Welcome to Optimum Chiropractic & Wellness Center

To The
NEW PATIENT
Outline of Procedures for Care And Consent to Initiate Care

We are dedicated to providing the highest quality chiropractic health care and education in a caring atmosphere. We are a leader in state of the art and traditional health care solutions for you and your family. It is our honor and pleasure to serve you. Please read over these procedures below to understand how our clinic functions, and to decide if you wish to participate.

Questions about your care are always encouraged.

What To Expect

Today

Step one:

All new patients are requested to fill out personal health history questionnaire.

Step two:

A one-on-one consultation with the doctor will be done to discuss your health problems and to determine what may be the cause.

Step three:

A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

Step four:

The doctor will advise you if additional tests or x-rays are needed.

Step five:

Your first treatment will be performed.

Day Two

The doctor will start by giving you a complete report of your findings and let you know if he can help you. We will also outline the best recommendations for correcting your problem and the choices that are available to you. You are welcome and encouraged to bring your spouse or significant other.

Day Three

Today the doctor will evaluate your body's response to your chiropractic adjustment. He will also review the previous day's report of findings.

I wish to initiate care at Optimum Chiropractic & Wellness Center. I have read and understand the Consent to Initiate Care and agree to all terms. I hereby authorize the Doctor to examine, xray and treat any condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. I understand that I am under no obligation to receive or continue care.

Print your Name___________________________________**Today's Date** ________________________

Sign your Name____________________________**Parent/Guardian** _____________________________

Welcome to Optimum Chiropractic & Wellness Center

Please Print Clearly and Fill in Completely.

Print Name________________________________ **Date of Birth** ______________________
St. Address__________________________________ **Home Phone** ____________________
City___________________________**State**_____ **Zip**________**Cell Phone**______________
Would you like to receive our monthly wellness e-newsletter?____**E-mail**_________________
Please Check Sex: Male[ ] Female[ ] Right Handed [ ] Left Handed[ ] Married[ ] Single[ ]
Emergency Contact Name and Phone number ____
Where did you hear about our clinic or who referred you?___________________________________
Name of Primary Insurance Company____
Name of Secondary Insurance Company(if any) ____

Health History:

Give reason for seeking chiropractic care: ____
____
Describe any health problems, including how long you've had them: ___________________________
____
Are you currently under the care of another physician? If so, for what?_________________________
Name & Number of Primary Care Physician____
May we update your physician with your progress here in the office? Yes [ ] No [ ]
List any current medications: ____
List any vitamins or supplements: ____
List any Allergies: ____
List any past surgeries & dates: ____
List any x-rays/scans you've had in the past 2 years: _______________________________________

Personal & Family History:

Your Occupation:_________________________Work Duties: ______________________________
Spouse's name and health status: ____
Children's names and ages: ____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes [ ] No [ ] If Yes, Doctor's name: _______________
Date of last chiropractic visit:__________________Reason for care: _____________________________
Date of last chiropractic x-rays:____________How long were you under care?:____________________
Are other family members under chiropractic care? Yes[ ] No[ ] Who? _________________________

Wellness Commitment

As a full spectrum Chiropractic Office, we focus on your ability to be healthy and active. Our goals are, first, to address the issues that brought you here & second, to offer you the opportunity of improved health potential & wellness services for you and your family in the future.

What results do you hope to obtain from care in our office? (CHECK ALL THAT APPLY)

- ❒ RELIEF- Relief from pain and symptoms to be more comfortable.
- ❒ CORRECTION- Going beyond relief from pain and correcting the problem at its source.
- ❒ WELLNESS- To become healthier, focusing on vitality & wellness.

