PATIENT UPDATE FORM 2022

PATIENT NAME: _____

LAST **FIRST** **MIDDLE** **PREFERRED**

MAILING ADDRESS: _____

STREET/P.O. BOX **CITY** **STATE** **ZIP**

DOB: _____ **Height**_____'_____" **Weight**_____ **Osteoporosis: YES/NO**

CELL PHONE: (_____**)**_____ **EMAIL:** _____

OCCUPATION: _____ **WORK PHONE: (**_____**)**_____

LIST ANY SURGERIES IN THE LAST FIVE YEARS: _____

_____

INSURANCE: Policyholder's Name? : _____**DOB:** _____

Policy Holder's Address (if different from above):

_____

STREET/P.O. BOX **CITY** **STATE** **ZIP**

Relationship to patient: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Paul Graves,DC, PA all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also certify that the above information is true, correct and complete.

_____ _____

Patient/Guardian Signature **Date**

INFORMED CONSENT

Patient Name: _____

Please read this entire document prior to signing. Ask questions before you sign if there is anything that is unclear.

The primary treatment used by doctors of Chiropractic is the Chiropractic adjustment. We will use this procedure to treat you. We may use our hands or a mechanical instrument in such a way as to move your joints. That may cause and audible "pop," similar to popping your knuckles. You may feel a sense of movement.

As a part of the analysis, examination, and treatment, you are consenting to: Chiropractic adjustment, palpation, massage therapy, spinal decompression, intersegmental traction, vital signs, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, hot/cold therapy, EMS, radiographic studies.

Possible risks with chiropractic adjustments. As with any healthcare procedure, there are certain complications which may arise during chiropractic adjustments and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options may include: Self-administered, over-the-counter analgesics and rest, medical care and drugs such as anti-inflammatory, muscle relaxants and pain-killers, hospitalization or surgery. If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Consent to Treatment (Minor)

I hereby request and authorize Paul Graves, D.C. PA, (DBA- Graves Family Chiropractic) to perform diagnostic tests and render chiropractic adjustments and other treatment to myself, my minor child or minor I am legal guardian of. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at a doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of the spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name: _____ Date: _____

Signature: _____

Signature of Parent/Guardian (if a minor): _____

NOTICE OF PRIVACY PRACTICES

PAUL GRAVES D.C., PA (GRAVES CHIROPRACTIC)

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.

Our Legal Duty

We are obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless given written authorization by you, which may revoke in writing at any time. We reserve the right to change our privacy practices and apply revised privacy practices to protect health information. The new notice will be available upon request, in our office, and on our website. This notice takes effect Nov.15thst 2014 and will remain in effect until we replace it. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact our privacy officer at Paul Graves D.C., PA, 7500 Stonebrook Pkwy., Suite 103, Frisco, Texas 75034. Telephone: 972-377-7117. For more information **see** **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Uses and Disclosures of Medical Information

We use and disclose medical information about you for treatment, payment, and/or health care operations. This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by health plans or other entities--such as insurance companies, HMOs and PPOs, managed care organizations, CMS, other governmental or third party payers, or any business associates of the covered entity and their employees for the above entities to perform such functions--for services rendered by us. Copies of your medical information may be delivered to other professionals who are directly or indirectly responsible for your medical care or the payment thereof. We may use or disclose your medical information to notify a family member or another person responsible for your care based on our professional judgment and the circumstances. We may use your medical information to contact you, leave a message, text and/or email to provide appointment reminders, thank you cards, and promotional information. We may use or disclose your medical information for purposes involving public health and safety issues and activities, death, certain requests from your employer, governmental personnel and programs, organ donation, judicial and administrative proceedings, law enforcement, abuse, neglect or domestic violence issues and workers' compensation issues. I give permission to receive treatment in an open room where other patients are also being treated. I am aware that others in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, I will notify the doctor and or staff for a private room.

Individual Rights

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time. You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. We charge a cost-based fee for copying of your paper or electronic records.

Authorization and HIPAA Acknowledgement

Please read carefully and sign/initial here indicated.

I acknowledge I have read and understand the HIPAA policy of Paul Graves, D.C. PA.

_____ _____

Signature of Patient/Legal Guardian Date

_____

Print name of Patient/Legal Guardian

I hereby authorize Paul Graves, D.C. PA, to discuss and disclose any healthcare information including billing/account information on my behalf anytime; to the person(s) listed below: **(If you do not permit anyone access to this information on your behalf, leave the area blank)**

_____	_____	_____
Print Authorized Person's Name	List authorized Party's Relationship to Patient	Patient's Initials
_____	_____	_____
Print Authorized Person's Name	List authorized Party's Relationship to Patient	Patient's Initials
_____	_____	_____
Print Authorized Person's Name	List authorized Party's Relationship to Patient	Patient's Initials

_____ _____

Signature of Paul Graves, D.C. PA Employee as Witness

Date

Questions and Complaints

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with appropriate address upon request.

If you have any questions or complaints, please contact:

Dr. Paul Graves Privacy Officer, Sandy Bowen Security Officer at 7500 Stonebrook Pkwy, Suite 103 Frisco, Texas 75034, (972) 377-7117