | ❑ Pulmonary embolism | ❑ Anemia |
| ❑ Hypothyroidism | ❑ Asthma | ❑ Jaundice |
| ❑ Goiter | ❑ Emphysema | ❑ Hepatitis |
| ❑ Cancer (type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Stroke | ❑ Stomach or peptic ulcer |
| ❑ Leukemia | ❑ Epilepsy (seizures) | ❑ Rheumatic fever |
| ❑ Psoriasis | ❑ Cataracts | ❑ Tuberculosis |
| ❑ Angina | ❑ Kidney disease | ❑ HIV/AIDS |
| ❑ Heart problems | ❑ Kidney stones |  |
|  |  |
| Other medical conditions (please list): |  |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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| **SOCIAL HISTORY** |
|  |  |
| Do you Smoke? \_\_\_Yes \_\_\_No  If yes, how many packs/daily:\_\_\_\_\_\_\_Do you drink? \_\_\_Yes \_\_\_No If yes, how many drinks/weekly:\_\_\_\_\_\_\_Use illicit substances? \_\_\_Yes \_\_\_No substance(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |  |
| Do you exercise regularly? \_\_\_\_Yes \_\_\_No  |
| If yes, describe what type and how often:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|   |  |  |
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| **CURRENT PAIN LEVELS** |
| How would you rate your pain in the last week?No Pain Worst Pain Possible0 1 2 3 4 5 6 7 8 9 10If you had to accept some level of pain after completion of treatment, what would be an acceptable level?No Pain Worst Pain Possible0 1 2 3 4 5 6 7 8 9 10 |  |
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| **SYSTEMS REVIEW** |
|  |
| **In the past month, have you had any of the following problems?** |
|  |  |  |
| **GENERAL** | **NERVOUS SYSTEM** | **PSYCHIATRIC**  |
| * Recent weight gain; how much\_\_\_\_
 | * Headaches
 | * Depression
 |
| * Recent weight loss: how much\_\_\_\_
 | * Dizziness
 | * Excessive worries
 |
| * Fatigue
 | * Fainting or loss of consciousness
 | * Difficulty falling asleep
 |
| * Weakness
 | * Numbness or tingling
 | * Difficulty staying asleep
 |
| * Fever
 | * Memory loss
 | * Difficulties with sexual arousal
 |
| * Night sweats
 |  | * Poor appetite
 |
|  |  | * Food cravings
 |
| **MUSCLE/JOINTS/BONES** | **STOMACH AND INTESTINES** | * Frequent crying
 |
| * Numbness
 | * Nausea
 | * Sensitivity
 |
| * Joint pain
 | * Heartburn
 | * Thoughts of suicide / attempts
 |
| * Muscle weakness
 | * Stomach pain
 | * Stress
 |
| * Joint swelling
 | * Vomiting
 | * Irritability
 |
| Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Yellow jaundice
 | * Poor concentration
 |
|  | * Increasing constipation
 | * Racing thoughts
 |
| **EARS** | * Persistent diarrhea
 | * Hallucinations
 |
| * Ringing in ears
 | * Blood in stools
 | * Rapid speech
 |
| * Loss of hearing
 | * Black stools
 | * Guilty thoughts
 |
|  |  | * Paranoia
 |
| **EYES** | **SKIN** | * Mood swings
 |
| * Pain
 | * Redness
 | * Anxiety
 |
| * Redness
 | * Rash
 | * Risky behavior
 |
| * Loss of vision
 | * Nodules/bumps
 |  |
| * Double or blurred vision
 | * Hair loss
 |  |
| * Dryness
 | * Color changes of hands or feet
 | **OTHER PROBLEMS:** |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **THROAT** | **BLOOD** |  |
| * Frequent sore throats
 | * Anemia
 |  |
| * Hoarseness
 | * Clots
 |  |
| * Difficulty in swallowing
 |  |  |
| * Pain in jaw
 | **KIDNEY/URINE/BLADDER** |  |
|  | * Frequent or painful urination
 |  |
| **HEART AND LUNGS** | * Blood in urine
 |  |
| * Chest pain
 |  |  |
| * Palpitations
 | **Women Only:** |  |
| * Shortness of breath
 | * Abnormal Pap smear
 |  |
| * Fainting
 | * Irregular periods
 |  |
| * Swollen legs or feet
 | * Bleeding between periods
 |  |
| * Cough
 | * PMS
 |  |
|  |  |  |
| **WOMENS REPRODUCTIVE HISTORY:**Have you reached menopause? Y / N At what age?Do you have regular periods? Y / N  |

**NOTICE OF PRIVACY PRACTICES**

**Round Rock Disc and Nerve**

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

PLEASE REVIEW IT CAREFULLY AND SIGN.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

**Uses And Disclosures Of Protected Health Information Based Upon Written Consent**

You will be asked by your provider to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your protected health information to pay your health care bills and to support the operation of the provider’s office.

**Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor’s office is permitted to make once you have signed this consent/acknowledgment form:**

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your care and any related services. This includes the coordination or management of your care with a third party that has already obtained your permission to have access to your protected health information.

**Payment**: Your protected health information will be used, as needed for your chiropractic and medical services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as ; making a determination of eligibility coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

**Healthcare Operations**: We may use or disclose, as needed, your protected health information in order to support the business activities of your provider’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic and medical students, substitute providers, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjustment room. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine or voicemail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open area where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a “Thank You for Referring”. “Welcome to Our Office” or office bulletin board unless you specifically request us not to do so. Your private information will be used when we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency.

We may share your protected health information with third party “business associates” that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contract to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action or reliance on the use of disclosure indicated in the authorization.

**Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object**

We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use of the disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

**Others Involved in Your Healthcare**: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your chiropractic and medical care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**Emergencies**: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your provider shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your provider or another provider in the practice is required by law to treat you, and the provider has attempted to obtain consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

**Communication Barriers:** We may use and disclose your protected health information if your provider or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communications barriers and the provider or staff member determines, using professional judgment, that you intend to consent to use or disclose under the circumstances.

**We may use or disclose your protected health information in the following situations without your consent or authorization:**

**When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement , Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:**

**Required Uses and Disclosures**: Under the law, we must take disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

**You have the right to inspect and copy your protected health information**

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, health operations or additional uses listed above in paragraph 8. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for the notification purposes as described in this Notice of Privacy Practices. Your request, must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your provider does not agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for this request. Please make this request in writing to our Privacy Contact.

You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

**Complaints**: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

Privacy Contact: Nastacia Robles\_, Office Manager ( 512)\_255-9887\_\_\_ Fax (512\_) 255-4715\_\_\_\_\_

I have received a copy of this office’s Notice of Privacy Practices and consent to the use and disclosure of protected health information by

Round Rock Disc and Nerve\_, provider, staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices.

**“You May Refuse To Sign This.” THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON APRIL 14, 2003.**

Printed Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**1930 Rawhide Dr, Ste 308**

**Round Rock, TX 78681**

**512.255.9887**

**Assignment of Benefits**

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician 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 Benefits:** 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 cost, or other legally compensable amounts owned by an insurance company, in accordance with Article 21.22 of the Texas Insurance Code or the applicable insurance or state status. 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 judgment, upon violation.

**Third Party Liability:** If my injuries are the result of negligence from a third party, then I instruct the liability carrier to cut a separate draft to pay in full all services rendered, payable directly to the physician/facility named above.

**Statue of Limitations:** I waive my rights to claim any Statute of Limitations regarding claims for service rendered or to be rendered by the physician/facility named above. I agree to any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing 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 clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted to me within a reasonable period of time. If, during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/ facility immediately. I understand that failure to do so may jeopardize my case.

A photocopy of this instrument shall serve as original.

Signature of Patients and/or Responsible parties:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_

**Informed Consent to Treatment**

**The nature of chiropractic treatment:** The doctor will use his/her hands or a 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, therapeutic ultrasound 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, muscle strain, ligamentous sprain, dislocations of joints, or injury to intervertabral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe 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 occurring:** The risks due to chiropractic treatment have been described as “rare”, about as often as complications are seen the taking of a single aspirin tablet. The risk of cerebral vascular injury or stoke, 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 reaction due to ancillary procedures is also consisidered “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 the 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 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**

**Round Rock Disc and Nerve**

**Dr. Eric Murphy DC**

**Ndukaku Ibe PAC**

**1930 Rawhide Dr. Ste# 308**

**Round Rock, TX 78681**

**(512) 255-9887**

**Fax (512) 255-4715**

**PATIENT REQUEST FOR RELEASE OF RECORDS**

Date: \_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the release of the following records:

 ( ) Patient Records

 ( ) X-Rays/ MRI

 ( ) Reports only

 ( ) Financial Records

These records are to be released to:

 ( ) Patient *or*

( ) To my Doctor at the address mentioned below: officemanager@roundrockdiscandnerve.com

 **PLEASE FAX TO 512-255-4715**

 Round Rock Disc and Nerve

 1930 Rawhide Dr. Suite 308

 Round Rock, TX 78681

 DOB\_\_\_\_\_\_\_\_\_\_

Patient Name

Patient Signature

Release Witness

Verification of non-pregnancy

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By my signature on this form, I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time.

Date of last period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_