PATIENT INFORMATION

Name: _____ Date: _____

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

HM Phone: _____ Mobile Phone: _____ Work: _____

Email: _____ Preferred method of contact: □ Phone □ Email □ Text

Age: _____ Date of Birth: _____ Gender: □ Female □ Male **Social Security No**: _____

Race: □ White □ Hispanic □ Black/African American □ American Indian/Alaskan □ Asian □ Pacific Islander □ Multi-racial

Ethnicity: □Hispanic or Latino □ NON-Hispanic or Latino □ Cuban □ Unknown or declined to disclose

Marital Status: □ Married □ Single □ Single with Partner □ Widowed □ Separated □ Divorced

Spouse / Partner Name: _____ Phone: _____

Emergency Contact Info: Name: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Next of Kin: Name: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Mother's Maiden Name: _____ **(For electronic access of records)**

CURRENT SYMPTOMS or ACCIDENT or INJURY

Type of care requested today: □New accident/Injury □ New problem □ Old problem □ Re-activation of old problem □ Maintenance

Date of accident / injury or date symptoms began: _____

Please describe your Accident or Injury: **What happen to cause your Injury?** _____

What was injured: **Where do you hurt?** _____

Prior treatment for this condition / Injury: □ No □Yes If yes Where:_____

Is the current pain from: □new accident □old Injury Date symptom(s) began: □ _____ or □ Gradual Onset

What makes the pain better?: _____

What makes it worse?: _____

How often is the pain?: _____ **When is the pain worst (AM or PM)?**:_____

Does the pain radiate, travel or shoot anywhere?: □ No □ Yes If yes where: _____

Have you had any changes in your health? (ie. new diagnosis, accident(s), injury(s) surgery, therapy, cancer, tumors, diabetes, heart problem, blood pressure, stroke, seizures, thyroid. or **other problems**? **Yes No**

Medication(s) / Conditions: □ **NONE** □Cancers/tumors □Diabetes □Kidney/Liver □Hepatitis □Auto-Immun □HIV □Blood Pressure □Stroke □Heart problems □Meningitis □ Mental disorders □Seizures □GU/GI □ Respiratory □Spinal problems □Arthritis □Bone □Soft Tissue □Birth Control □Muscle relaxers □Pain Killers □Anti-Inflammatory □Anti-Depressants □Antibiotics □Hormones □Thyroid Meds □Inhaler □ Allergy Meds □Steroid's □other(s) **O-T-C Medications**: □ **NONE** □ Aspirin □ Tylenol □ Ibuprofen(Advil, Motrin) □ Naproxen(Aleve) □ Creams(Icy Hot, Ben Gay) □ Allergy Medications □other(s)_____

Vitamin / Nutritional Supplements: □**NONE** □ Multi-vitamin □Vit. A □Vit. B □Vit. C □Vit. D □Vit. E □Vit. K □Pre-natal □Calcium □Herbs □ Naturalpathic /Homeopathic Remedies □ other(s) _____

Other Current Conditions which may affect treatment outcome: □Obesity □ Poor Physical Condition □ Sedentary Lifestyle □ Disability □ Age □ Occupation □ Diabetes □Smoker □ Coffee/tea Drinker □ Alcohol Drinker □Soda Drinker □ High Blood Pressure □ Arthritis □other(s)_____

OTHER TREATMENTS RECEIVED: □ ER □ MD/DO/NP □ Chiropractor/Acupuncture □ Pain Management □ Physical Therapist □ Psychologist □ Counselor □ Massage □ TENS unit □ Medication □ O-T-C Medication □ Home Treatment □ Rest

ADDITIONIAL SYMPTOMS

Since the Motor Vehicle Collision, have you experienced any of the following:

A. Loss of Range of Motion: □yes □ no
   a. What body parts: _____

B. Visual Disturbance : □yes □ no □ blurring l/r % of time: ___ □ floaters l/r % of time: ___ □ vision loss l/r % of time: ___ □ hypersensitivity l/r % of time: ___

			Before	**Now**
C. Dizziness:	□ yes	□ no	_____ % of time:	____
D. Anxiety:	□yes	□ no	_____ % of time:	____
E. Depression:	□yes	□ no	_____ % of time:	____
F. Difficulty Sleeping:	□yes	□no	_____ % of time:	____ _____
G. Problems Walking	□yes	□no	% of time:	____ _____

OCCUPATION INFORMATION

Occupation: _____ Supervisor: _____:

Employer: _____ Supervisor Phone: _____

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

How long employed: _____ Work Hours: _____ Missed any work? □ No □ Yes How Much: _____

Describe your normal work duties: _____

FINIANCAL RESPONSIBILIY

Insurance: □ Major Medical / Health □ Work Comp □ (Slip and Fall) Liability □ Automobile □ Attorney □ Cash

Insurance Company Name: _____ Phone: _____

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

Claim / Policy Number: _____ Attorney Name: _____

Please note we will make a photocopy of your Picture ID, Divers License, Insurance Card, Attorney Card, and Police Report.

