IN BALANCE
CHIROPRACTIC & ACUPUNCTURE

9800 N Lamar Blvd Suite 140
Austin, TX 78753
p. 512.873.9355
f. 512.873.8858
www.inbalanceatx.com
info@inbalanceatx.com

NEW PATIENT APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist. **PLEASE PRINT.**

Date: _____

Name _____Home Phone _____ Cell Phone _____
Address _____City _____State _____ Zip _____
Email Address_____

Age _____ Birth date _____Height_____ Weight_____ Lbs.

Marital Status: S M W D Number of Children: _____

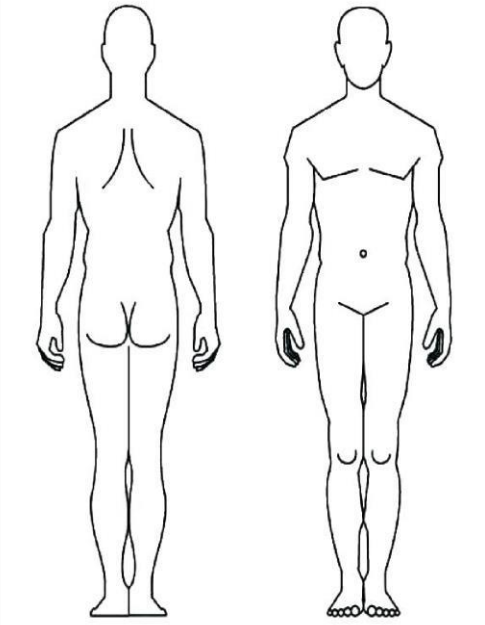
Would you like to receive reminders by (check all that apply):

☐Text Reminder- Cell Phone ☐Call Reminder

Insurance Company _____ Your Social Security # _____
Your Employer _____ Occupation _____ Years at Job _____
Employer Address _____ City _____ State _____ Zip _____
Are you the primary policy holder? Yes ____ No ____ If not, please complete the following
Name of Primary policy Holder _____ Birth date _____
Employed By_____ Employer Address _____
City _____State _____ Zip _____

Is your Condition due to an accident? Yes_____ No_____ Date of Accident: _____/_____/_____
Type of Accident: Auto_____ Work/On Job_____ At Home_____ Other_____

If you are in pain, please mark the exact location of your pain on the diagram.



MAJOR COMPLAINTS:

Please list any symptoms you are experiencing.
Describe the type and frequency of your pain. For example: dull, sharp, constant, off and on, when standing, when sitting, etc.

_____
_____
_____
_____
_____
_____
_____
_____
_____

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List any activities, hobbies, or interests that you are unable to enjoy because of your pain.:

_____

_____

I/we agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

Patient Signature _____ Date _____

Or Guardian Signature _____ Date _____

Confidential Patient Case History

Dr. Buffy De Luna
9800 North Lamar Blvd.
Ste.140, Austin, TX 78753
512-873-9355

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ Date _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL F – FREQUENT C-CONSTANT

O F C

☐☐ ☐ Allergy
☐☐ ☐ Convulsions
☐☐ ☐ Dizziness
☐☐ ☐ Fainting
☐☐ ☐ Fatigue
☐☐ ☐ Headache
☐☐ ☐ Loss of sleep
☐☐ ☐ Loss of weight
☐☐☐ Nervousness/anxiety
☐☐☐ Depression
☐☐ ☐ Neuralgia
☐☐ ☐ Numbness
☐☐ ☐ Tremors

MUSCLE & JOINT

☐☐ ☐ Bursitis
☐☐ ☐ Foot trouble
☐☐ ☐ Hernia
☐☐ ☐ Low back pain
☐☐ ☐ Neck pain or stiffness
☐☐ ☐ Pain between shoulders

GASTROINTESTINAL

O F C

☐☐ ☐ Colitis
☐☐ ☐ Constipation
☐☐ ☐ Diarrhea
☐☐ ☐ Difficult digestion
☐☐ ☐ Gall bladder trouble
☐☐ ☐ Hemorrhoids
☐☐ ☐ Pain over stomach

EYES, EARS, NOSE, THROAT

☐☐ ☐ Enlarged glands
☐☐ ☐ Enlarged thyroid
☐☐ ☐ Nosebleeds
☐☐ ☐ Sinus infection
☐☐ ☐ Sore throat
☐☐ ☐ Tonsillitis

CARDIO-VASCULAR

O F C

☐☐ ☐ Hardening of arteries
☐☐ ☐ Pain over heart
☐☐ ☐ Poor circulation

RESPIRATORY

☐☐ ☐ Chest pain
☐☐ ☐ Chronic cough
☐☐ ☐ Difficult breathing
☐☐ ☐ Wheezing

SKIN

☐☐ ☐ Boils
☐☐ ☐ Bruise easily
☐☐ ☐ Dryness
☐☐ ☐ Hives or allergy
☐☐ ☐ Itching
☐☐ ☐ Skin eruptions (rash)
☐☐ ☐ Varicose veins

