HOOGEVEEN
HEALTH CENTER
CHIROPRACTIC • NEUROLOGY • NUTRITION

CONFIDENTIAL PATIENT INFORMATION

Date__________ Name________________________ Sex____ Marital Status_________ DOB_________ Age_______

Address____ City_________________________ State____________

Zip_____________ Social Security________________________ Email_____________________________________

Home Phone____________________ Cell Phone __________________________ Work Phone____________

Occupation________________________ Company Name________________________ Location________________

Spouse Name__________________ Children Name/Age____

Emergency Contact (Not Spouse)____________________________________ Phone Number____________________

Who Referred You To This Clinic____

Is Your Visit Due To An Accident? Y N (If yes, please see receptionist for injury report)

Your Present Complaint____

Briefly Describe Your Symptoms____

Describe Any Operations You've Had & Dates____

____

Have You Been Treated By A Physician For Any Health Condition In The Last Year? Y N

Describe Condition____ Date Of Last Physical Exam____________

List All Medications Being Taken____

List Any Allergies____

Are You Pregnant? Y N Date Of Last Menstrual Period__________________________________

Personal Medical History (Please Circle The Following Relevant To Your Medical History)

Cancer	*Muscular Dystrophy*	*Rheumatic Fever*	*Digestive Disorders*	*Tuberculosis*	*Convulsions*
Polio	*Multiple Sclerosis*	*Scarlet Fever*	*Sinus Trouble*	*Concussion*	*Backaches*
Diabetes	*Nervousness*	*Numbness*	*Heart Trouble*	*Hepatitis*	*Dizziness*
Asthma	*Venereal Disease*	*High Cholesterol*	*High Blood Pressure*	*HIV*	*Hepatitis C*

Do You Have Insurance? Y N Company_________________________ ID Number________________________

Group Number______________________ Primary Holder______________________________ DOB_______________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company. I permit this office to endorse co-issued remittances for the conveyance of credit to my account, however, I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable unless prior arrangements are made. I hereby authorize The Hoogeveen Health Center, PA, and whomever he may designate as his assistants, to administer treatment as he deems necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above is true and correct.

