SA ELITE CHIROPRACTIC
NEW PATIENT REGISTRATION

Date: _____ Phone:_____ Appointment Reminders? Y N Carrier_____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: ☐ M ☐ F Age: ____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Number of Children_____Occupation_____

Social Security #: _____ Email: _____

Insured's Name: _____
Last Name First Name Initial

Patient Agreement:
ASSIGNMENT AND RELEASE
I, the undersigned, have insurance coverage with (Health Insurance Company)_____ and assign directly to **SA Elite Chiropractic/Dr. Matthew James** all medical 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 my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Present Complaints (Please circle the appropriate ones)

Headache
Mental dullness
Loss of memory
Dizzy
Ears ringing/buzzing
Upper back pain
Lower back pain
Midback pain
Pins and needles in hands right/left

Feet/Hands Cold
Depression
Rib pain
Nervousness
Eye strain/pain
Shortness of breath
Fear
Confusion
Pins and needles in arms right/left

Unbalanced
Fainting
Blurred vision
Irritability
Double vision
Loss of smell
Chest pain
Neck pain
Pins and needles in legs right/left

Medical Implants: _____ **Medical alerts:** _____
Surgical Implants: _____ **Pregnancy: yes ____ no ____**

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain**

Reason for today's visit: (Circle all that apply)
Pain Relief
Corrective Care
Wellness/Management
Massage Therapy
Auto Injury
Weight Loss Solutions
Increased Energy
Better Sleep
Other_____

Patient Name: _____ Date: _____

Medications: *(please list all medications and supplements that you currently take)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies: *(please list all medications that cause allergic reaction)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____ Date _____

_____ _____

_____ _____

_____ _____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

□ asthma □ pulmonary embolism □ respiratory arrest
□ COPD □ pneumonia □ sleep apnea
□ emphysema □ tuberculosis □ other: _____

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina □ high blood pressure □ irregular heartbeat, arrhythmia
□ heart attack □ heart murmur, valve disorder □ peripheral vascular disease
□ congestive heart failure □ mitral valve prolapse □ deep vein thrombosis
□ other: _____ □ bleeding problems

Neurologic Disorders

□ stroke or TIA □ Parkinson's □ cerebral palsy
□ peripheral neuropathy □ MS □ polio
□ other: _____

Bone & Joint Disorders

□ osteoarthritis □ gout □ osteomyelitis
□ rheumatoid arthritis □ lupus □ ankylosing spondylitis
□ other: _____

Patient Name: _____ Date: _____

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer
□ acid reflux, GERD
□ GI bleed
□ other: _____
□ diverticulitis
□ irritable bowel
□ inflammatory bowel disease
□ hepatitis - Type _____
□ liver disease

Genitourinary Disorders

□ urinary tract infection
□ bladder problems
□ kidney problems
□ kidney stones
□ dialysis, kidney failure
□ other: _____

Metabolic & Other Disorders

□ Diabetes x _____ years
□ thyroid problems
□ sickle cell disease
□ high cholesterol or lipids
□ skin disorder _____
□ psoriasis
□ any skin ulcer
□ tooth abscess, gingivitis
□ depression
□ anxiety
□ alcohol or drug dependency
□ other: _____

Cancer : any type -- please specify

_____

Other medical problems NOT included above (explain)

_____

_____

Family History:

Please indicate with an "X" any significant family medical history or problems.

□ asthma
□ COPD or Emphysema
□ heart attack, myocardial infarction
□ irregular heartbeat, arrhythmia
□ MS or Parkinson's
□ osteoarthritis
□ rheumatoid arthritis
□ acid reflux, GERD
□ liver disease
□ kidney problems
□ diabetes
□ thyroid problems
□ Malignant hyperthermia
□ tuberculosis
□ other lung :_____
□ sickle cell disease
□ other neuro :_____
□ Lupus
□ Other bone & joint: _____
□ inflammatory bowel disease
□ other GI :_____
□ dialysis, kidney failure
□ psoriasis
□ sleep apnea
□ congestive heart failure
□ bleeding problems
□ Peripheral neuropathy
□ gout
□ hepatitis - Type _____
□ high cholesterol or lipids
□ any skin ulcer

Cancer : any type -- please specify

_____

Other medical problems NOT included above (explain)

_____

_____

Patient Name: _____ Date: _____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

