CONFIDENTIAL PATIENT INFORMATION

Date _____

Home Phone (____) _____

Name _____ Work Phone (____) _____

Address _____ Cell Phone (____) _____

City _____ Zip Code _____ Email _____

Age _____ Birth Date _____ M F Marital: M S W D How Many Children? _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Spouse (or Parent if Minor) _____ Work Phone _____

Employer _____ Address _____

Emergency Contact _____ Address _____ Phone _____

Whom may we thank for referring you? _____

Purpose of this appointment/current problem _____

Other doctors seen for this condition _____

Is the condition due to injury or sickness arising out of employment or auto accident? _____

Date symptoms appeared or accident happened: _____ Days lost from work? ( ) YES ( ) NO

Do you suffer from:

1. Dizziness _____ 5. Neck Pain _____ 9. Shoulder/Arm Pain _____ 13. Nervousness _____
2. Back Pain _____ 6. Arthritis _____ 10. Hip/Leg Pain _____ 14. Sinus Trouble _____
3. Heart Trouble _____ 7. Headaches _____ 11. Urinary Problems _____ 15. Male/Female Troubles _____
4. Diabetes _____ 8. Numbness _____ 12. Digestive Disorders _____ 16. Cancer _____

Do you smoke? ( ) NO ( ) YES _____ packs/day Do you have a pacemaker? ( ) YES ( ) NO

Have you been treated for any health condition by a physician in the last year: ( ) YES ( ) NO

Describe _____

Date of last physical examination _____ List surgeries _____

Serious illnesses _____ Medications _____

What vitamins are you taking? _____

If female, are you taking birth control pills? ( )YES ( ) NO Pregnant? ( ) YES ( ) NO

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION: By signing this form, you are granting consent to ACC-Georgetown to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

_____

Patient Signature (or Guardian Signature Authorizing Care) Date

Insurance Company _____ Insured _____ SS# _____

1. What is your major symptom? _____

2. When was the first time you noticed this problem? _____

   How did it occur? _____

   Has it become worse recently? _____ If yes, when and how? _____

3. How frequent is the condition? _____

   How long does it last? _____

4. Have you ever had the same or a similar condition: ( ) Yes ( ) No

   If yes, when and describe: _____

5. Are there any conditions or symptoms you have that may be related to your major symptom?

   _____

6. If pain is involved, is it – sharp, dull, throbbing, stabbing, aching, burning, tingling, shooting?

   (other) _____

7. Is there anything you can do which seems to provide relief? _____

   _____

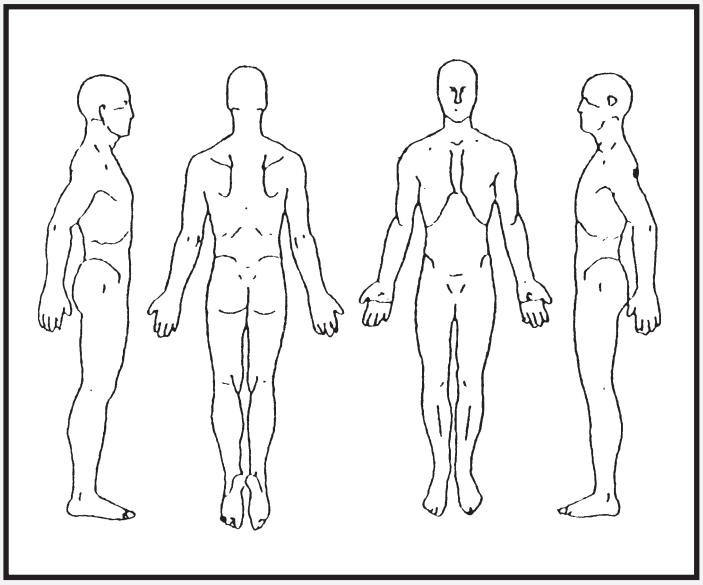
8. What makes the problem worse? _____

9. List accidents, illness, surgeries, or broken bones. _____

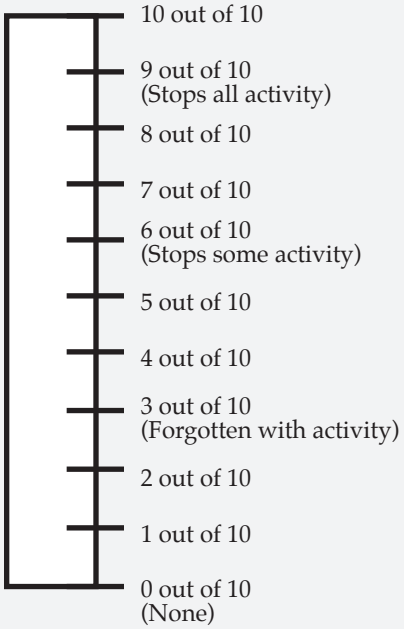
   _____

IMPORTANT!

10. **Please Mark Your Symptom Areas**



11. **Rate the Severity of Your Condition**



ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
Private and Group Accident and Health Insurance

Patient Name _____

Employer _____

Claim/Group _____

SSN/ID# _____

I hereby instruct and direct the _____ Insurance Company to pay by check, made out to and mailed directly to:

ACC-Georgetown, LLC
3007 Dawn Drive, Suite 101
Georgetown, Texas 78628

OR

If my current policy prohibits direct payment to my doctor, then I hereby instruct and direct you to make the check payable to me, and mail it to:

ACC-Georgetown, LLC
3007 Dawn Drive, Suite 101
Georgetown, Texas 78628

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for processional services rendered. THIS IS A DIRECT ASSIGMENT OF MY RIGHTS, TITLES INTERESTS, AND BENEFITS TO THIS OFFICE UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in current manner, and balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

A PHOTOCOPY OF THIS ASSIGMENT SHALL BE CONSIDERED AS EFFECTIFFVE AND VALID AS THE ORIGINAL.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim.

Dated in Williamson County, this _____ day of _____, 20_____

Signature of Policy Holder and or Claimant _____

Signature of Witness _____

STEP 1.

Welcome! We are excited to serve your health care needs in an effective and efficient manner. Please select times that would work best for your follow-up visits.
Please circle <u>all</u> that might apply for any <u>3 days</u>:

Monday: Early Morning Late Morning
Early AfternoonLate Afternoon

Tuesday: Early Morning Late Morning
Early AfternoonLate Afternoon

Wed: Early AfternoonLate Afternoon

Thursday: Early Morning Late Morning
Early AfternoonLate Afternoon

Clinical Hours are M, T, Th 9:00 am to 11:30 am and 2:00 pm to 5:40 pm
Wed 2:00 pm to 5:40 pm

STEP 2.

When it comes to your health, we believe medical doctors and chiropractors should work together for YOUR benefit.

I agree! I give you permission to inform my personal medical doctor of my condition, treatment and expected / actual response to care at this office.

_____ _____
Signature of Patient or Guardian Date

_____
Please print your name

Your Medical Doctor _____
Doctor's Address _____
Doctor's Phone _____