Patient's (Parent or Gaurdian's) Signature____

PAIN DRAWING

Patient Name____ Date__________________________

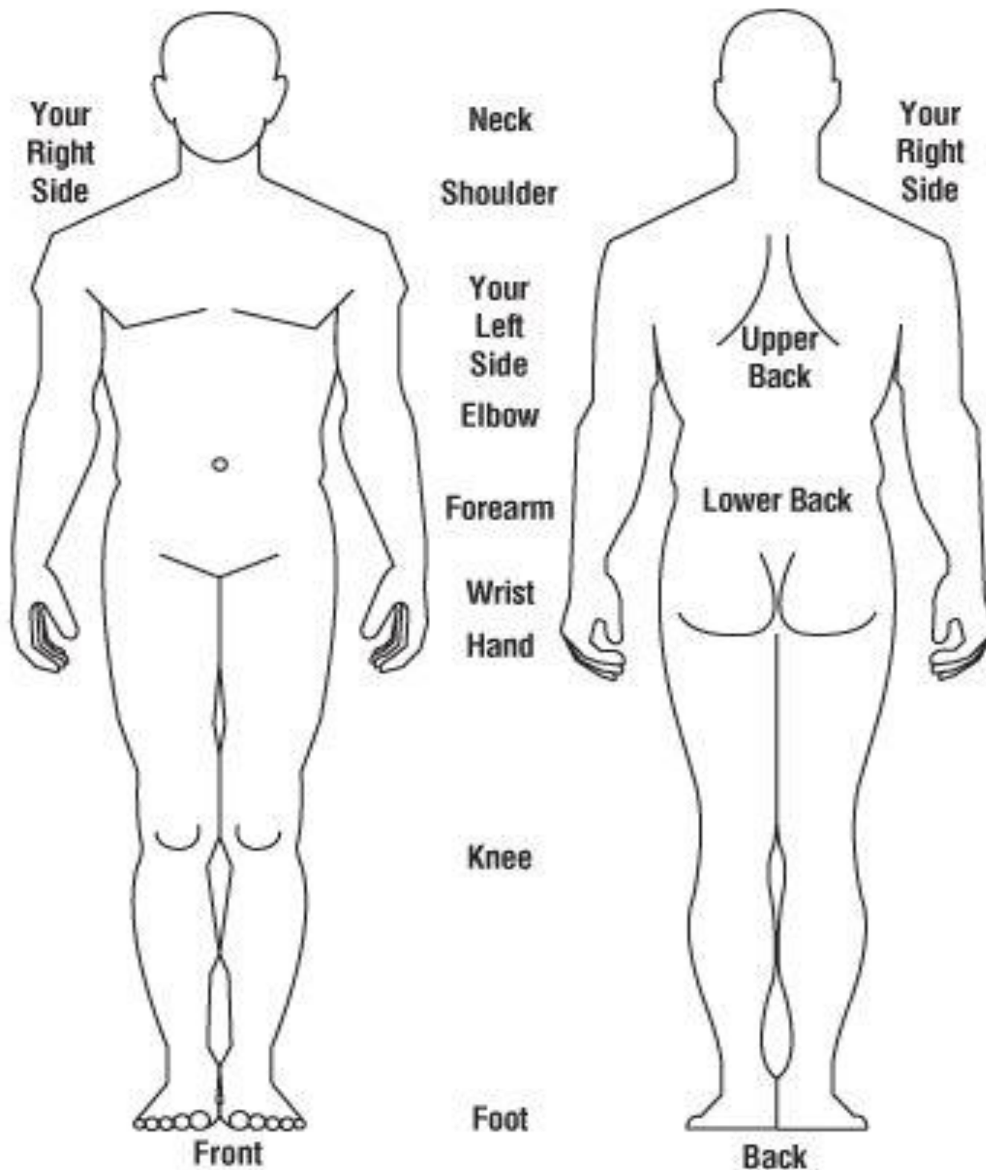
Attending Doctor____

Do you suffer from: Headaches Neck Pain Back Pain Fatigue Numbness Tingling

Using the *letters below*, mark the areas on the body where you feel the described sensations. Include *all* affected areas.

Rate your pain: 1=subtle, 10=intense 1 2 3 4 5 6 7 8 9 10

A= Ache **B**= Burning **N**= Numbness **P**= Pins & Needles **S**= Stabbing



Patient Signature____

5850 Town & Country Blvd. Suite 1301 – Frisco, TX 75034 – P: 972.335.7994 F: 972.335.7250

CONSENT TO CHIROPRACTIC TREATMENT

A **vertebral subluxation** is a misalignment or distortion of your spinal column or related structures that can affect your brain, nervous system and overall body function. **Subluxations can cause disease** or loss of proper body function.

We do not medically diagnose or treat any disease, symptom or condition. No matter what condition(s) you may have been diagnosed with and no matter what symptom(s) your body is expressing**, you always need a body free from subluxations.**

If during the course of your chiropractic spinal examination, we encounter unusual findings, **we will let you know of them.** You may then decide whether you wish to investigate further and discuss your healthcare options with other healthcare professionals. **We will work with you and your goals.**

To summarize: the purpose of chiropractic care is not to treat diseases or conditions, nor to suppress symptoms, not to perform surgery, but rather to make your body function better by **removing spinal nerve stress (subluxations).** Therefore we do not prescribe surgery or medications. If you wish to decrease or stop medications you should discuss that with your MD.

I hereby request and consent to the performance of chiropractic care and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or the patient named below for which am legally responsible) which are recommended by Dr. George Hoogeveen.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications may include but are not limited to fracture ,disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of the manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications that may include stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctors to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts know, are in my best interest.

I have had the opportunity to discuss with the doctor and/or with the office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results of my treatment vary from patient to patient and with the severity of condition and are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of chiropractic adjustments and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

______________________________	______________________________	______________________________
Printed Name	Signature /Guardian	Date

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ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns Dr. George Hoogeveen D.C., of Hoogeveen Health & Wellness the following rights, power and authority.