Females: **Please check One.** Is there a possibility of you being pregnant? **Yes** [ ] **No** [ ]

If you have had the following, or if you suffer From the following, Please Check ✓

Condition, Symptom Or Problem	Often	Sometimes or Occasionally	Never
Headaches			
Migraines			
Neck Pain			
Shoulder Pain			
Arm/Hand Pain			
Mid Back Pain			
Low Back Pain			
Hip Pain			
Leg/Foot Pain			
Disc Problems			
Arthritis			
Other Joint Pain			
Numbness			
Joint Swelling			
Dizziness			
Nausea			
Weakness			
Fatigue			
Nervousness			
Insomnia			
Heart Problems			
Frequent Colds			
Nose Bleeds			
Ringing in Ear			
Earache			
Hearing Loss			
Cough			
Chest Pains			
Female Problems			
Allergies			
Asthma			
Cancer			
Osteoporosis			
Diabetes			
Hypoglycemia			
Digestive Problems			
Urinary Problems			
Skin Conditions			
Bowel/Bladder Problems			
Other:			

Doctor's Use Only

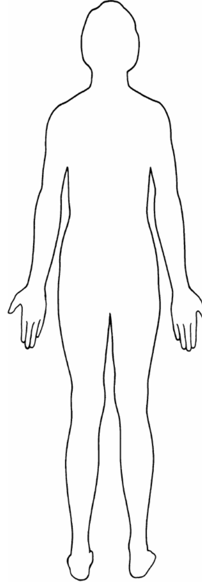
Patient Accepted

❐ Yes ❐ No ❐ Referred

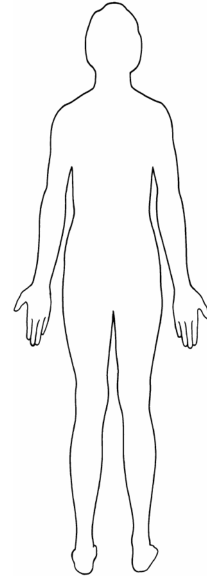
Please Fill in Below

Circle the areas where you have problems.
Please also describe these problems.

Front



Back



Please mark on the pain scale the pain you feel with these conditions. Zero being the least amount and 10 being the worst.

Headaches (None) 0-1-2-3-4-5-6-7-8-9-10 (Severe)

Neck/Shoulder/Arm Pain or discomfort (None) 0-1-2-3-4-5-6-7-8-9-10 (Severe)

Mid-Back Pain or discomfort (None) 0-1-2-3-4-5-6-7-8-9-10 (Severe)

Low Back or Leg Pain (None) 0-1-2-3-4-5-6-7-8-9-10 (Severe)

Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

____

____

____

____

Signature:______________________________

Date: ______________________________

Trauma History

Starting from birth, we all experience thousands of physical, mental, and chemical stresses. These stresses can cause subluxations (misalignments of the spine). Please write down the falls, injuries, and traumas that you have experienced in your life.

A. Car Accidents (even minor ones)
(A 5 mph crash from a 3000 lb vehicle can cause damage to your spine even if you didn't feel injured.)

Collision

	SIDE	FRONT	REAR	SPEED
Example: Year: 2000		X		20 mph
1. Year: ____________				
2. Year: ____________				
3. Year: ____________				

B. Sports Injuries

(If there are too many to list please write the name of the sport and many next to it)

Example #1 Year: 1995 Lower Back injured playing soccer
Example #2 Year: 1997-2000 Hockey- Multiple injuries and falls

1. **Year:** ______________ ____________________________________
2. **Year:** ______________ ____________________________________
3. **Year:** ______________ _________________________________

C. Slips, Falls, & Bike Wrecks

(We understand there may have been many since birth. So please list major ones.)

Example: Year: 1986 Fell off bike, dislocated right shoulder

1. **Year:** ____________ ____________________________________
2. **Year:** ____________ ____________________________________
3. **Year:** ____________ _________________________________

D. Work

Injuries: ❒ **Yes** ❒ **No** **What year:** __________________ Please describe:____

Repetitive Movement: ❒ **Yes** ❒ **No** **What Type:**________________________

E. Stress:

At home: ❒ **Yes** ❒ **No** **At work:** ❒ **Yes** ❒ **No**

Optimum Chiropractic & Wellness Center
6224 Colleyville Blvd, Ste B Colleyville, Texas 76034

WORK/AUTO INJURY FORM

NAME____ DATE______________________

Date of Accident___________Time:____am ____pm Location of Accident__________________

