Office: (214) 971-6969
11402 Audelia Rd, Dallas, TX 75243
theflexchiropractic@gmail.com

Name _____ Age _____ Date of Birth _____

Address _____
Street or PO Box Apt# City State/Zip

Phone (Hm)_____ (Cell) _____ (Wk)_____
Email:_____ HT: _____ WT:_____

Please indicate your preferred contact number above with a (*).

Do you prefer to be contacted via text / email / or phone call? (Please Circle all that apply)

E-Mail Address _____
Employer: _____ _____

Sex: M _____ F _____ Marital Status: Single Married Widowed Div.
Are you pregnant: _____

How did you find out about The Flex Chiropractic?
_____

Occupation, please describe what type of work you do daily: _____

Have you ever consulted a Doctor of Chiropractic? _____
If yes, who? _____
When? _____ How long were you under care?_____

Please describe what brought you into the office today:
_____
What activities or responsibilities are being or have been affected by the above issue?
_____

What are your goals for care?
_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation. I understand that I am responsible for all payment of fees charged in this office of services rendered:

X_____ _____
Signature *Date*

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WE do not accept health Insurance at The Flex Chiropractic for wellness care*

Privacy Act:
I consent to the use of my protected health information by The Flex Chiropractic for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or conduct health care operations, court order, dispute, law enforcement. HIPAA Compliance.

X_____ _____ _____
Signature of Patient *Printed Name of Patient* *Date*

1. **Fees.** In exchange for the services described herein, Patient agrees to pay The Flex Chiropractic for the services provided to Patient. First initial Visit Fees: $29, Subsequent office visits/adjustments: $39, or Chiropractic wellness care membership: $_____/month for 4 visits (Individual) non-transferable, with an Additional $10/visit above the 4 visits/month

2. **Non-Participation in Insurance.** Patient acknowledges that The Flex Chiropractic does **not** participate in any health insurance or HMO plans or panels and provides wellness services that are not covered under Medicare guidelines. Neither of the above make any representations whatsoever that any fees paid under this Agreement are covered by your health insurance or other third party payment plans applicable to the Patient. The Flex Chiropractic will not submit claims to the health insurance or medicare on behave of the patient. The Patient shall retain full and complete responsibility for any such determination. If the Patient is eligible for Medicare, or during the term of this Agreement becomes eligible for Medicare, then Patient will sign the Advanced Beneficiary Notice. This agreement acknowledges your understanding that the Chiropractor is providing wellness/maintenance services that are not covered by Medicare, and as a result, ***Medicare cannot be billed for any services performed for you by the Chiropractor. Patient agrees not to bill Medicare or attempt Medicare reimbursement for any such services***. Patient shall renew and sign the Advanced Beneficiary Notice every year thereafter chiropractic care is provided.

3. **Insurance or Other Medical Coverage.** Patient acknowledges and understands that this Agreement is not an insurance plan, and not a substitute for health insurance or other health plan coverage (such as membership in an HMO). It will not cover hospital services, or any services not personally provided by The Flex Chiropractic, or its Chiropractors. Patient acknowledges that The Flex Chiropractic has advised that Patient obtain or keep in full force such health insurance policy(ies) or plan(s) that will cover Patient for general healthcare costs. Patient acknowledges that this Agreement is not a contract that provides health insurance, and this Agreement is not intended to replace any existing or future health insurance or health plan coverage that Patient may carry.

4. **Work or Automobile Injury.** If you are involved in a Work injury or Automobile injury and your care is covered under the respective policies, your Chiropractic Wellness treatment Program may be suspended without penalty and may be reinstated once care for those injuries has completed. You will also be eligible to resume your Chiropractic Wellness treatment Program without a new setup fee.

5. **Communications**. You acknowledge that communications with The Flex Chiropractic /Chiropractor(s) using e-mail, facsimile, video chat, instant messaging, and cell phone are not guaranteed to be secure or confidential methods of communications. As such, you expressly The Flex Chiropractic /Chiropractor's obligation to guarantee confidentiality with respect to correspondence using such means of communication. You acknowledge that all such communications may become a part of your medical records.

   By providing Patient's e-mail address, Patient authorizes The Flex Chiropractic and its Chiropractors to communicate with Patient by e-mail regarding Patient's "protected health information" (PHI) (as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations). Patient acknowledges that:

(a) E-mail is not necessarily a secure medium for sending or receiving PHI and there is always a possibility that a third party may gain access; Although and The Flex Chiropractic/Chiropractor(s) will make all reasonable efforts to keep e-mail communications confidential and secure, neither The Flex Chiropractic nor the Chiropractor(s) can assure or guarantee the absolute confidentiality of e-mail communications;

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(b) At the discretion of The Flex Chiropractic/Chiropractor(s), e-mail communications may be made a part of Patient's permanent chiropractic record; and,

(c) Patient understands and agrees that e-mail is not an appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information. **In the event of an emergency, or a situation in which the patients could reasonably expect to develop into an emergency, Patient shall call 911 or the nearest emergency room, and follow the directions of emergency personnel.**

If Patient does not receive a response to an e-mail message within one day, Patient agrees to use another means of communication to contact The Flex Chiropractic /Chiropractor(s). Neither The Flex Chiropractic nor the Chiropractor(s) will be liable to Patient for any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to Patient as a result of technical failures, including, but not limited to: (I) technical failures attributable to any internet service provider, (II) power outages, failure of any electronic messaging software, or failure to properly address e-mail messages, (III) failure of the Practice's computers or computer network, or faulty telephone or cable data transmission, (IV) any interception of e-mail communications by a third party; or (V) your failure to comply with the guidelines regarding use of e-mail communications set forth in this paragraph.

_____
Patient's Signature

_____
Date

Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that which will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation and joint. Our Chiropractic method of correction is by specific adjustments to the spine and joint. Risks may include but are not limited to cardiovascular, muscle, ligament, joint, fracture, or disc injury. Symptomatic aggravation of the condition is also possible. Risk factors have been reduced to the best of our ability. However, any increase in the current level of discomfort, or any other change in symptoms should be immediately reported to a staff

Health: The state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer the diagnosis or treatment of any disease. We only offer to diagnose either vertebral subluxation complex and/or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter unusual finding which are outside the scope of practice for a Doctor of Chiropractic, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

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Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatments prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is the specific adjustment to correct vertebral subluxation. However, we may use other procedures to help your body hold those adjustments.

Informed Consent for Chiropractic Treatment:

I hereby request and consent to chiropractic manipulation and other procedures, including various modes of exercise therapy, soft tissue therapy, or diagnostic testing services by The Flex Chiropractic. I understand that results are not guaranteed and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, burn, disc injuries, cardiovascular, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I agree to hold The Flex Chiropractic harmless for claims or damages in connection with my treatment. This is a contract between myself and The Flex Chiropractic, and I understand that it is also a release of potential liability.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

I, _____ have read and fully understand the above statements.
(Print name)
All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ Age_____ Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

X_____ _____ _____
Signature of Guardian *Printed Name of Guardian* *Date*

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Patient Name: _____ DOB:_____

List conditions in order of concern. *Date of Onset* *Due to:*

1. _____ _____

(minor) **Pain Scale** *(extreme)*

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Auto Work Other

Has condition changed since onset? Yes No Better Worse *Explain:*

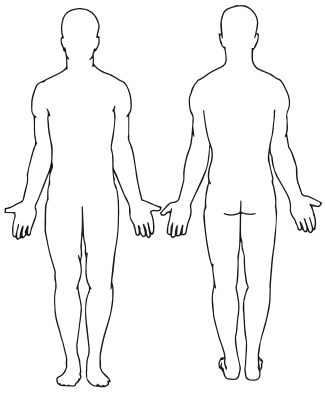
What makes pain better?_____

What makes pain worse?_____

Have you ever had the same or similar symptoms? Yes No *If Yes, when and describe:*

_____

Pain Location



Front Back

A = Achy
B = Burning
ST = Stabbing
SP = Spasm
N = Numbness
P = Pins and Needles
T = Throbbing

List conditions in order of concern. *Date of Onset* *Due to:*

2. _____ _____

(minor) **Pain Scale** *(extreme)*

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Auto Work Other

Has condition changed since onset? Yes No Better Worse *Explain:*

What makes pain better?_____

What makes pain worse?_____

Have you ever had the same or similar symptoms? Yes No *If Yes, when and describe:*

_____

3. _____ _____

(minor) **Pain Scale** *(extreme)*

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Auto Work Other

Has condition changed since onset? Yes No Better Worse *Explain:*

What makes pain better?_____

What makes pain worse?_____

Have you ever had the same or similar symptoms? Yes No *If Yes, when and describe:*

_____

Doctor Notes:

Doctor Notes:

Have you had any major past or recent illnesses, injuries, falls, auto accidents or surgeries?
Women, please include information about childbirth (include dates):

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Do you now or have you ever suffered from:

Dizziness ___
Heart disease ___
Diabetes ___
Frequent UTIs_____
Asthma ___
High Blood Pressure ___
Neuritis ___
Digestive disorder or troubles__
Heart Burn ___
Headaches___
Arthritis ___
Sinus pain/congestion ___
Cancer/tumor___
Anxiety ___
Anemia ___
Brain Fog ___
Low Energy__
Poor Circulation ___
Anxiety ___
Seizure_____
Tuberculosis___
Joint replacement____
Metal implant in body_____

Menstrual Pain or Difficulties__
Allergies ___
Tired Easily ___
Kidney stones___
Cold/Tingling/Numbness in Hands/Feet ___
Muscle aches or arthritis_____
Irritability___
Depression___
Mood swings____
Skin Irritations_____
Frequent Colds/URIs_____
PCOS____
Adrenal dysfunction____
Cognitive Changes____
Concentration Challenges____
Balance or Coordination Decline____
HIV/AIDS_____
Stroke_____
Pacemaker____
Stroke____

Hernia____
Hepatitis___
Heart palpitations or arrhythmia____
Autoimmune Conditions_____
Other_____
Other_____
Other_____
Thyroid Dysfunction____
Hormone dysfunction____
Difficulty Sleeping ___
Memory Decline____
Acne____
Speech changes____
Reflux____
Painful breasts or breast cancer_____
Frequent Cravings____
Hyperactivity____
Restlessness____

Osteoporosis/osteopenia____

Have you at any time in your life taken "broad spectrum" antibiotics? Yes / No
Are your symptoms worse on damp, muggy days or in moldy places? Yes / No
Do you crave sugar? Yes / No
Do you have a feeling of being drained? Occasional or Mild / Frequent/Moderate/ Severe

Please list any other health concerns you have at this time:
_____
_____
What would you like to re-gain in your life by becoming healthier? _____
_____
Are you avoiding any specific foods? If so, Why? _____
_____
Do you eat fresh fruits and/or vegetables on a daily basis? If not, how often?
_____

Physical Stressors:

Any Accidents or Injuries (childhood, broken bones, etc.)? _____
_____
Surgeries: _____

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Any Other Medical Procedures? _____
Do you do any physical activity on a daily basis? Please Describe. _____
_____

Chemical Stressors:
List any and all Prescriptions or OTC drugs: _____
_____
Do you smoke or chew tobacco? _____
Do you drink alcohol, how often? _____
Do you drink diet sodas or eat sugar-free foods? _____

Emotional Stressors: Have you had any strong emotional stressors either recently, or that has an effect on your daily life? _____

What aspects of Wellness do you want for yourself? (Please check as many as you'd like)

___ More Energy	**___ Better Sleep**	**___ Freedom from pain**
___ Better Concentration	**___ Enhanced emotional Well-being**	**___ Reduce/Eliminate Medication use**
___ Improved Digestion	**___ Improved strength And endurance**	**___ Greater resistance to Disease**
___ Easier breathing, Deeper breaths	**___ Better sports performance**	**___ Better reaction time/reflexes**
___ Better Balance	**___ Improved Posture**	**___ Overall Health Improvement**
___ Increased zest for Living		

Wellness goals for you and your family: _____