FOR WOMEN ONLY

O F C

☐☐ ☐ Cramps
☐☐ ☐ Menopausal symptoms
Are you pregnant? YES☐ NO☐

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Arthritis
☐ Cancer
☐ COPD
☐ Cold Sores
☐ High Blood Pressure
☐ Disc Injury
☐ Diabetes
☐ Eczema
☐ Emphysema
☐ Epilepsy
☐ Fibromyalgia
☐ Heart Disease
☐ Pneumonia
☐ Miscarriage
☐ Multiple Sclerosis
☐ Low Blood Pressure
☐ Polio
☐ Seizures
☐ Stroke
☐ Tuberculosis
☐ Ulcers
☐ Rheumatoid Arthritis
☐ Osteopenia
☐ Osteoporosis

Do you have any other health problems? ☐ YES ☐ NO If the so, please list them below.

_____

_____

Confidential Patient Case History

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List surgical operations and dates:

Surgery_____ Date:_____ Surgery_____ Date:_____

Surgery_____ Date:_____ Surgery_____ Date:_____

Medications currently taking:

_____

Age of mattress: _____ ☐ Comfortable ☐ Uncomfortable

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Arch support

Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Describe: _____

Have you ever had/or have any mental or emotional disorders? ☐ Yes ☐ No If so, what type? _____

Have others in your family had such disorders? ☐ Yes ☐ No

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for anything other than surgery?	☐	☐	_____

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Physical examination	☐	☐	☐	☐

HABITS	**Heavy**	**Moderate**	**Light**	**None**
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐

IN CASE OF EMERGENCY: NAME _____Phone_____

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Cancellation Policy

In Balance Chiropractic & Acupuncture has instituted the following policies to better serve our patients.

Please provide at least 24 hours for canceling and rescheduling of appointments so that those who are waiting for an appointment can be scheduled. Cancellations with less than a 24-hour notice will result in a $30.00 charge. No Show/failure to cancel will also result in a $30.00 charge. In Balance Chiropractic & Acupuncture always attempts to confirm all appointments the day before the scheduled appointment. If you need to respond after hours to notify us of a cancellation or to confirm your appointment, feel free to leave a message.

Due to the policy as stated above, the cancellation fee should be paid before another appointment is made with our office. Please understand that we are implementing this policy in order to better serve and accommodate all of our patients, who are seeking appointments for chiropractic care.

I have read and understand the Appointment Cancellation and Rescheduling Policy.

_____ _____

Patient Name Date:

_____

Patient Signature

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OFFICE FINANCIAL POLICY

SELF-PAY

1. All patients are on a self-pay basis until their respective insurance coverage and deductible are be verified by our staff.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations provided that we have prior certification from your insurance company.
2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment for each visit.
3. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information to this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any overpayment exists after all insurance billing has been done, we will issue you an overpayment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.
5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.
6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services, and you will be expected to pay such charges on a timely basis.
7. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.
8. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full expected immediately regardless of any claims submitted.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient Signature Date

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Ph 512.873.9355
Fax 512.873.8858

INFORMED CONSENT TO TREAT

Chiropractic treatment: Is a health care discipline and profession that emphasizes diagnosis, treatment and prevention of mechanical disorders of the musculoskeletal system, especially the spine, under the hypothesis that these disorders affect general health via the nervous system. The main chiropractic treatment technique involves manual therapy, including manipulation of the spine, other joints, and soft tissues. The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Treatment may also include ancillary procedures, but not limited to, hot and cold packs, electric muscle stimulation, therapeutic ultrasound, and non-surgical spinal decompression therapy.

Possible risk factors: Complications are possible following chiropractic manipulation. The risks of complications due to chiropractic treatment have been described as "rare," about as often as complications are seen from taking a single aspirin tablet. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be further reduced by screening procedures. Other complications could include muscular strain, ligamentous strain, fractures of bones, dislocation of joints, or injury to intervertebral discs, nerves, or spinal cord. A small percentage of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. The probability of adverse reaction due to ancillary procedures is considered "rare." Delay of treatment allows the formation of scar tissue, adhesions, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycle. It is quite probable that delay in treatment will complicate the condition and make future rehabilitation more difficult.