AUTO INJURY

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No

ON-THE-JOB INJURY

How did the injury occur? ____ _____________

Did you report the injury to your foreman or employer: ( ) Yes ( ) No

Employer:____________________________ Address ____

OTHER

Describe the circumstances of the accident (Be Specific)_________________________________

____

* *

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

( ) Headache	( ) Sleeping Problems	( ) Lights Bother Eyes	( ) Diarrhea
( ) Neck Pain	( ) Head Too Heavy	( ) Loss of Memory	( ) Feet Cold
( ) Neck Stiff	( ) Pins & Needles in Arms	( ) Ears Ringing	( ) Hands Cold
( ) Dizziness	( ) Pins & Needles in Legs	( ) Face Flushed	( ) Stomach Upset
( ) Back Pain	( ) Numbness in Fingers	( ) Buzzing in Ears	( ) Constipation
( ) Nervousness	( ) Numbness in Toes	( ) Loss of Balance	( ) Cold Sweats
( ) Tension	( ) Shortness of Breath	( ) Fainting	( ) Fever
( ) Irritability	( ) Fatigue	( ) Loss of Smell	( ) Other
( ) Chest Pain	( ) Depression	( ) Loss of Taste	

Did you require post-accident hospitalization? ( ) Yes ( ) No

Have you lost any days of work? ( ) Yes ( ) No If Yes,__________ through _________

INSURANCE INFORMATION

Your Insurance Company______________________________Address_______________________

Other Party's Name___________________________________Address_______________________

Other Party's Ins. Co.________________________________Address_____________________

Have you been contacted by an insurance adjustor regarding this claim ( ) Yes ( ) No

If yes, name of adjustor_________________Claim #_____________Company________________

Do you have an attorney that has advised you in this case: ( ) Yes ( ) No

If yes, attorney's name_________________________________Address_____________________

Signature__________________________________

Optimum Chiropractic & Wellness Center

6224 Colleyville Blvd, Ste B Colleyville, Texas 76034

Release and Consent

Personal Injury: Insurance Assignment of Benefits

I hereby instruct and direct my personal injury protection carrier and/or my auto insurance carrier and any liability carriers of any and all person(s) at fault of my injuries, and my attorney to DIRECTLY pay in full to Optimum Chiropractic & Wellness Center in the state of Texas, the professional and/or medical expense benefits allowed and otherwise payable to Optimum chiropractic & Wellness Center under current insurance policy as payment towards the total charges for the services rendered to me. This is a direct assignment of my rights and benefits under my policy. If I retain an attorney for my case I am declining Optimum Chiropratic & Wellness Center to file any claims from this personal injury case to my medical health insurance for any treatment as a result of this injury. If I obtain an attorney after I sign this I authorize all PIP and medpay payments to be paid directly to the provider and not the newly acquired attorney. I authorize my attorney to send a Letter of Protection to this office. This document supersedes any document stating otherwise.

I further direct my personal injury protection carrier and all other insurance companies involved, to pay Optimum Chiropractic & Wellness Center directly, overriding any and all powers of attorney, which may have been or may be submitted by an attorney. A photocopy of this assignment shall be considered as claims paid, to my insurance companies and/or my attorney.

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

I authorize Dr. Colin Tkachuk to administer diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

Release of Records

I give my consent for this office to release necessary medical records in the event that further testing or treatment is required.

Signature:______________________________ Date:_____________

Dr. Colin Tkachuk
6224 Colleyville Blvd, Ste B
Colleyville, Texas 76034
Telephone 817-481-9339
Fax 817-481-9669

Auto Accident - Financial Responsibility

I understand and agree that auto insurance policies are an arrangement between an insurance carrier and me. However, I understand that filing with a 3rd party insurance company is NOT a guarantee of payment. I fully understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. Furthermore, I give my consent for Optimum Chiropractic & Wellness to share any necessary reports and forms with the insurance company/billing service 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 on receipt.

I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I agree that I am responsible for all of my bills incurred in this office.

____ I have PIP (personal injury protection) as well and would like Optimum chiropractic to file my bills with my PIP.

____ I do not have or do not wish to use my PIP.

____

Patient/Parent or Guardian Signature *Date*

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Colleyville, Texas 76034
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Fax 817-481-9669

Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed.

