SandStone Chiropractic

Name: _____ Date: _____

Sex: _____ Birth Date: _____ Age: _____ Social Security #: _____

Address: _____ _____ _____ _____
Residence and Mailing City State Zip Code

Home Phone: _____ Mobile Phone: _____ Email: _____

Occupation: _____ Employer: _____ Work Phone: _____

Marital Status: S M D W Spouse's Name: _____ Spouse's Birth Date: _____

No. of Children: _____ Emergency Contact: _____ Contact Phone: _____

How did you hear about us?

_____ Billboard
_____ Facebook
_____ Television
_____ Instagram
_____ Google
_____ Yelp
_____ Referral (Please Name) _____
_____ Physician Referral (Please Name) _____
_____ Magazine Ad (Please Name) _____
_____ Event (Please name event) _____
_____ Other (Please list) _____

Primary (First) Complaint and Location

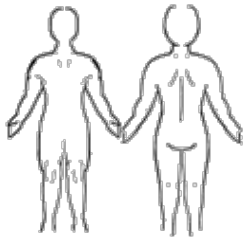
Chief Complaint (Reason for Visit): _____

When did your symptoms appear (Onset Date)? _____

Please describe the cause of the injury: _____

Is this condition getting progressively worse? _____ Yes _____ No _____ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Please describe your symptoms:

_____ Sharp _____ Shooting _____ Stiffness _____ Crawling _____ Pulsating
_____ Dull _____ Burning _____ Deadness _____ Pins and Needles _____ Prickly
_____ Throbbing _____ Tingling _____ Stabbing _____ Stinging _____ Pounding
_____ Aching _____ Cramping _____ Numb _____ Excruciating

What makes it worse?

_____ Sitting _____ Lifting _____ Driving _____ Looking Down _____ Sneezing
_____ Standing _____ Coughing _____ Walking _____ Rotating Head _____ Carrying
_____ Bending _____ Straining _____ Exercising _____ Stress _____ Climbing Stairs
_____ Lying Down _____Get out of bed _____ Looking Up _____ Bright Lights _____ Movement

What makes it better?

_____ Ice _____ Rest _____ Pain Medication _____ Lying Down _____ Exercising

_____ Heat _____ Tylenol _____ Mineral Ice _____ Sleeping _____ Anti-inflammatory

_____ Massage _____ Advil _____ Muscle Relaxers Other: _____

What time of day is it worse? _____ Morning _____ End of day _____ Night _____ Various Times

What percentage of the day is the condition present? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Does it interfere with your: _____ Work _____ Sleep _____ Daily Routine _____ Recreation _____ None

Have you seen other doctors for this condition? _____ Yes _____ No If yes, who? (Name) _____

Type of Treatment: _____ Are you satisfied with the results of the treatment? _____ Yes _____ No

Do you exercise? _____ None _____ Infrequent _____ Regular _____ Frequent and Heavy

Sufficient rest _____ Never _____ Rarely _____ Occasionally _____ Moderately

Hours of sleep _____ 3-4 _____ 5-6 _____ 7-8 _____ 9-10 _____ More than 10

Personal stress _____ Low _____ Medium _____ High _____ Very high

Occupational stress _____ Low _____ Medium _____ High _____ Very high

Well balanced diet _____ Never _____ Rarely _____ Occasionally _____ Regularly

Do you smoke? _____ No _____ Rarely _____ Occasionally _____ Daily

Do you drink alcohol? _____ No _____ Rarely _____ Occasionally _____ Daily

Do you drink caffeine? _____ No _____ Rarely _____ Occasionally _____ Daily

Are you pregnant? Y N Unsure Last menstrual cycle: _____

Secondary Complaint and Location

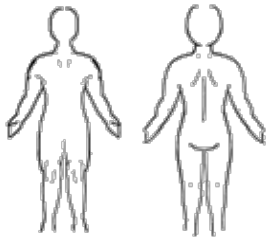
Secondary Complaint: _____

When did your symptoms appear (Onset Date)? _____

Please describe the cause of the injury: _____

Is this condition getting progressively worse? _____ Yes _____ No _____ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Please describe your symptoms:

_____ Sharp _____ Shooting _____ Stiffness _____ Crawling _____ Pulsating

_____ Dull _____ Burning _____ Deadness _____ Pins and Needles _____ Prickly

_____ Throbbing _____ Tingling _____ Stabbing _____ Stinging _____ Pounding

_____ Aching _____ Cramping _____ Numb _____ Excruciating

What makes it worse?

_____ Sitting _____ Lifting _____ Driving _____ Looking Down _____ Sneezing

_____ Standing _____ Coughing _____ Walking _____ Rotating Head _____ Carrying

_____ Bending _____ Straining _____ Exercising _____ Stress _____ Climbing Stairs

_____ Lying Down _____Get out of bed _____ Looking Up _____ Bright Lights _____ Movement

What makes it better?

_____ Ice _____ Rest _____ Pain Medication _____ Lying Down _____ Exercising

_____ Heat _____ Tylenol _____ Mineral Ice _____ Sleeping _____ Anti-inflammatory

_____ Massage _____ Advil _____ Muscle Relaxers Other: _____

What time of day is it worse? _____ Morning _____ End of day _____ Night _____ Various Times

What percentage of the day is the condition present? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Does it interfere with your: _____ Work _____ Sleep _____ Daily Routine _____ Recreation _____ None

Have you seen other doctors for this condition? _____ Yes _____ No If yes, who? (Name) _____

Type of Treatment: _____ Are you satisfied with the results of the treatment? _____ Yes _____ No

Third Complaint and Location

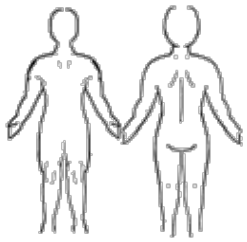
Third Complaint: _____

When did your symptoms appear (Onset Date)? _____

Please describe the cause of the injury: _____

Is this condition getting progressively worse? _____ Yes _____ No _____ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Please describe your symptoms:

_____ Sharp _____ Shooting _____ Stiffness _____ Crawling _____ Pulsating

_____ Dull _____ Burning _____ Deadness _____ Pins and Needles _____ Prickly

_____ Throbbing _____ Tingling _____ Stabbing _____ Stinging _____ Pounding

_____ Aching _____ Cramping _____ Numb _____ Excruciating

What makes it worse?

_____ Sitting _____ Lifting _____ Driving _____ Looking Down _____ Sneezing

_____ Standing _____ Coughing _____ Walking _____ Rotating Head _____ Carrying

_____ Bending _____ Straining _____ Exercising _____ Stress _____ Climbing Stairs

_____ Lying Down _____Get out of bed _____ Looking Up _____ Bright Lights _____ Movement

What makes it better?

_____ Ice _____ Rest _____ Pain Medication _____ Lying Down _____ Exercising

_____ Heat _____ Tylenol _____ Mineral Ice _____ Sleeping _____ Anti-inflammatory

_____ Massage _____ Advil _____ Muscle Relaxers Other: _____

What time of day is it worse? _____ Morning _____ End of day _____ Night _____ Various Times

What percentage of the day is the condition present? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Does it interfere with your: _____ Work _____ Sleep _____ Daily Routine _____ Recreation _____ None

Have you seen other doctors for this condition? _____ Yes _____ No If yes, who? (Name) _____

Type of Treatment: _____ Are you satisfied with the results of the treatment? _____ Yes _____ No

Review of Systems

Indicate which of the below you have experienced in the last **1-2 months**
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore Throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/Needles in Hands or Feet	1 2 3 4 5

Musculoskeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling Foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5

Past Health History

Below is a list of conditions that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care. Please mark all that apply.

Neurological Health History

_____ Facial Weakness	_____ Loss of Balance	_____ Sensation Loss	_____ Memory Loss
_____ Smell Disturbance	_____ Stroke	_____ Incontinence	_____ Dizziness
_____ Speech Disturbance	_____ Seizures _____	_____ Ringing in Ears	_____ Nervousness
_____ Visual Disturbance	_____ Numbness in Toes	_____ Headaches	_____ Stomach Upset
_____ Loss of Taste	_____ Numbness in Fingers	_____ Irritability	_____ Tension

Musculoskeletal Health History

_____ Abnormal Posture	_____ Disc Herniation	_____ Osteopenia	_____ Elbow Problem
_____ Osteoarthritis	_____ Degenerative Disc Disease	_____ Osteoporosis	_____ Wrist Problem
_____ Dislocation/Fracture	_____ Shoulder Problem _____	_____ TMJ Syndrome	_____ Ankle Problem
_____ Lower Back Pain	_____ Knee Problem _____	_____ Headaches	_____ Pes Planus
_____ Neck Pain	_____ Sprain/Strain _____	_____ Tendonitis _____	Other _____

Childhood Illnesses

_____ ADD / ADHD
_____ Allergies / Hay Fever
_____ Asthma
_____ Eczema
_____ Cerebral Palsy
_____ Chicken Pox
_____ Depression
_____ Diabetes (Type I)
_____ Fetal Drug Exposure
_____ Food Allergies
_____ Headaches
_____ Hepatitis
_____ Measles
_____ Mumps
_____ Rash
_____ Scoliosis
_____ Sickle Cell Anemia
_____ Ear infections
_____ Other _____
_____ Bed Wetting

Adult Illnesses

_____ Alzheimer
_____ Anemia
_____ CRPS (RSD)
_____ Cancer _____
_____ Chicken Pox
_____ Crohn's / Colitis
_____ Heart Disease
_____ Kidney Problems
_____ Depression
_____ Diabetes (Type II)
_____ Liver Disease
_____ Emphysema
_____ Eye Problems
_____ Fibromyalgia
_____ Parkinson's Disease
_____ STD's (unspecified)
_____ Hypertension
_____ Pneumonia
_____ Seizure Disorder
_____ Hepatitis
_____ Lupus Erythema
_____ Multiple Sclerosis
_____ Vertigo
_____ Other _____
_____ Psychiatric Problems
_____ Scoliosis
_____ Asthma
_____ Suicide Attempt(s)
_____Thyroid Problems
_____ Ear Infections (frequent)

Past Surgeries

_____ Angioplasty
_____ Appendectomy
_____ Ceaserian Section
_____ Carpal Tunnel Repair
_____ Coronary Artery Bypass
_____ Cosmetic
_____ D & C
_____ Rotator Cuff
_____ Hemorrhoidectomy
_____ Hernia Repair
_____ Hysterectomy
_____ Gallbladder
_____ Laminectomy _____
_____ Mastectomy
_____ Pacemaker Insertion
_____ Knee Replacement
_____ Spinal Fusion _____
_____ Tympanostomy
_____ Cardiac Catherization
_____ Hip Replacement

Family Medical History

	Age	Disease	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

Current Medications

_____ _____ _____
_____ _____ _____
_____ _____ _____

Vitamins and Supplements

_____	_____	_____
_____	_____	_____
_____	_____	_____

Known Drug Allergies

_____	_____	_____
_____	_____	_____
_____	_____	_____

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:

_____ _____

Signature (Patient or Guardian) *Date*

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR/FACILITY
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient Name: _____

Employer:_____

Claim Group #:_____

SS or ID#: _____

I hereby instruct and direct the_____ Insurance Company to pay by check made out to and mailed directly to:

Jill Crocker, DC
Sandstone Chiropractic Gosling, PLLC
24527 Gosling Rd., Suite D-110
Spring, TX 77389

OR

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O

24527 Gosling Rd., D-110
Spring, TX 77389

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy has payment toward the total charges for professional services rendered. **This is a direct assignment of my rights and benefits under this policy**. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorized to release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this claim.

Dated at Montgomery County, this _____day of _____2021

_____ _____
Signature of Policyholder *Witness*

_____
Signature of Claimant, if other than Policyholder

SandStone Chiropractic

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: Additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: Ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____

SandStone Chiropractic

NOTICE OF PRIVACY PRACTICES

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.

This notice takes effect on the date received and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

This Notice explains how our office may collect, use and disclose your protected health information. It also explains your rights regarding your protected health information and the steps we take to keep your protected health information secure. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health condition, the provision of care to you or the payment for that care.
Our office is required to provide you with this Notice by state and federal law. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards. Our office is legally required to maintain the privacy of protected health information and to follow the privacy practices that are described in this Notice. However, we reserve the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to all of the protected health information that we maintain, including any information we have created or received prior to issuing any new Notice. When we make an important change to our privacy policies, we will promptly change this Notice and post a new Notice in the office. You may also obtain any new Notice by asking for one at any time. This Notice goes into effect April 14, 2003.

2. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

Our office uses and discloses your protected health information for different reasons. We may collect and disclose protected health information from you and your other healthcare providers for the purposes of coordinating treatment, payment, or operating your health care plan. Any uses or disclosures other than those described herein will be made only with your prior written authorization, unless otherwise permitted or required by law. In the event you authorize us to use or disclose your protected health information in ways other than those described above, you have the right to revoke that authorization at any time by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

FOR TREATMENT: We may use and disclose your protected health information to assist in your diagnosis and treatment. For example, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

FOR PAYMENT: We may use and disclose your protected health information in order to bill and collect payment for the treatment and services provided to you. For example, we may provide your protected health information to our billing department and your health plan to get reimbursed for health care services. We may also provide your protected health information to our business associates, such as billing companies, claims processing companies, and others that participate in claims payment process.

FOR HEALTH CARE OPERATIONS: We may use and disclose your protected health information for activities necessary to operate your health care plan including quality management, utilization review, anti-fraud and claims payment, provider credentialing activities, underwriting or determining premiums. We may also collect and disclose your protected health information as required by industry or government regulators such as the state licensing boards and insurance regulatory agencies. Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes.

ADDITIONAL USES AND DISCLOSURES: As required, we may also disclose protected health information to the sponsor of your health plan (usually your employer). Our office must disclose protected health information about you when required by law. Examples of such disclosures include the following:

Avoid Threat to Health or Safety: We may disclose protected health information to law enforcement personnel or persons able to prevent or lessen a serious threat to the health or safety of a person or the public.

Coroners, Funeral Directors, Organ Donation: We may disclose protected health information to coroners, medical examiners, and funeral directors as is necessary for such persons to carry out their duties. Additionally, we may disclose protected health information relating to organ, eye, or tissue donations and transplants.

Health Oversight Activities: We may disclose protected health information to assist the government agencies for activities allowed or required by law such as when it conducts an investigation or inspection of a health care organization.

Health-Related Benefits or Services: We may disclose protected health information to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits that may be of interest to you.

Law Enforcement, Judicial and Administrative Proceedings: We may disclose protected health information when ordered to do so in a judicial or administrative hearing. We may disclose protected health information in response to a subpoena, discovery request or other lawful process. Finally, we may disclose protected health information in response to a warrant, to identify or locate a suspect, or to provide information about the victim of a crime.

National Security and Intelligence: We may disclose protected health information as required by military officials for national security and military intelligence purposes.

Public Health Activities: We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.

Research: In certain circumstances, we may disclose protected health information in order to conduct medical research. Such circumstances include taking steps to protect your privacy.

Victims of Abuse, Neglect or Domestic Violence: We may disclose protected health information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence.

Workers' Compensation: We may provide protected health information in order to comply with workers' compensation laws.

3. YOUR INDIVIDUAL RIGHTS

Right To Request Restrictions On Uses And Disclosures of Protected Health Information: You have the right to request restrictions on the use and disclosure of your protected health information. To request a restriction please speak to our privacy officer. Please note that while you may request a restriction, we have a right to refuse that request. If we accept your request, we will put the limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.

Right To Receive Confidential Communications: You have the right to receive confidential communications, including the right to direct where communications containing protected health information are sent. For example, you may request that information be sent to your work address rather than your home address or via alternative means such as email rather than regular mail. To verify or modify where or how you would like such communications sent, contact our privacy officer. We will accommodate all reasonable requests. Unless requested otherwise, we will direct mailings and telephone messages containing protected health information to the address and telephone number we have on record for the subscriber of the health plan.

Right To Inspect And Copy Protected Health Information: In most cases, you have the right to see and get copies of your protected health information that we maintain. If you want to see or get copies of your protected health information you must submit your request in writing to our privacy officer. If we do not have your protected health information but knows who does, we will tell you where you can get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do deny your request, we will tell you, in writing, the reasons for the denial and explain your right to have the denial reviewed. If you request copies of your protected health information, we will charge you a reasonable copying fee for each page and mailing costs but will inform you of that fee in advance. Instead of providing the protected health information you requested, we may provide you with a summary or explanation of the protected health information as long as you agree to the summary and any applicable charges in advance.

Right To Amend Protected Health Information: If you believe that there is a mistake in your protected health

information or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reasons for the request in writing to our privacy officer. We will respond within 60 days of receiving your request. We may deny your request in writing if the protected health information is (1) correct and complete, (2) not created by us, (3) not allowed to be disclosed or (4) not part of our records. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file a rebuttal, you have the right to request that copies of your initial request and our denial be attached to all future disclosures of your protected health information. If we approve your request, we will make the change to your protected health information, inform you when the change is completed, and inform others that need to know about the change to your protected health information.

Right To Receive An Accounting Of Disclosures Of Protected Health Information: You have a right to receive an accounting of any disclosures of your protected health information that were made for purposes other than coordinating treatment, payment or other health care services plan operations. The accounting will not include uses or disclosures made for treatment, payment, or health care operations, disclosures made directly to you or your family, or disclosures that you have already authorized. Additionally, the accounting will not include uses and disclosures made for national security purposes, or to corrections or law enforcement that has lawful custody over you. We will respond within 60 days of receiving your written request. The accounting will include the date of the disclosure, to whom protected health information was disclosed (including their address, if known), a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting you request within a 12-month period at no charge. For additional accountings within the same time period, we may charge you a fee for each additional request but will inform you of that fee in advance. To request an accounting of any such disclosures submit your request in writing to our privacy officer stating the time period for which you want the accounting. This time period may not be longer than six years and may not include dates before April 14, 2003.

Right To Get A Paper Copy Of This Notice: You have the right to get a paper copy of this Notice at any time even if you previously agreed to receive an electronic copy.

4. DISCLOSURE OF PHYSICIAN OWNERSHIP – NOTICE TO PATIENTS

Disclosure of Physician Ownership: Sandstone Chiropractic has partial ownership of Essential Imaging. You have the right to choose the provider of your health care services. Therefore, you have the option to use an imaging facility other than Essential Imaging.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Sandstone Chiropractic, P.A. or Essential Imaging. By signing this form, you understand the forgoing notice and understand that your physician has an ownership interest in Essential Imaging.

5. QUESTIONS AND COMPLAINTS

Right To File a Complaint: If you believe that your protected health information has been improperly used or disclosed, or that your privacy rights have been violated you may file a privacy complaint with us. To file such a complaint you should contact our privacy officer. You also have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services (DHHS). We will take no retaliatory action against you if you file a complaint with us or the DHHS.

Address: Please send all correspondence to:

Compliance Officer
Megan Cole
Sandstone Chiropractic Gosling, PLLC
24527 Gosling Rd., Suite D-110
Spring, TX 77389

_____ _____

Patient Signature Date

OFFICE POLICY

We believe that a clear definition of our office policies will allow you, the patient, and us, the doctor, to concentrate on the big issue - regaining and maintaining your health.

APPOINTMENT POLICY

Multiple appointments will be scheduled, for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine.

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that counts, and not the days.

Therefore, if you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. It is your obligation to **make up a missed appointment within 7 days of any cancellation.**

The office reserves the right to charge for those appointments canceled without six hours notice. The cancellation fee is $25.

When entering the office on any given visit, please go directly to the front desk and "sign-in." We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our office policy or your appointments, please do not hesitate to ask.

The purpose of requiring all new patients to attend a Special Consultation/Spinal Health Orientation is to educate you about your body, especially the spine and nervous system. Since chiropractic is clearly not the practice of medicine, and is probably new to you, it is essential to understand how to help us help you get well faster. We have found that patients attending the class seem to respond better because they understand the cause of their problem and what we are attempting to do to correct it.

Your attendance at the Special Consultation is mandatory! It is part of your program of care. Further, we request that you bring your spouse or another family member, so he/she can understand too, and learn to assist you in your quest to regain your health. Friends and relatives may also attend, as this is a terrific way for them to find out the value of chiropractic care. Just ask at the front desk to reserve a place for your guests.

FINANCIAL POLICY

1. Ultimately, the patient is responsible for all services rendered, including those not reimbursed by third party payers. Insurance verification is a courtesy we provide for the patient. **Sandstone Chiropractic recommends that all patients call their respective insurance companies to verify the benefits we have been quoted.**

2. All payments are expected at the time of service, or at the beginning of each week. Payment plans are available through the written authorization of Sandstone Chiropractic.

3. All insurance patients must pay their deductibles in full and the co-payment at the time of service, or at the beginning of each week.

4. All accounts not paid within 90 days will automatically be transferred to a collection agency.

5. Any changes of insurance companies and/or information needs to be reported immediately. All services rendered will be charged directly to you for failure of notification.

_____ _____

Signature *Printed Name*

_____ _____

Witness *Date*

24527 Gosling Rd., Suite D-110
Spring, TX 77389
281-214-1850

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, authorize _____

to have access to the following information indicated below in my patient file at Sandstone Chiropractic.

☐ Records ☐ Reports ☐ X-Rays ☐ MRI ☐ Patient Schedule ☐ Account Balance

Delivery Method:

☐ Mail ☐ Fax ☐ Patient Pick-up ☐ Phone

_____ _____
(Patient Signature) (Patient Name)

_____ _____
(Witness Signature) (Date of Birth)

_____ _____
(Date of Request) (Daytime Phone Number)

SandStone Chiropractic

24527 Gosling Rd., Suite D-110
Spring, TX 77389
(281) 214-1850 Office

PHONE CONTACT CONSENT AND AUTHORIZATION

I, _____, with respect to any services provided or that are planned to be provided to myself or, as an authorized legal representative, for the below listed individual, fully consent to and authorize Sandstone Chiropractic or any of its automated systems to contact me via phone (including to my cellular phone by way of phone call or text message) in relation to any services received from Sandstone Chiropractic or any services planned to be received from Sandstone Chiropractic (including any billing items or appointment reminders).

If this Consent and Authorization *applies to someone for whom you are a legal representative, **please print their name below**, if not please indicate so by populating the blank with N/A*.

_____ _____
Patient Name Patient Signature

_____ _____
Legal Representative Name Legal Representative Signature

_____ _____
Witness Date