KATY ELITE CHIROPRACTIC
SPORTS & FAMILY WELLNESS CARE

Weight _____ BP ___/___
Height _____ Pulse _____
*Account #*_____

PATIENT INFORMATION

Patient Name:_____ Today's Date:_____

Sex: [ ] M [ ] F Age:_____ Date of Birth:_____ Social Security #:_____

Marital Status: [ ] Married [ ] Single [ ] Minor Home Phone:_____ Cell Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Best way to contact you? Email [ ] Phone [ ]

Employer/School:_____ Occupation:_____

Emergency Contact: _____ Relationship:_____ Phone:_____

Who may we thank for your first visit? Referred By:_____

OR did you hear from us on: [ ] Google [ ] Website [ ] Facebook/Instagram [ ] TV/Radio [ ] Other:_____

Financial Information: [ ] Self-Pay (cash) [ ] Insurance [ ] Personal Injury/Auto [ ] Other (explain)_____

Person Responsible for Payment:_____ Relationship:_____ Phone:_____

Primary Insurance:_____ Insured's Name: _____ Member ID:_____

MEDICAL HISTORY AND SYMPTOM / PAIN INFORMATION

Reason for today's visit:

[ ] New Injury [ ] Old Injury [ ] Chronic Pain [ ] Wellness

Condition we are seeing you for:

Primary:_____ **Secondary:**_____

Rate your pain with the following scale: (circle one)

None 1 2 3 4 5 6 7 8 9 10 *Intense*

When did your symptoms appear: _____

What percentage of the day is the condition present?

10-20% 30-40% 50-60% 70-80% 90-100%

Is this interfering with your:

[ ] Work [ ] Sleep [ ] Recreation [ ] Daily Routine [ ] None

Symptoms you have experienced in the past 6 months:

[ ] Low Back Pain
[ ] Pain Between Shoulder Blade
[ ] Neck Pain
[ ] Tension/Migraine Headaches
[ ] Tired/ Fatigued

[ ] Tension Across Top of Shoulders
[ ] Numbness/Tingling in Arms or Hands
[ ] Numbness/Tingling in Legs or Feet
[ ] Dizziness
[ ] Ringing of Ears

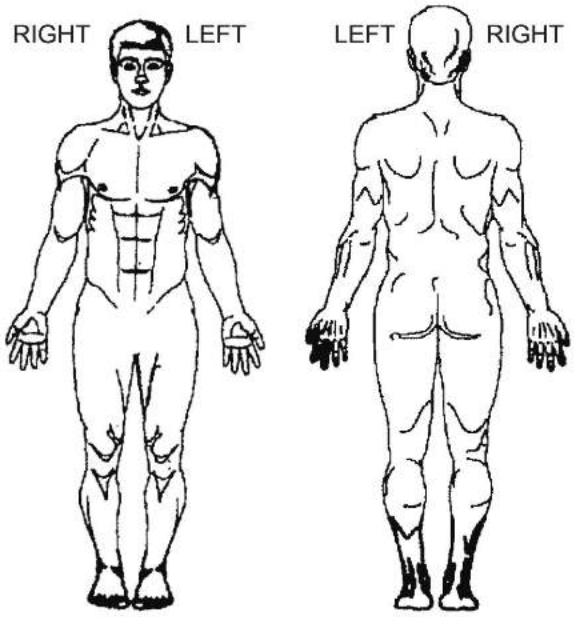
[ ] Nervous
[ ] Difficulty Sleeping
[ ] Allergies
[ ] Digestive Problems
[ ] Weight Problems
[ ] Other:_____

PAIN DIAGRAM

Please complete the following "Pain Diagram" by using letters to indicate your areas of pain.

P.	PAIN
T.	TINGLING
N.	NUMBNESS
B.	BURNING
S.	STIFFNESS

FRONT **BACK**



Initials here _____

KATY ELITE CHIROPRACTIC
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416 Park Grove Ln, Katy TX 77450
Office: 281-994-9020

MEDICAL HISTORY

IMPACT OF YOUR SYMPTOMS

Describe how this pain is impacting your life (examples: not being able to work or excercise, energy, attitude, productivity, self-care)

_____

What would you like to gain from chiropractic care? [ ] Resolve Existing Condition(s) [ ] Overall wellness [ ] Both

How Committed are you to correcting this issue? NOT COMMITTED 1 2 3 4 5 6 7 8 9 10 VERY COMMITTED!