This is to acknowledge that I have been informed and understand the above and following:

- This form has been explained to me and I fully understand this consent to treatment and agree to its contents.
- I have fully evaluated the risks and benefits of undergoing treatment.
- I have been informed that I have the right to refuse any form of treatment.
- I have freely decided to undergo recommended treatment and herby give my full consent to treatment.
- I have read and understood the explanation above regarding chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction.
- That this consent form will be valid and remain in effect as long as I receive chiropractic treatment at In Balance Chiropractic and Acupuncture.
- I am at liberty to seek chiropractic care from a chiropractic physician or other health care provider qualified to practice in the state of Texas.
- Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future receive from another licensed health care provider.

Patient Name_____ **Patient Signature**_____ **Date**_____

Name of Legal Guardian _____

Signature of Legal Guardian_____ **Date**_____

Please complete the following if the patient is a minor or is unable to consent:
Patient is unable to consent because_____

Patient is a minor and is ____years of age.

Patients can understand the language and meaning of this document as printed.
YES____ NO___
Patient is mentally oriented as to current time, today's date, and physical location.

Doctor's Signature_____ Date:_____Time_____ AM/PM

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AUTHORIZATION, ASSIGNMENT & RELEASE FORM

In consideration of your undertaking to care for me, I agree to the following*:*

1) I agree that health and accident insurance policies are an arrangement between the insurance carrier and the insured. Even though I authorize insurance carriers to assign benefits directly to In Balance Chiropractic and Acupuncture LLC, I clearly understand and agree that all services rendered are charged directly to me and that by signing below I accept personal responsibility for payment of said services
2) You are hereby authorized to release any information you deem appropriate concerning my physical condition for reimbursement of charges incurred.
3) I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case and/or by any insurance company obligated to me or to you based in whole or in part upon the charges made for your services.
4) Patient agrees, that in the event patient receives any checks, drafts or other payment subject to this agreement, patient agrees to act as fiduciary agent to In Balance Chiropractic and acupuncture LLC by **Immediately** delivering said payment to In Balance Chiropractic and Acupuncture LLC. Additionally, I hereby assign Power of Attorney to In Balance Chiropractic and Acupuncture LLC and its assignee/sign my name on any and all checks and payments for my indebtedness to In Balance Chiropractic and Acupuncture LLC.
5) In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the names) of which is believed to be correctly set forth under pertinent data and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance company's proceeds, whether it be all or part of what is due, I personally owe and will agree to pay you.
6) I understand that if In Balance Chiropractic and Acupuncture LLC must employ collection counsel and/or legal counsel to obtain payment for my debt, that I will be responsible for any and all collection fees, interest fees and reasonable attorney's fees. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in the state of Texas.
7) I agree In Balance Chiropractic and Acupuncture LLC has the right to call my home/cell or place of employment regarding an appointment or insurance issue.
8) I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
9) This Authorization and Assignment will be in full effect until revoked by both parties.

I have read or have had read to me the above consent. I have also have had an opportunity to ask questions about its content, and by signing below I agree to comply with all parts of this document. I, the undersigned patient and/or responsible party, state that all information provided on intake has been true and correct to the best if my knowledge. **A photocopy of this form shall be deemed as valid as the original.**

Date: _____ Patient Signature: _____

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Consent For Use and Disclosure of Health Information

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care info:

•We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for diagnosis, assessment, of treatment of your health condition.
•We may have to disclose your health information and billing records to another party if they are responsible for the payment of your services.
•We may need to use your health information within our practice for quality control or other operational purposes.
We have a more complete notice that provides detailed description of how your health information may be used or disclosed. You have the right to review that notice before signing this consent form (164.520). We reserve the right to change our privacy notices.

Your right to limit uses of disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclose of your health information, please let us know in writing. We are not required to agree with your restrictions, the restriction is binding on us.

Your right to revoke uses of disclosures: You may revoke your consent to us at any time, however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive you request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they need decide to consent any of your claims.

I have read the consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Patient Name _____ Patient Signature _____ Date _____

Doctor/Staff Signature _____ Date _____

I acknowledge that it is an invasion of my privacy to allow my spouse, or family member to enter the medical rooms during my visits, and I hereby give authorization to allow others to enter during my consultations/sessions.

Patient Signature _____ Date _____

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MEDICAL RECORDS REQUEST

Patient's Name: _____ Date: _____

Social Security #: _____ DOB: _____

Phone Number: _____

I hereby authorize you to release to In Balance Chiropractic and Acupuncture all medical records and information including the diagnosis and records of treatment or examination rendered to me.

Sensitive Information: I understand that this may include information relating to:

- Acquired Immunodeficiency Syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
- Behavioral health services, psychiatric care, mental health treatment
- Sexually transmitted diseases
- Diagnosis/treatment for alcohol and/or drug abuse
- Information for research purpose

Date: _____ **Patient/Insured Signature:** _____

Date: _____ **Staff Signature:** _____