Confidential Patient Information
(Please Print)

Name:_____ Date:_____

Address:_____City:_____State:_____Zip:_____

Phone:Home:(____)_____ Cell:(____)_____ Pager:(____)_____

Is it okay to contact you at the above listed contact numbers? ☐ Yes ☐ No

Birth Date:_____/_____/_____ Age:____ Sex: M F Marital Status: S M W D

Occupation:_____Employed By:_____

Work Phone:(____)_____Ext:_____City:_____State:_____

Driver's License #:_____ SSN:_____-_____-_____

Spouse's Name:_____# of Children:_____

How were you referred to our office?_____

Have you ever been to a chiropractor before? Yes No If so, when?_____

List your chief concerns in order of severity.

1._____For how long?_____

2._____For how long?_____

3._____For how long?_____

4._____For how long?_____

List other doctors consulted for these conditions.

1._____Address:_____

2._____Address:_____

If this is an injury:

1. Work related? Yes No Reported to your employer? Yes No

2. Related to an auto accident? Yes No

**If this is an accident, fill out the appropriate report form which will be provided to you and return it on your next visit.

Females: Are you pregnant? Yes No Not Sure

Please indicate the type of care desired:

____ Temporary Relief ____ Lasting Correction

____ I would like the Doctor to recommend the best type of care.

Name_____Date_____

Please check any out-of-the-ordinary pains, discomforts, or other symptoms you have experienced:

___Headaches
___Shooting Head Pains
___Loss of Smell
___Loss of Taste
___Tightness of Throat
___Inflammation of Throat
___Face Flushed
___Twitching of Face
___Loss of Memory
___Head Feels Too Heavy
___Dizziness
___Fainting
___Lights Bother Eyes
___Muscle Spasms in Neck
___Grinding in Neck
___Tightness of Shoulders
___Tingling in Arms/Hands
___Cold Hands
___Chest Pains
___Shortness of Breath

___Loss of Balance
___Muscle spasms in low back
___Indigestion
___Intestinal Gas
___Constipation
___Diarrhea
___Tingling in Legs
___Swollen Ankles
___Cold Feet
___Pains in Legs/Feet
___Fatigue
___Depression
___Nervous Stomach
___Stomach Trouble
___Nervousness
___Inner Tension
___Irritability
___Difficulty Sleeping
___Painful Joints
___Swollen Joints

On the illustrations below, please draw a line from the area of pain to the word which most accurately describes:

What kind of pain is it?

Sharp

Dull

Tingling

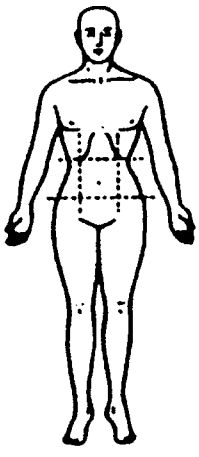
Numbness

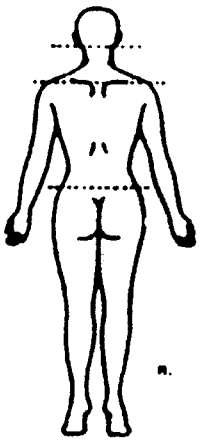
Constant

Comes&Goes

Other:

_____





General Health:

Present		Past	Family History
___	Hearing	___	___
___	Sinus	___	___
___	Hayfever	___	___
___	Asthma	___	___
___	Thyroid	___	___
___	Sight	___	___
___	Tuberculosis	___	___
___	Heart Attack	___	___
___	HighBloodPress	___	___
___	Low Blood Pres	___	___
___	Anemia	___	___
___	RheumaticFever	___	___
___	Ulcers	___	___
___	Liver Trouble	___	___
___	Gall Bladder	___	___
___	MenstrualCramps	___	___
___	Menst.Irregular	___	___
___	Diabetes	___	___
___	Cancer	___	___
___	Seizures	___	___
___	Ear Infections	___	___

Please list any medications___
_____

OFFICE POLICY

1. *ALL CHARGES ARE PAYABLE WHEN SERVICES ARE RENDERED.*
2. THE FEE PAID FOR TREATMENT X-RAYS IS FOR ANALYSIS ONLY. THE FILM ITSELF IS THE PROPERTY OF THIS OFFICE. ONCE FILMS ARE USED FOR TREATMENT PURPOSES, THEY CANNOT BE RELEASED. COPIES CAN BE MADE IF NECESSARY.
3. Method of payment with which you plan to take care of today's charges:
   Cash _____ Check _____ Visa/MC _____ Discover _____
   Do you have any type of insurance? Yes No Company_____
   Policy # _____ Group #_____Phone_____
   Address to mail claims_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Hoover Wellness Care will prepare any necessary reports and forms to assist me in making collections from the insurance company and any amount authorized to be paid directly to Hoover Wellness Care will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

I agree that I will be responsible for all attorney and legal fees if legal action is necessary to collect this account. I authorize Hoover Wellness Care to obtain a credit report if necessary.

Patient's Signature _____Date_____
Guardian or Spouse's Signature Authorizing Care
_____Date_____

In case of emergency, please notify:
Name of Closest Relative (outside the home)_____
Relationship_____
Address_____
Phone_____

David W. Hoover, D.C.
16990 Dallas Parkway, Suite 110
Dallas, TX 75248
214-505-5600

David W. Hoover, D.C.
6300 Ridglea Place – Suite 1100
Fort Worth, TX 76116
817-346-2211

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

HIPAA Notice of Privacy Practices

David W. Hoover, D.C.
16990 Dallas Parkway, Suite 106
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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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, 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, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to 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 purposes of treatment, payment or healthcare operations. 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 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 physician is not required to agree to a restriction that you may request. If physician 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. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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 alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. 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.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

HEALTH CARE AUTHORIZATION FORM - NET

Patient's Name _____

Patients SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **David W. Hoover, D.C.** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to **David W. Hoover, D.C.** to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information. This includes calling me at any of my contact numbers listed on file.

- By signing this form you are giving **David W. Hoover, D.C.** permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

This Authorization shall expire five (5) years from today's date or may be revoked with written request by the patient.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **David W. Hoover, D.C.** The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by **David W. Hoover, D.C.** for its own use/disclosure of PHI.
(Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **David W. Hoover, D.C.** will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.
A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU

_____
Print Name of Patient

_____
Signature of Patient

_____
Date

_____
Signature of Personal Representative
Description of Representative's Authority To Act for Patient: