# Dr. Ronald G. Hernandez, Jr.
# At Hill Country Indoor

**Patient Information** **Date:**

| | | | | | |
|---|---|---|---|---|---|
| First Name: | MI: | Last Name: | | SSN: | |
| Birth Date: | | Age: | Please Circle One: | Male | Female |
| Address: | | City: | | State: | Zip: |
| Phone- Home: | | | Cell: | | |
| Work: | | | | | |
| Marital Status: Single Married Divorced Separated | | | Spouse's Name: | | |
| How did you hear about us? Current Patient _____ Another Physician _____ | | | | | |
| Print Advertising Insurance Carrier Internet Yellow Pages Other _____ | | | | | |
| Email address: | | | | | |

**Employer Information**

| | | |
|---|---|---|
| Employer: | Employer Phone: | Fax #: |
| Employer Address: | City: | State: |
| Are you currently working? Yes No | If Not, Last Day Worked: | |

**Emergency Contact** (Closest relative or friend not living with you)

| | | |
|---|---|---|
| Name: | Relationship to patient: | |
| Address: | | |
| Phone- Home: | Work: | Cell: |
| Primary Care Physician: | Location: | Phone: |

**Is the patient younger than 18 years old? If so, please complete the following:**

## Authorization to Treat a Minor

I, the undersigned, hereby attest and warrant that I am the legal guardian of:

_____ _____ _____
Name of minor patient Child's DOB Child's Social Security Number

a minor child as described by law. Further I warrant that my authority to act on the child's behalf is by virtue of my

_____ Being the child's natural parent.

_____ Having been duly appointed legal guardian by a Court of Competent Jurisdiction (Copy of the order is attached)

And that I hereby give my consent to such medical examinations, diagnostic procedures and treatments as may be deemed necessary by the physician for the evaluation and treatment of the condition for which this minor child has been presented. This consent begins on the date below and remains in effect unless revoked in writing.

Signed in the presence of this witness on _____ 20_____

_____ _____ _____
Printed Name of Parent/Consenting Adult Signature of Parent/Consenting Adult Date

**Name: _____**

## FINANCIAL POLICY

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the doctor to diagnose and treat my condition(s).

I understand that I am responsible for all charges at time of service, and will be informed of current charge(s) or additional charges at that time. I understand that the doctor or clinic does not accept any forms of health insurance, or provide any billing of any kind, and a superbill can be generated upon request. In addition, I understand that any number of letters or paperwork requested by any person or company, that are deemed by the clinic to be excessive, may incur a fee for the production and authentication thereof, prior to being provided.

I understand a valid credit card (not HSA) is required to secure my appointment time. It is my responsibility to keep the clinic updated on any changes to my card account. Credit cards may be charged $0.01 randomly to verify a valid account.

24 Hour Cancellation policy: If less than 24 hours is provided to change my appointment time, there is a cancellation fee of 50 applied to the credit card on file per occurrence. If the patient has purchased a package, then they forfeit 1 office visit of their package per cancellation. **INITIALS**_____

_____
**Print**

_____ _____
**Signature** **Date**

## REQUIRED CREDIT CARD INFORMATION

***If HSA card is provided, a NON-HSA card will be required to secure the account***

Name on Card (PRINT as appears on card):

_____ _____

Card Type:
VISA MASTERCARD DISCOVER HSA VISA MASTERCARD DISCOVER HSA

Card Number:

_____ _____

Expiration: _____ _____

SEC: _____ _____

Billing Zip Code: _____ _____

Authorization Signature: _____

**Name: _____**

## Today's Visit

What is the reason for your visit today?

_____

_____

What treatment have you already received for this condition, if any?
Medications Surgery Physical Therapy Chiropractic Services Acupuncture Massage
Other _____ None

What other doctors, facilities, etc., if any, have you seen for this condition? Please list names and practice locations to the best of your ability.

_____

_____

May we share this information or our treatment procedures with them? YES NO

Which advanced imaging was performed for this ailment? MRI X-Ray CT PET Other None
What were the results?

_____

_____

Please list any/all **prescriptive medications** with dosages.

_____

_____

Please list any/all **allergies** (food, insect, environmental, etc).

_____

_____

Please list any/all nutritional supplements with dosages.

