

# 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

Please Print Clearly and Fill in Completely.

Print Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

St. Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Would you like to receive our monthly wellness e-newsletter? \_\_\_\_\_ E-mail \_\_\_\_\_

**Please Check** Sex: Male ☐ Female ☐ Right Handed ☐ Left Handed ☐ Married ☐ Single ☐

Emergency Contact Name and Phone number \_\_\_\_\_

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

Name of Primary Insurance Company \_\_\_\_\_

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

## Health History:

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

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

Are you currently under the care of another physician? If so, for what? \_\_\_\_\_

Name & Number of Primary Care Physician \_\_\_\_\_

May we update your physician with your progress here in the office? Yes ☐ No ☐

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

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

List any Allergies: \_\_\_\_\_

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

List any x-rays/scans you've had in the past 2 years: \_\_\_\_\_

## Personal & Family History:

Your Occupation: \_\_\_\_\_ Work Duties: \_\_\_\_\_

Spouse's name and health status: \_\_\_\_\_

Children's names and ages: \_\_\_\_\_

## Chiropractic History:

Have you 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 were you under care?: \_\_\_\_\_

Are other family members under chiropractic care? Yes ☐ No ☐ Who? \_\_\_\_\_

## Wellness Commitment

As a full spectrum Chiropractic Office, we focus on your ability to be healthy and active. Our goals are, first, to address the issues that brought you here & second, to offer you the opportunity of improved health potential & wellness services for you and your family in the future.

What results do you hope to obtain from care in our office? (CHECK ALL THAT APPLY)

- ☐ RELIEF- Relief from pain and symptoms to be more comfortable.
- ☐ CORRECTION- Going beyond relief from pain and correcting the problem at its source.
- ☐ WELLNESS- To become healthier, focusing on vitality & wellness.

**Females:** Please check One. Is there a possibility of you being pregnant? Yes ☐ No ☐

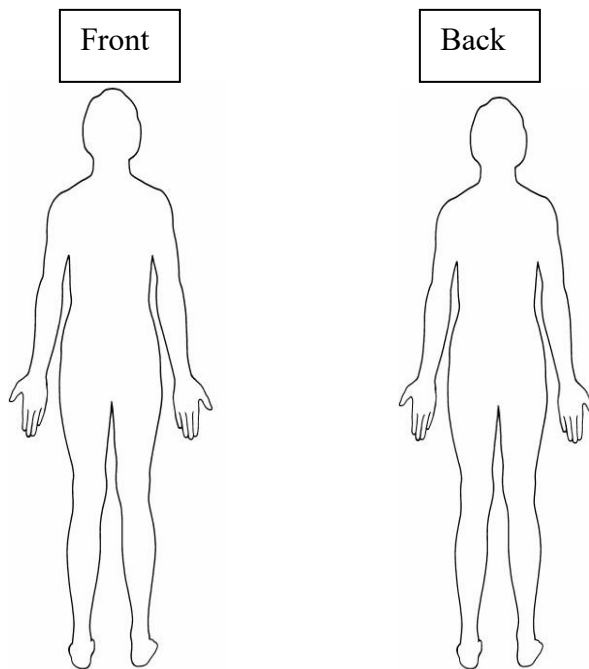
If you have had the following, or if you suffer

From the following, **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                         |       |                           |       |
| Chest Pains                   |       |                           |       |
| Female Problems               |       |                           |       |
| Allergies                     |       |                           |       |
| Asthma                        |       |                           |       |
| Cancer                        |       |                           |       |
| Osteoporosis                  |       |                           |       |
| Diabetes                      |       |                           |       |
| Hypoglycemia                  |       |                           |       |
| Digestive Problems            |       |                           |       |
| Urinary Problems              |       |                           |       |
| Skin Conditions               |       |                           |       |
| Bowel/Bladder Problems        |       |                           |       |
| Other:                        |       |                           |       |

Please Fill in Below

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



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

**Headaches** (None) 0-1-2-3-4-5-6-7-8-9-10 (Severe)

**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 Pain** (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 Care.**

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*Thank you for being complete and thorough.*

**Your Signature Below Please**

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**Date:** \_\_\_\_\_

**Doctor's Use Only**

Patient Accepted

☐ Yes ☐ No ☐ Referred

**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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*Parent or Guardian Signature Authorizing Care*

*Date*

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 personally 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.

*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 \$20 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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Signature

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Date

**Dr. Colin Tkachuk**  
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Colleyville, Texas 76034  
Telephone 817-481-9339  
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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 an 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.

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

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

## **Notice Of Non-Coverage For Medicare Services**

It is important that you understand that Medicare does NOT pay for all chiropractic services.

**Medicare only pays for chiropractic care that they consider medically reasonable and necessary.**

**Medicare will not pay for certain services, including but not limited to:**

1. Initial or Re-exams;
2. X-rays;
3. Therapies/Rehab;
4. Nutritional Supplements;
5. Any tests performed in our office;
6. Maintenance care.

### **Payment of services:**

You will be required to pay the balance of your yearly deductible, co-payment and 100% of all non-covered services.

**Supplemental insurance may cover services that Medicare does not cover.** If you are unable to pay any portion of your deductible or co-payments, please let us know immediately so that we can work out financial arrangements with you.

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Patient Name

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Patient Signature

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Date