All fees are due and payable at the time of service, unless other arrangement has been made in advance. I understand that I am personally responsible for the total amount of remaining charges on my account. I understand that if this account payment balance is due within 30 days of service. After 30 days interest charges of (1.5% / month or 18% annually) for unpaid balance and $5.00 billing charge for each time you are billed. If sent to collection all collection fees, attorney fees, court fees and other related fees will also apply. X-rays remain the property of this clinic. Thank You.

I, undersigned, herby give permission for treatment and.

(X) 12. PATIENTS AUTHORIZED PERSON'S SIGNATURE: I Authorize the release of any medial or other information necessary to process this claim. I also request payment of benefits to the party who accepts assignment below.
(X) 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described on itemized statement or claim form..
(X) Benefits have been assigned to the doctor please pay the doctor direct.
(X) The Insurance company or attorney is authorized and directed to make check out and mail settlement check of the claim to Joseph H. Lones III
(X) I hereby authorize the doctor who treats me to designate his assistants to administer treatment as he so deems necessary.

X_____ Date: _____

PREVIOUS HEALTH HISTORY

Illness: □ **None** □ Mumps □ Measles □ Rubella □ Chicken Pox □ Whooping Cough □ TB □ HIV □ Communicable Disease

Vaccinations: □ Measles □ Rubella □ Chicken Pox □ Whooping Cough □ Hepatitis □ Meningitis □ Pneumonia □ Flu

Prior Injury: □ **None** □ Automobile Accident □ Work Comp injury(s) □ Sports Injury □ Slip and Fall

Prior Treatments: □**None** □ER □MD/DO □Chiropractor/Acupuncture □Physical Therapist □Psychologist □Counselor □Massage

Prior History: □ **None** □ Pregnancy □ Hospitalization □ Surgery □ Serious Conditions □ Accidents □ Fractures

Allergies: □**None** □Medication □Food □Stinging Insects □Pollen/grasses □Environment □Latex □Dogs/cats □Chemicals □ Other

FAMILY HISTORY

Prior Surgeries / Hospitalizations: □**None**

Condition	Self	Family Member	Condition	Self	Family Member	Condition	Self	Family Member
Cancer/Tumors	□	□	Heart Disease	□	□	Spinal Problems	□	□
Diabetes	□	□	High Blood Pressure	□	□	Arthritis	□	□
Kidney/Liver	□	□	Stroke	□	□	Asthma	□	□
GU/GI	□	□	Seizures	□	□	Addiction(s)	□	□
Auto-Immun	□	□	Mental Disorder(s)	□	□	Headaches	□	□
Hepatitis	□	□	Meningitis	□	□	Bone	□	□
Thyroid Disorders	□	□	Bleeding Disorders	□	□	Soft Tissue	□	□
Respiratory	□	□	Other	□	□	**NONE**	□	□
NONE	□	□	**NONE**	□	□			

PERSONAL & SOCIAL HISTORY

Children: □ No □ Yes Names/ages: _____

Religious Affiliation: □ **NONE** □ Catholic □ Protestant □ Jewish □ Muslim □ Hindu □ Buddhist □ Other

Hobbies / Leisure Activities: _____

(Gardening, playing with children/Grand children, cards/games, walking, hiking, swimming, exercising, swimming, sewing, softball, soccer, dancing, social events, theater, reading etc)

Exercise: □ Walk/Run/Jog □ Aerobic □ Workout/Gym □ Weights/Bands/Machines □ Stretching/Yoga □ Bike □ Swim □ Sports

Diet: □ Regular American Diet □ Vegetarian Diet □ Diabetic Diet □ Gluten Free □ Low Calorie Diet □ Junk Food □none □some

Appetite Good: □ Yes □No **Do you skip meals:** □ Yes □ No **Do you sleep well?** □ Yes □ No How many hours: _____

Drinks: □ Water mostly or some □ Fruit Drinks □ Coffee □Tea □ Soda □ Alcohol How many/ How often: _____

Smoking: □ No one smokes at home □ Never Smoked □ Quit When_____ □ Trying to quit □ Smokes: _____

Sex: □ Not sexually active □ Sexually active: □ Birth Control Method: _____

Addictions: _____

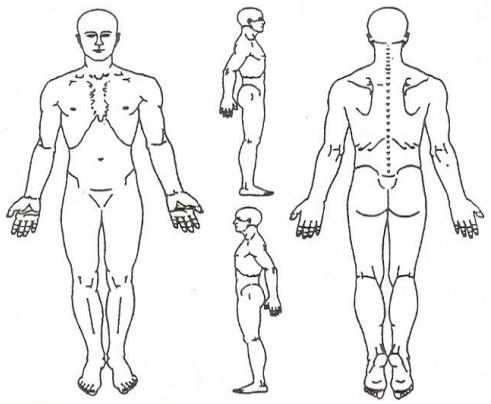
(Smoking, alcohol, drugs, coffee, tea, soda, sugar, carbohydrates,, fat's, exercise, TV, Computer, video games, gambling, sex, etc.)

Stressors: **What cause you stress:** _____

(Traffic, School, Work, Inability to Work, Money Problems, Bills, Car Damage, Insurance Company, Children, Spouse, Neighbors, Driving, Pain, Disability

Name: _____ Date: _____

SUBJECTIVE DAILY



Please shade problems areas

New Injury or symptom(s)? □ Yes □ No
Any changes in symptoms since last visit? □ Yes □ No
□ Improved □ Unchanged □ Regressed
Pain Scale 0-10 (10=worse) ……Today is _____
Percentage time bothersome 0-100 (100 =Constant) _____

Initials: _____

□ W/C □ MVA □ S/F □ Sports □ Other DOI: _____

How are your symptoms changing with time?
□ Getting Worse □ Staying the Same □ Slightly Better □ Much better □ Resolved

Description of Pain & Symptoms:
□ Sharp □ Dull □ Diffuse □ Achy □ Burning □ Shooting □ Squeezing □ Cramping □ Numbness □ Tingling
□ Tightness □ Stiffness □ Loss of Strength □ Weakness □ Loss of Motion □ Feels Asleep
□ Sharp with Motion □ Stabbing with Motion □ Shooting with Motion □ Electric Like with Motion

Activities Affected:
□ Bending □ Squatting □ Stooping □ Kneeling □ Leaning □ Twisting □ Turning □ Rotating □ Nodding □ Balance
□ Reaching □ Pushing □ Pulling □ Elevating □ Lifting □ Carrying □ Standing □ Walking □ Climbing □ Crawling
□ Sitting □ Getting Up □ Getting Down □ Lying □ Sleeping □ Riding □ Driving □ Opening Things
□ Loss or Decreased Grip Strength □ Loss or Decreased Motion □ Loss or Decreased Fine Motion □ Fatigue □ Nausea

How much is the problem interfering with your **house work / home activities**?
□ Not at all □ Little bit □ Moderately □ Quite a bit □ Extremely

How much is the problem interfering with you **leisure / social activities**?
□ Not at all □ Little bit □ Moderately □ Quite a bit □ Extremely

How much is the problem interfering with your **work or school**?
□ Not at all □ Little bit □ Moderately □ Quite a bit □ Extremely

Working: □No □ Yes □ Full Time □ Part Time □ Full Duties □ Limited Duties

Home Treatment: □ Rest □ Heating pad □ Hot showers/Hot baths □ Cold pack □ Cold showers/baths
□ Hot tub, Jacuzzi, Sauna □ Massage □ Stretches/Yoga □ Exercise
□ Creams □ Icy Hot □ Ben Gay □ Bio-Freeze □ Skinner's Salve
□ Aspirin □ Tylenol □ Ibuprofen (Advil) □ Naproxen (Aleve) □ Medication(s

How often do you experience your symptoms? □ Constantly (76-100% of the time) □ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time) □ Intermittently (1-25% of the time)

Severity of Symptoms
□ **Minimal**– When the symptoms or signs constitute an annoyance but cause ***no impairment*** in the performance of a particular activity.
□ **Slight** – When the symptoms or signs can be tolerated but would cause ***some impairment*** in the performance of an activity that precipitates the symptoms or signs.
□ **Moderate** - When the symptoms and signs would cause ***marked impairment*** in the performance of an activity that precipitates the symptoms or signs.
□ **Marked** – When the symptom or signs ***preclude any activity*** that precipitates the symptoms or signs

Name: _____ Date: _____

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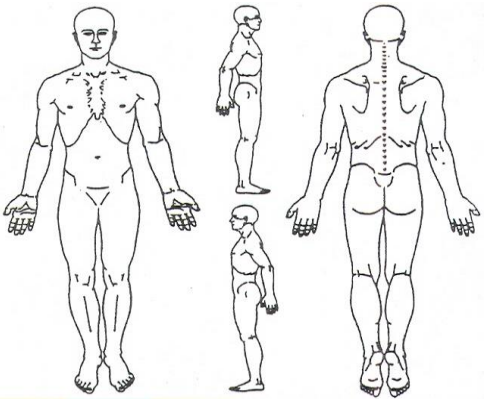
PROPOSED TREATMENT PLAN

□ Initial □ Subsequent

DIAGNOSIS: □ 739.1 □ 739.2 □ 739.3 □ 728.85 □ 784. □ _____ □_____ □ _____ □ _____ □ _____

FREQUENCY X's DURATION: _____ **X's**_____ _____**X's**_____ _____**X's**_____

PHYSICAL MEDICINE:



MANIPULATION:

Occ C SH AT T L P S P RIBS Rt. Lt. UE Rt. Lt. LE

□ Mild □ Activator □ Anterior Thor □ Side Posture □ Drop □ Pierce

□Treatment perform without incident □Continue current treatment plan as prescribed.

□ Modify plan next visit: _____ □ Referral: _____

□ Improved □ Unchanged □ Regressed □ Exacerbation □ Aggravated □ Re-Injured □ Approaching MMI

Restricted Motion: C SH T L SI Tenderness/Pain C SH T L SI

Misalignments fixations: C SH T L SI Asymmetry: C SH T L SI

Edema/Swelling: C SH T L SI Spasm/rigidity: C SH T L SI

5X 4X 3X 2X 1X Weeks Monthly PRN Released

□ Office Visit (99013) (Re-exam) (99213) □ EMS (97014-G0283) □ Therapeutic Exercise (97110)

□ Manipulation (Spinal) (98940-98942) □ Hot/Cold Packs (97010) □ Bio-Freeze □ Massage (97124)

□ Manipulation (Extra-spinal) (98943) □ Mechanical Traction (97012) □ Attended EMS (97132)

□ Manual Traction (97140 Flex-Distraction) □ Diathermy (97024) □ NMR (97112)

□ Axial Traction (Decompression) (97012) □ Ultrasound (97032) □ Therapeutic Activity (97530)

□ Treatment perform without incident □ Continue current treatment plan as prescribed. □ Modify plan next visit: _____

□ Referral: _____

□ Improved □ Unchanged □ Regressed □ Exacerbation □ Aggravated □ Re-Injured □ Approaching MMI

Home Treatment: □ Rest □ Heating pad □ Hot showers/Hot baths □ Cold pack □ Cold showers/baths

□ Hot tub, Jacuzzi, Sauna □ Massage □ Stretches/Yoga □ Exercise

□ Creams □ Icy Hot □ Ben Gay □ Bio-Freeze □ Skinner's Salve

□ Aspirin □ Tylenol □ Ibuprofen (Advil) □ Naproxen (Aleve) □ Medication(s)_____

□ **Patient is advised to continue Rx & additional care recommended by other providers:** MD, DO, NP/PA, PT, OT, MT, ACU, etc.

Complicating Factors (factors which may affect outcome and length or amount of treatment): □ Obesity □ Diabetes

□ Smoker □ High Blood Pressure □ Arthritis □ Disability □ Sedentary Lifestyle □ Age □ Physical Condition □ Diet □ Medication

□ Occupation □ Prior Accident/Injury □ Mechanism of Injury □ Other Medical Conditions □ Exacerbation □ Aggravated □ Re-Injured

Treatment Goals: □ Decreased Pain □ Decreased stiffness/tightness □ Increase Range of Motion □ Increased ADL

Measurements (any may be used): □ Pain Scales □ Patient's Descriptions □ Examination Findings □ OATS

Anticipated Outcomes: □ Excellent □ Good □ Fair □ Poor

□ with full compliance. □ with some compliance. □ with minimal to some compliance. □ with no compliance.

Optimal Treatment Outcomes (improved with): □ Keeping appts □ Supplements □ Plenty of Rest □ Exercise □ Proper Diet

□ Avoidance of Aggravating Factors

Recommended Re-examinations: □ Every 30-60 days while under active treatment. □ 1X year for Maintenance Patients.