TRAUMAS: PHYSICAL INJURY HISTORY

Notable chilhood Injuries? [ ] Yes [ ] No - Explain: _____

Any significant falls or injuries as an adult? [ ] Yes [ ] No - Explain:_____

Auto Accidents: [ ] Yes [ ] No - Date:_____ - Injuries?_____

Sport Injuries? [ ] Yes [ ] No - Explain:_____

Exercise frequently? [ ] None [ ] 1-2x p/week [ ] 3-5x p/week [ ] Daily

How do you normally sleep? [ ] Back [ ] Side [ ] Stomach - Do you wake up: [ ] Refreshed and Ready [ ] Stiff and Tired

Do you commute to work? [ ] Yes [ ] No - How many minutes per day?_____

How may hours per day do you spend sitting at a desk on a cumpoter, tablet or phone?_____

TOXINS: CHEMICAL AND ENVIRONMENTAL EXPOSURE

Are you taking any medications? [ ] Yes [ ] No - List them:_____

Do you drink alcohol?_____ Do you smoke?_____ Do you drink caffeine? _____ Recreational Drugs?_____

Well Balanced Diet? [ ] Rarely [ ] Occasionally [ ] Moderately

EMOTIONAL STRESSES AND PHYSICAL CHALLENGES

Personal Stress? [ ] Low [ ] Medium [ ] High - Occupational Stress? [ ] Low [ ] Medium [ ] High

Do you experience fatigue and/or struggle to fall or stay asleep? [ ]Never [ ]Rarely [ ]Sometimes [ ]Often [ ]Very Often

List any problems with flexibility (ex. putting on shoes/socks, etc)_____

WOMEN ONLY:

How many children do you have?_____ - Are your periods regular? [ ] Yes [ ] No - Suffer from cramping? [ ] Yes [ ] No

Other menstrual / Hormonal symptoms: _____ - Use birth control? [ ] Yes [ ] No

Are you pregnant? [ ] Yes [ ] No How many weeks:_____ Are you nursing:_____

HEALTH AND ILLNESS HISTORY

Emotional and Mental
- _ Depression
- _ ADHD
- _ Alzheimer's
- _ Anger Disorders
- _ Anxiety Disorders
- _ Autism
- _ Bipolar disorder
- _ Eating Disorder
- _ Obsessive Compulsive Disorder (OCD)
- _ PTSD
- _ Sexual Dysfunctions
- _ Sleep Disorders
- _ Substance Abuse
- _ Other:_____

Musculoskeletal Health
- _ Scoliosis
- _ Arthritis
- _ Herniated Disk
- _ Lyme Disease
- _ Meningitis
- _ Multiple Sclerosis
- _ Muscular Dystrophy
- _ Osteoporosis
- _ Parkinson's Disease
- _ Rheumatoid Arthritis
- _ Sciatica
- _ TMJ
- _ Foot/Ankle Issues
- _ Other: _____

Sensory
- _ Cataract
- _ Deafness or Hearing Loss
- _ Ear ringing
- _ Eczema
- _ Glaucoma
- _ Laryngitis (chronic)
- _ Macular Degeneration
- _ Psoriasis
- _ Vertigo
- _ Other: _____

Gastrointestinal and Neurological
- _ Bladder Disease
- _ Diabetes
- _ Food Allergy
- _ Fibromyalgia
- _ Epilepsy
- _ Headaches/Migraines
- _ Constipation
- _ Irritable Bowel Syndrome (IBS)
- _ Kidney Disease
- _ Liver Problems
- _ Stomach Ulcers
- _ Thyroid Dysfunction
- _ Other: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for futher evalutation. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient Signature:_____ Date:_____

Guardian or Spouse Signature: _____ Date: _____

KATY ELITE CHIROPRACTIC
SPORTS & FAMILY WELLNESS CARE

OUR MISSION: offer our patients a drugless, non-surgical approach to health that will allow them to reach their greatest potential... naturally!

OUTLINE PROCEDURE FOR NEW PATIENTS

1. All new patients are requested to fill out paperwork forms
2. Consultation with Dr. Z to discuss your health problems
3. Exam and x-rays if necessary, to determine if chiropractic care is appropriate for your condition
4. If your case requires immediate attention, emergency care will be administered
5. You will be advised as to a time you can return for your "Report of Findings" appointment, during the second appointment Dr. Z will inform you of your examination results and whether or not your case has been accepted.
6. Your recommended program of care will be explained to you along with financial arrangements and insurance coverage as appropriate
7. Care will begin and continue as scheduled until your condition has been fully corrected or until the maximum possible improvement has been obtained

CONSENT FOR TEXT/EMAIL NOTIFICATION

I give Katy Elite Chiropractic permission to send text/email notifications regarding upcoming appointments, news and events.

