

# 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

## Pediatric History

Please Print Clearly and Fill in Completely.

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

As a parent, would like to receive our monthly newsletter by e-mail? **E-mail** \_\_\_\_\_

✓ **Please Check** Sex: Male [ ] Female [ ] Right Handed [ ] Left Handed [ ]

Emergency Contact Name and Phone Number \_\_\_\_\_

Name of Secondary Insurance Company (if any) \_\_\_\_\_

### Health History:

Give reason for seeking chiropractic care: \_\_\_\_\_

Describe any health problems, including how long they've had them: \_\_\_\_\_

Is your child under the care of any other doctor i.e. pediatrician, allergist etc.? Yes [ ] No [ ]

If Yes, name of doctor and the conditions being treated for: \_\_\_\_\_

May we update your child's pediatrician with his/her condition and treatment? Yes [ ] No [ ]

List any current medications: \_\_\_\_\_

List any vitamins or supplements: \_\_\_\_\_

List any past surgeries & dates: \_\_\_\_\_

List any past accidents & dates: \_\_\_\_\_

List any x-rays in the past 2 years: \_\_\_\_\_

### Personal & Family History:

Parent's health status: \_\_\_\_\_

Other Sibling's ages and health status: \_\_\_\_\_

### Chiropractic History:

Has your child 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 was your child under care?: \_\_\_\_\_

Are other family members under chiropractic care? Yes [ ] No [ ] Who?

### Wellness Commitment

At Optimum Chiropractic & Wellness Center we are dedicated toward achieving the goal of total lasting health for our members. To better help your child achieve this, we need to understand your commitment towards your child being healthy. We do not ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness for your child.

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

Where did you hear about our clinic or who referred you?

\_\_\_\_\_

Please Fill in Below

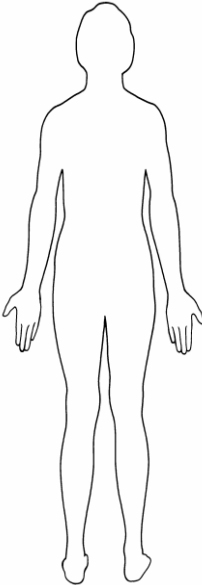
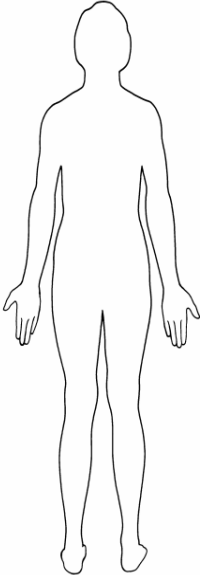
**Please Check** ✓

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			
Colic			
Ear Infections			
Allergies			
Asthma			
Cancer			
Bed Wetting			
Diabetes			
Hypoglycemia			
Digestive Problems			
Urinary Problems			
Skin Conditions			
Bowel/Bladder Problems			
Other:			

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

Front

Back

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

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 (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 Child's Care.**

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*Thank you for being complete and thorough.*

**CONSENT TO TREAT A MINOR CHILD (if applicable)**  
 I, the undersigned, parent or legal guardian for the above named child, hereby authorize the doctor of Optimum Chiropractic & Wellness Center, or whomever they delegate, to examine, and/or treat the above named child, within the scope of Chiropractic examination and treatment guidelines. I have had any questions or concerns addressed to my satisfaction.

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**Doctor's Use Only**

Patient Accepted

Yes   
  No   
  Referred

## 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.)

<b>Collision</b>			
<b>SIDE</b>	<b>FRONT</b>	<b>REAR</b>	<b>SPEED</b>
	X		20 mph

**Example: Year: 2000**

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

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

## **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 for the welfare of my optimum health and wellness.

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*Patient Signature*

*Date*

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*Guardian Signature Authorizing Care*

*Date*

*Parent or*

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. 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. However, I fully understand and agree that all services rendered me are charged directly to me and that I am personal responsible for payment. 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.

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*Patient/Parent or Guardian Signature*

*Date*

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## **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.

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*Patient/Parent or Guardian Signature*

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*Date*

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### **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.**

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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).

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## 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 these revisions, 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 in writing. 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 your chiropractor outlining your concerns at:

Optimum Chiropractic & Wellness Center  
6224 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 filing a complaint.

### Contact Person

The name and address of the person you may contact for further information concerning your privacy practices is **Dr. Colin Tkachuk 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.

PATIENT NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_