Name: _____ Date: _____

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REVIEW OF SYSTEMS

CONSTITUTIONAL: □ **Generally Healthy** □ **No changes** □ **No Problems**
□ changes in appetite/weight □ fatigue/malaise/lethargy □ fever □ night sweats □ changes sleeping pattern

EYES: □ **Normal vision**
□ tearing □ visual changes □ eye pain □ eye discharge □ double vision □ floaters □ scotomas (blind spots)

ENT: □ **No Problems**
□ nasal drainage □ ear drainage □ hearing loss □ sinus pressure □ sore throat □ difficulty swallowing □ hoarseness

INTEGUMENTARY (SKIN) /BREAST: □ **No Problems**
□ rashes □ pruritus (itching) □ lesions □ dryness and/or discoloration □ eczema □ psoriasis □ Breast pain □ discharge

CARDIOVASCULAR: □ **No Problems**
□ high blood pressure □ chest pain □ claudication □ edema □ irregular heart beat / palpitation's □ heart problems

RESPIRATORY: □ **No Problems**
□ shortness of breath □ prolonged cough □ wheezing □ sputum production □ known tuberculosis exposure

GASTRO-INTESTINAL: □ **No Problems**
□ constipation □ diarrhea □ abdominal pain □ nausea □ vomiting □ blood in stools □ unexplained change in bowel habits

GENITO-URINARY: □ **No Problems**
□ painful urination □ frequent urination □ urgency □ bladder problems □ impotence □ hematuria (blood in the urine)

MUSCULOSKELETAL: □ **No Problems other than the chief complaints**
□ rheumatoid arthritis □ gout □ spinal surgery □ joint surgery □ arthritis □ scoliosis □ joint pain □ swelling.

NEUROLOGICAL: □ **No Problems other than the chief complaints**
□ headaches □ weakness □ change in sensation □ problems with walking or balance □ dizziness, tremor, loss of consciousness

PSYCHIATRIC: □ **No Problems**
□ insomnia □ irritability □ depression □ anxiety □ recurrent bad thoughts□ mood swings □ hallucinations □ compulsions.

ENDOCRINE: □ **No Problems**
□ thyroid problem □hormonal replacement therapy □ diabetes □ menstrual irregularities □ changes in sex drive

ALLERGIES/ IMMUNOLOGIC: □ **No problems**
□ seasonal allergies □ food allergies □ environmental allergies □ hay fever symptoms □ itching □ frequent infections □ HIV

HEMATOLOGIC/LYMPHATIC: □ **No Problems**
□ easy bleeding □ easy bruising □ anemia □ abnormal blood tests □ leukemia □ swelling (lymphadenopathy)

Name: _____ Date: _____

Auto Accident Mechanism of Injury Form

Date of Collision: _____ Hour of Accident: _____ AM / PM

Please describe how the collision happened: _____

_____

What was your position in the car? (Circle) **Driver** / **Front Passenger** / **Left Rear** / **Right Rear**

If "Driver", were your hands on the steering wheel? **Both** / **Left** / **Right** Did the airbags deploy? **Yes** / **No**

Did you strike another vehicle? **Yes** / **No** Did another vehicle strike your vehicle? **Yes** / **No**

Angle of Impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____

If Second Collision – Angle of 2nd impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____

1) In relation to the back of your head, was your headrest set: **Low** / **Middle** / **High**

2) Were you surprised by the impact? **Yes** / **No** If "NO", how did you brace? **With Hands** / **With Feet**

3a) Where was your head facing at the time of impact? **Straight Ahead** / **Left** / **Right** / **Behind**

3b) Were you leaning forward at the time of impact? **Yes** / **No**

4) What type and year of vehicle were you in? _____

4a) What was the approximate speed of your vehicle when the accident occurred? _____ mph

5) What type and year of vehicle struck yours?_____

5b) What was the approximate speed of the other vehicle when the accident occurred? _____ mph

6) Were you wearing a seatbelt? **Yes** / **No** What type: **Lap Belt** / **Shoulder Belt** / **Both**

7) Did you feel pain immediately after the accident? **Yes** / **No** Were you rendered unconscious as a result of the accident? **Yes / No**

Did you strike anything in the vehicle at the time of impact? **Yes** / **No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other	

Did your seat break or bend? Yes / **No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy** / **Dazed** / **Weak** / **Upset Disoriented** / **Nervous** / **Nauseous Other**: _____

Police and Ambulance:

Was the accident reported to the police? **Yes** / **No** Were traffic citations issued? **Yes** / **No** If "YES", to whom? _____

Did you go to the hospital **Yes** / **No** If "YES", when? _____If "YES", how did you get there? **Ambulance** / **Police Car** / **Private Transportation**

Were you admitted? **Yes** / **No** If "YES", how long? _____

Name of Hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply) **None** / **X-rays** / **Pain Medication** / **Stitches / Muscle Relaxants** / **Bandaged** / **Cervical Collar**

Physical Therapy / **Instructed Regarding Concussion** / **Instructed Regarding Sprains & Strains** / **Instructed to Call an Orthopedist** /

Instructed to Call a Private Physician / **Referred to This Office** / **Other**: _____

What other doctor have you seen as a result of this injury? _____

Do you have difficulty in excessive: **Standing** / **Walking** / **Riding** / **Bending** / **Twisting** Do you have difficulty in excessive lifting:**Light** / **Moderate** / **Heavy** / **Repetitive** Symptoms other than above: _____

Name: _____ Date: _____

Duties Under Duress & Loss of Enjoyment Summary

Complete the following summary as it relates to your lifestyle, living and work duties and how the injury(s) are affecting your performance. List the day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. Include those duties/responsibilities which require that you reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your performance.

Work	**Reason for the difficulty**	**Duration**
Job Description: _____		
↑Lifting	Increased Pain	_____
↑Bending	Increased Pain	_____
↑Sitting	Increased Pain	_____
↑Walking	Increased Pain	_____
↑Computer Duties	Increased Pain	_____
Other: _____	Increased Pain	_____

Studies/School	**Reason for the difficulty**	**Duration**
↑Lifting	Increased Pain	_____
↑Bending	Increased Pain	_____
↑Sitting	Increased Pain	_____
↑Walking	Increased Pain	_____
↑Computer Duties	Increased Pain	_____
↑Studying	Increased Pain	_____
Other: _____	Increased Pain	_____

Domestic Duties	**Reason for the difficulty**	**Duration**
↑Vacuuming	Increased Pain	_____
↑Taking Care of Kids	Increased Anxiety	_____
↑Cleaning	Increased Pain	_____
↑Preparing Meals	Increased Pain	_____
Other: _____	Increased Pain	_____

Household Duties	**Reason for the difficulty**	**Duration**
↑Yardwork	Increased Pain	_____
↑Transportation	Increased Anxiety	_____
↑Shopping	Increased Pain	_____
↑Taking Out Trash	Increased Pain	_____
Other: _____	Increased Pain	_____

Sports	**Reason for the difficulty**	**Duration**
↑Social	_____	_____
↑Competitive	_____	_____
↑Regional	_____	_____
Other:	_____	_____

Name: _____ Date: _____

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Joseph H. Lones, III DC
10102 North Lamar Bld.
Austin, TX 78753

HIPAA NOTICE OF PRIVACY PRACTICES

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 describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our 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, pay your health care bills, to support the operations 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 health care 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 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, marketing, and fund raising activities, and conduction 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 included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you 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.

_____ _____
Printed Name Date

Signature _____

North Lamar Chiropracatic Center___

(512) 835-1955
(512) 835-4424 (Fax)
North LamarChiropractic@gmail.com

Joseph H. Lones, III DC
10102 North Lamar Bld.
Austin, TX 78753

Informed Consent Document

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.
The primary treatment used by doctors of chiropractic is spinal manipulative therapy, I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
___ spinal manipulative therapy ___ palpation ___ vital signs ___ range of motion testing ___ orthopedic testing ___ basic neurological testing ___ muscle strength testing ___ postural analysis testing ___ ultrasound ___ hot/cold therapy ___ EMS ___ radiographic studies ___ traction _____ Other (please explain)
Initials: _____ Patient should initial here indicating all procedures are consenting to, and **SCRATCH OUT** all procedures **NOT CONSENTING** to.

The material risks inherent in chiropractic adjustment
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.
Other treatment options for your condition may include:
- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)
I hereby request and authorize Joseph H Lones III, DC (AKA North Lamar Chiropractic Center) to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter:_____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.
As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

[ ] I have read or **[]** have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Joseph H Lones III, DC and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Print Patient's Name: _____

Signature: _____

Date: _____

Signature (Parent or Guardian (if a minor): _____

Doctor's Name: Joseph H. Lones III, DC

Signature: _____

Date: _____

Add here

Check list form

Add here

functional disability index form.