There is a $15 charge if you do not reschedule or notify us at least 12 hours from the time of your appointment so please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

__________________________________ _________________

Signature Date

Dr. Colin Tkachuk
6224 Colleyville Blvd, Ste B
Colleyville, Texas 76034
Telephone 817-481-9339
Fax 817-481-9669

Notice of Privacy Practices

We are required by law** to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this 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.

Optimum Chiropractic & Wellness Center has adopted the following privacy policies.

Uses & Disclosures
Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. Example; results of tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. Example; your health plan may request and receive information of dates of services, the services provided, and the medical condition being treated.

Healthcare operations: Your health information may be used as necessary to support the day-to-day activities and management of our office. Example; information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. Example; we are required to report certain communicable diseases to the state's public health department.

Other uses & disclosures require your authorization: Disclosure of your health information or its use for any other purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of the information that occurred before you notified us of your decision.

Additional Uses of Information
Appointment reminders: Because we believe regular care is important to your general health, we will remind you of a scheduled appointment or that is time to contact us to make an appointment.

Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health related goods and services that we believe may interest you.

These communications are in important part of our philosophy of partnering with our patients to be sure they receive the best preventative care we can offer. They may include postcards, letters, telephone reminders and/or electronic reminders (unless you tell us you do not wish to receive reminders).

Notice of Privacy Practices Cont'd

Individual Rights

You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your Protected Health Information.
2. The right to receive confidential communications concerning your medical condition and treatment.
3. The right to inspect and copy your Protected Health Information.
4. The right to amend or submit corrections to your Protected Health Information.
5. The right to receive an accounting of how and to whom your Protected Health Information has been disclosed.
6. The right to receive a printed copy of this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for theserevisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy Protected Health Information be submitted inwriting. You may obtain a form to request access to your records by contacting our office. Be aware that we reserve the right to charge for copies of your records.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter to yourchiropractor outlining your concerns at:

Optimum Chiropractic
& Wellness Center6224
Colleyville Blvd. Ste B
Colleyville, TX 76034

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concerns to the same address. You will not be penalized or otherwise retaliated against for filinga complaint.

Contact Person

The name and address of the person you may contact for further information concerning your privacy practices is **Dr. ColinTkachuk at the address listed above.**

****HIPAA** (Health Insurance Portability and Accountability Act) was signed into law on August 21, 1996, Public Law, 104-191. This was designed to provide insurance portability, to improve the efficiency of health care by standardizing the exchange of administrative and financial data, and to protect the privacy, confidentiality, and security of health care information. It impacts all areas of the health care industry.

I have received the Notice of Privacy Practices and I have been given the opportunity to review it.

NAME____BIRTHDATE______________________________

SIGNATURE____DATE_______________________

Optimum Chiropractic & Wellness Center
Colin Tkachuk, DC
6224 Colleyville Blvd, Suite B
Colleyville, Texas 76034

Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Optimum Chiropractic & Wellness Center/ Colin Tkachuk, DC, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all 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 for 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 cost, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. If I retain an attorney for my case I am declining the physician/facility named above to file any claims from my personal injury case to my medical health insurance for any treatment as a result of this injury. If I obtain an attorney after I sign this I authorize all PIP and medpay payments to be paid directly to the provider and not the newly acquired attorney. I also authorize my attorney to send a Letter of Protection to this office. This document supersedes any document saying otherwise.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct my carrier to make all checks payable to Optimum Chiropractic & Wellness Center, and send to 6224 Colleyville Blvd, Suite B, Colleyville, Texas, 76034.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Optimum Chiropractic & Wellness Center, and to send any and all checks to Optimum Chiropractic & Wellness Center 6224 Colleyville Blvd, Suite B, Colleyville, TX, 76034.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the doctor/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that 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.

REJECTION IN WRITING: I hereby authorize the doctor/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, 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.

Signature of Patient and/or Responsible Parties:
I declare under penalty of perjury that the forgoing is true and correct. [CPRC: Sec. 132.001(a)]

Signature____ Date:____