_____

_____

Please answer the following questions to the best of your ability, have you ever or are you currently being treated for any of the following conditions?

If answering "**YES**," please **check all that apply**:

**CARDIOVASCULAR**
__Pacemaker/Internal Device __Bleeding/Clotting Disorder __Heart Attack __Chest Pain __Irregular HR
__Heart Murmur __High/Elevated BP __Shortness of Breath __High/Elevated Cholesterol __Anemia
__Stroke

**RESPIRATORY**
__Asthma __Bronchitis __Emphysema __COPD __Sleep Apnea __Smoker

**GI/DIGESTIVE**
__Crohn's Disease __Colitis __Acid Reflux/Heart Burn __Ulcers __Hernia __Hemorrhoids
__IBS __Hepatitis __Celiac Disease __Cirrhosis

**METABOLIC/ENDOCRINE**
__Diabetes __Thyroid Disorder __High/Low Blood Sugar __Adrenal/Pituitary/Other Glandular Disorder
__Chronic Fatigue Syndrome __Fibromyalgia __Obesity/Weight Loss Surgery

**Name: _____**

**BRAIN/NERVOUS SYSTEM**
__Seizures __Migraine __Epilepsy __Chronic Headaches __Stroke or TIA __Head Injury __Concussion
__Blacked Out/Knocked Out __Multiple Sclerosis __Parkinsons Disease __Restless Leg Syndrome __Dizziness
__Visual Disturbances __Internal Device __Other_____

**IMMUNE SYSTEM**
__HIV Positive __AIDS __Leukemia or Lymphoma

**MUSCULOSKELETAL**
__Arthritis __Gout __Lupus __Herniated Disc __TMJ __Carpal Tunnel Syndrome __Rheumatoid Arthritis
__Other Bone or Joint Disorder

**MENTAL/BEHAVIORAL/EMOTIONAL**
__Depression __Anxiety Disorder __Attention Deficit Disorder __BiPolar Disorder __Eating Disorder

**SKIN CONDITIONS**
__Acne __Psoriasis __Eczema __Pre-Cancerous Lesions __Herpes __Melanoma

**GENERAL HEALTH**
__Currently Pregnant __Cancer (Current or Remission) __Organs Lost or Missing __Smoker
__Consume Alcohol

Please explain all "**Yes**" answers to the above questions.

_____
_____

Are you currently pregnant? If so, what trimester/weeks? If not, date of last menstrual cycle.

_____

Have you ever been hospitalized? If so, please specify.

_____
_____

Please list all surgical procedures performed and date/year.

_____
_____

Are there any diseases or ailments that are common to your family? If so, please list who, what condition, and their relation to you.

_____
_____

Do you use any special equipment for participation in sports? If so, please specify.

_____
_____

Other than the reason for this visit, do you experience any chronic ailments/pain? If so, please specify.

_____
_____

**<u>If your current condition involves pain, please complete the following section.</u>**

1. When did you first notice your complaint/condition? _____
2. Is your condition getting worse? Yes No Unknown
3. Have you had anything like this before? Yes No
4. How often do you have this pain? _____

**Name: _____**

5. What makes it better? _____

6. What makes it worse? _____

7. Is it better or worse in the morning? _____

8. Please circle the best description of your pain.
   Constant
   On and off, lasting ____ minutes ____ hours ____ days ____ weeks at a time.

**For questions 9-11, circle all that apply.**

9. Describe how it feels: Numb Aching Pins and Needles
   Throbbing Cramping Stiffness Burning Stabbing Dull Sharp

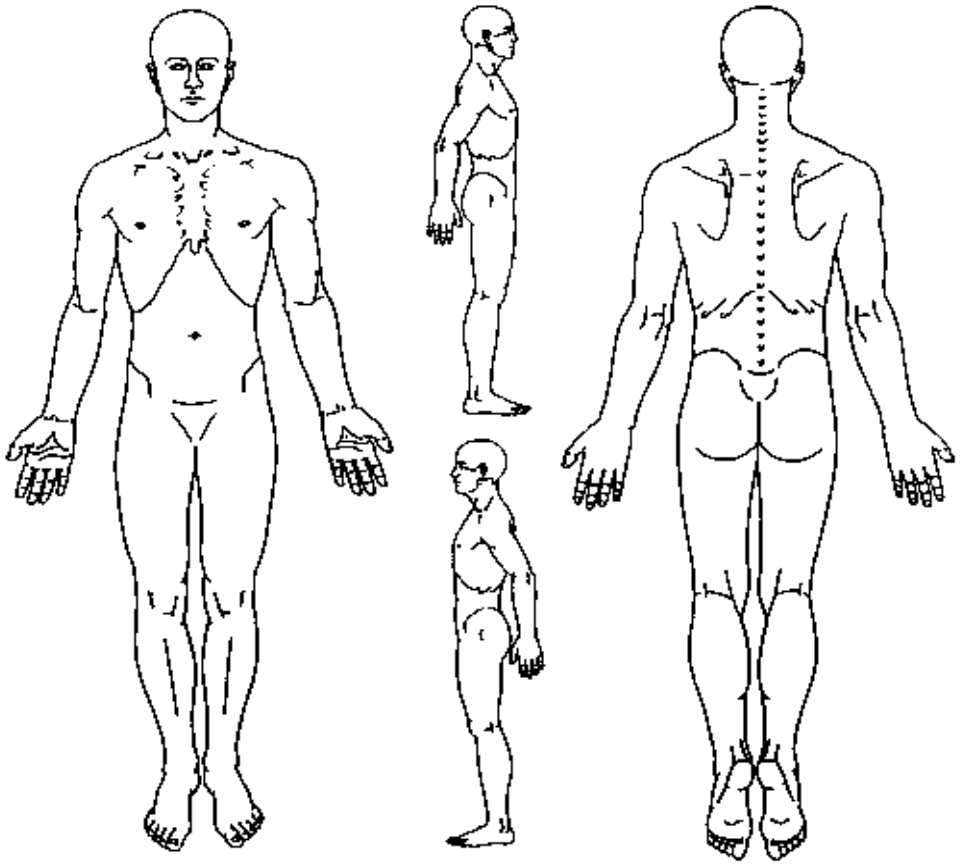
10. Does it interfere with: Work Sleep Recreation Daily Routine

11. Activities that are painful to perform: Sitting Standing Walking Bending Lying Down

12. Please rate your pain on the scale below. 0= No Pain and 10= Severe Pain

| 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 |
|---|---|---|
| Pain currently | Pain at its worst | Pain typically |

13. Please mark the area(s) of injury or discomfort as shown in the example below.
    N= Numbness P= Pins and needles A= Aching B= Burning S= Stabbing



**Name: _____**

## HIPPA Declaration

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law

(c) Is required to abide by the terms of the Privacy Notice

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains

(e) Will distribute any revised Privacy Notice to you prior to implementation

(f) Will not retaliate against you for filing a complain

## EFFECTIVE DATE

This Notice is in effect as of 7/26/04

## PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

_____ _____

PATIENT DATE

*By signing below, I agree for sharing of this information with Dr. Ronald G. Hernandez, Jr., ChiroSports, Inc. SC and their representatives, and any AIM Coaching staff, including any other providers, students, interns, or residents, under allowance by HIPPA.*

PATIENT: _____

## FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Acknowledgment
Patient's acknowledgment of this notice could not be obtained because:

__Patient refused to sign
__Communication barrier prohibited obtaining acknowledgment
__Emergency circumstances
__Other
Details:

_____
Signature of Practice

_____
Date

**Name: _____**

## INFORMED CONSENT TO CHIROPRACTIC TREATMENT

**The nature of chiropractic treatment:** 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 made when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, dry hydrotherapy, acupuncture, or photolight/infrared light therapy may also be used.

**Possible risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness, soreness, or discomfort after or within the first few days of treatment. The ancillary procedures could produce skin irritation, burns, bruises, minor complications, or possible discomfort.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

**Other treatment options which could be considered may include the following:**

- *Over the counter analgesics.* The risks of these medications include irritation to stomach, liver, and kidneys as well as other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.

**Unusual risks: I have had the following unusual risks of my case explained to me**.

**I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.**

_____ _____ _____

**Printed Name** **Signature** **Date**

**WITNESS:**

_____ _____ _____

**Printed Name** **Signature** **Date**