Printed name_____

Signature_____

KATY ELITE CHIROPRACTIC PHOTO RELEASE

I grant Katy Elite Chiropractic and its employees the right to take photographs of me with connection to the promotion of chiropractic services via their website, social media, and any other avenues. I agree that Katy Elite Chiropractic may use such photographs of me for publicity, illustration, advertising, and web content.

Printed name_____

Signature_____

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INFORMED CONSENT

By signing this form, I am requesting and consenting to the diagnostic and therapeutic procedures which may include, but are not limited to, physical modalities, x-rays, physical examination and history and chiropractic treatment performed by Dr. Ammon Zukeran/ Katy Elite Chiropractic and anyone working in the practice authorized by the above doctor of chiropractic.

I recognize that no guarantees have been or can be made regarding the likelihood of the success of the outcome of any evaluation, treatment, test, procedure, or therapy performed by Katy Elite Chiropractic staff.

"Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, and x-rays.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life".

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care.

"Risks associated with some chiropractic treatment may include slight pain, discomfort, soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain".

_____INTIAL I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE KATY ELITE CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____ _____

Patient Signature Date

KATY ELITE CHIROPRACTIC
SPORTS & FAMILY WELLNESS CARE

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name: _____ Date: _____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA. The notice is available on our website and also a paper copy is available upon request.

In order for our office to provide ANY information to a partner, spouse, parent, relative or other designates, we must have your permission. (This would include appointment schedules, X-rays, receipts, health records and any other information that pertains to your treatment). You may indicate your permission by listing names here:

My information may be shared with: (list names):

_____
_____
_____
_____
_____

Please indicate the name and contact information of your primary care physician for the purpose of care coordination with the chiropractic physician.

(Primary Care Doctor Name): _____

Address/Phone: _____

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

PATIENT NAME: _____ DATE: _____

PATIENT/GUARDIAN SIGNATURE: _____ RELATIONSHIP: _____

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Financial Policy

1. Appointments/Cancellations - Please be 5 minutes early for your appointment. Each patient is scheduled an individual time slot. If you are late, or cancel without 24 hours' notice this causes other patients to be late or denied an appointment when they might otherwise be seen. You will be financially responsible for all missed appointments or untimely cancellations.

2. All payments are due at the time the services are rendered unless other agreements for care plan payments have been made. We accept cash, checks, Visa, MasterCard, Discover and American Express.

3. There will be a $25.00 charge for returned checks due to nonsufficient funds (NSF). After two NSFs, checks can no longer be accepted as a method of payment.

4. Private Insurance: Our office will always do its best to give you accurate information about insurance deductibles, copays, and other expenses that your insurance may require you to pay. We will always try to do this before you incur any expenses, so that you may make the most informed decision possible regarding your health and wellness.
Please be aware, however, that the information we provide you is only as good as the insurance company that gives it to us. We work with many insurance companies each year; some are better than others at providing accurate information about patient expenses. Our office will always try to provide you with information about your coverage that is as complete and accurate as possible.
No matter what information your insurance company provides, the best way for you to know what your coverage levels are, is to see exactly what they pay for your care when they send an actual payment. We will know the answer within approximately 30 days. Please inquire at that time if you would like to know more about your coverage.
Remember at all times that insurance is a private contract between you and your insurance company. Our office has no control over it. In the rare instance that your insurance company does not pay as promised, we will make you aware as soon as possible so that you may pay the portion they ask of you.

6. Personal injury/auto claims may also be handled through your personal injury protection (PIP) insurance. I authorize Katy Elite chiropractic to release any medical information and to complete any usual and customary reports to assist in collecting from my insurance company.

7. Medicare and Medicaid - We accept assignment from Medicare BUT it has very limited chiropractic coverage. It covers 80% of chiropractic adjustments after the Part B deductible is satisfied. Medicare does not cover the cost of the initial examination, x-rays, or other services. These non-covered charges, as well as 20% of the chiropractic adjustment is patient responsibility. We will file your Medicare or Medicare Replacement claims as a courtesy.

8. Care plans - are non-transferable. If you become involved in any injury resulting from liability, auto accidents, workers compensation, etc. your care plan will be frozen until you have been released from any liability claims. I also understand that if I suspend or terminate my care and treatment plan, I will be responsible for all professional services rendered at the rate card price and these charges will be immediately due and payable upon suspension/cancellation of care.

9. I understand that Katy Elite Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Katy Elite Chiropractic will be recorded on my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I HAVE READ, UNDERSTAND AND AGREE WITH THE PAYMENT POLICY:

PATIENT NAME: _____ DATE: _____

PATIENT/GUARDIAN SIGNATURE: _____ RELATIONSHIP: _____