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, insurance adjuster, or other doctors for the purpose of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against my insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by the insurance company, in accordance with Article 21.55 of the Texas Insurance Code or other applicable insurance or state statue. I, as the patient and/or responsible part, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution if such claims for benefits upon request exist.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for the treatment rendered by Dr. George Hoogeveen D.C., you are hereby tendered demand to pay in full the bill for services rendered by Dr. George Hoogeveen D.C. within 60 days following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/We personally owe which are not payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court costs, and interest from judgment, upon violation.

STATUTE OF LIMITATIONS: I waive my rights to claim my Statute of Limitations regarding claims for services rendered or to be rendered by Dr. George Hoogeveen D.C., in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant Dr. George Hoogeveen D.C. of Hoogeveen Health & Wellness the power to endorse my name upon any checks, drafts or other negotiable instrument representing payment from any insurance company for treatment and health care rendered by Dr. George Hoogeveen D.C.. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account and forwarded to my/our address upon request in writing to Dr. George Hoogeveen and the offices of Hoogeveen Health Center.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by Dr. George Hoogeveen D.C. of Hoogeveen Health Center, the doctor has full and complete rights to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time.

A photocopy of this instrument shall serve as original.

______________________	______________________	______________________
Printed Name	Signature /Guardian	Date

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HIPPA Notice of Privacy Practices

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

In the course of your care as a patient at Hoogeveen Health Center we may disclose personal and health related information about you the following ways:

***** *Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer the information for further diagnosis, assessment or treatment.*
***** *Your health care records as well as billing records may be disclosed to another party, such as an insurance carrier, clearinghouse ,an HMO, A PPO, or your employer (if they are or may be responsible for the payment of your services).*
***** *Your name, address, phone number and your health care records may be used to contact you regarding your appointment, to provide information about alternatives to your present care or other health related information that may be of interest to you.*

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for theses purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances.

***If we are providing health care services to you based on the orders of another health care provider.**
***If we provide health care services to you in an emergency.**
***If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.**
***If there are substantial barriers to communication with you, but In our professional judgment we believe that you intend for us to provide care.**
***If we are ordered by the courts or other appropriate agencies.**
Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also call, leave a message on your answering machine, mail or email information to you regarding your health care or about the status of your account. If you would like the information indifferent form, please advise us as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subjected to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint or you would like further information regarding our privacy notice, policy, and practices or any aspect of our privacy activities you should direct your questions or complaints to Dr. Hoogeveen or one of the staff members.

This notice, is effective as of the date signed and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I agree to this notice and may request a copy

____________________	__________________________	____________________
Printed Name	**Signature /Guardian**	**Date**

RELEASE OF RECORDS

Patient Name: ______________________________

Date of Birth: _______________________________

Social Security: _____________________________

To:
____
____

Telephone: _______________________ **Fax:** ___________________________

I hereby authorize you to release to Dr. George Hoogeveen of Hoogeveen Health Center any and all information including the diagnosis and recourse of any examination or treatment rendered to me at your facility. This includes the actual radiographic films as well as reports and all lab work.

___________________________	_____________________________	___________________
Printed Name	**Signature /Guardian**	**Date**

Medical Massage
“Bringing Relaxation to Your Muscles”

Massage Client Waiver Form

In the event that Dr. Hoogeveen recommends massage or if you choose to have massage therapy rendered here in this office, please take a moment to read and initial all of the following statements:

If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session. ____

By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork. ____

I understand that should I cancel an appointment less than 24 hours before the scheduled time or “no show” an appointment, I am subject to a fee of 50% of the services scheduled. ____

Additional Information

- Tips are greatly appreciated, but not mandatory.
- Please be on time with your appointments as the massage therapists’ schedules book up quickly and appointments are scheduled back to back. If you are late to an appointment, you can still be seen, but not for the full amount of time. However, you will still be charged for the full amount that was booked originally.

I have received the policy statement, and have read and agree to the policies therein.

Client Name: ____________________________________

Client Signature: _________________________________

Date: _______________

Therapist Signature: _______________________________

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