☐ BCBS	☐ Ambetter	☐ 3rd Party Auto
☐ United	☐ Oscar	☐ 1st Party PIP
☐ Humana	☐ Medicare	☐ Other_____

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

Major Medical or Auto Insurance:

Date of Accident: _____
Insurance Company Name: _____
Adjuster: _____
Address/Phone: _____
Claim #: _____ Policy #: _____ Effective Date: _____

Primary Care Physician:
Name & Address:

_____

_____

Phone #: _____

*Person to contact in an emergency (Name and Phone #):

_____

I declare under penalty of perjury (under the laws of the United States of America) that the foregoing is true and correct: I am not attempting to investigate San Antonio Elite Chiropractic as a representative of any agent or entity, or any insurance company or other organizational entity or person.

Signature: _____ Date: _____

Printed Name:_____

SA Elite Chiropractic

MATT JAMES, D.C.
2397 N.W. MILITARY HWY STE D SAN ANTONIO, TX 78231
PHONE: 210-342-3507 | FAX: 210-342-0504

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays and/or other tests 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 treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and 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, including, but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

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.

Signature of Patient and/or Responsible Parties:

_____
Print Name

_____
Signature

Date: _____

SA Elite Chiropractic

OWNERSHIP OF RECORDS

ALL PATIENT RECORDS, RADIOGRAPHS, DOCUMENTS, ETC., CONCERNING A PATIENT'S CARE ARE THE DOCTOR'S PROPERTY.

The patient pays for professional services which may include the following:

X- Rays, report of findings, diagnosis, treatment recommendations, patient care plans, but the patient does not own the records from which these services are based. This clinic will be happy to forward copies of records or X-rays to any other doctor or facility of the patient's choice but is not entitled to the originals.

The patient must sign an "Authorization to Release" form if the records leave these premises. You will need to sign out the records you hand carry.

The doctor retains the right to submit the X-rays at any time deems necessary to a licensed Radiologist for evaluation and any reports. The patient is responsible for these charges if this service is needed.

_____ _____

Patient Signature Date

CHARGE FOR X-RAY COPIES: 8x10 = $5.00 14x17 = $19.00

****

VERIFICATION OF NON-PREGNANCY

FEMALE PATIENTS ONLY

I,_____do hereby state that, to the best of my knowledge, **I am not pregnant**, nor is pregnancy suspected or confirmed at the particular time.

_____ _____

Patient Signature Date

_____ _____

Witness

NOTICE OF PRIVACY PRACTICES FOR SA ELITE 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.** This Notice of Privacy Practice describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by federal to abide by the terms of this Notice of Privacy Practices. We may change the terms of out notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by calling the office and requesting a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

I. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

By applying to be treated in our office, you are implying consent to the use and disclosure of you protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice. Following are examples of the types of uses and disclosures of your protected health information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician bas the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your healthcare diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities., For example, obtaining approval for chiropractic spinal adjustments may require that your relevant protected health information may be disclosed to the health plan to obtain approval for those services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of chiropractic students. For example, we may disclose your protected health information to chiropractic interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk or where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist in accurately capturing your responses. We may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by Law *as* described below. For example, with your written, signed authorization, we may use your demographic information and the dates that you received treatment from our office, as necessary, in order to contact you for fundraising activities supported by our office. With your written, signed authorization, we may do so. You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

I_____**have received and read the above "NOTICE OF PRIVACY PRACTICES" for SA ELITE CHIROPRACTIC.**

PRINT NAME

Patient Signature:_____**Date:**_____

Broken Appointment Policy

We understand that plans change and there are unforeseen delays in your schedule. Our office is always willing to reschedule or cancel your appointment, if notified in a timely manner.

Please remember that the massage therapist is here and the room is prepared for **YOU.**

Since the therapist are contract MTs, if you do not show up, they can't get paid... and the slot you don't show up, could have been for another patient.

If we are not notified in a timely manner, we will not be able to schedule another patient in your place, so please be prompt, or respectfully give us a courtesy call.

We require that you notify SA Elite Chiropractic of your cancellation by **24 hours before your appointment**.

Failure to do so will result in a **$30 cancellation / no show fee**.
The collected fee will go directly to the Massage Therapist for the appointment time/ inconvenience.

I_____understand and agree to the broken appointment policy.
PRINT NAME

Signature: _____

Date: _____

SA ELITE CHIROPRACTIC
2397 N.W. MILITRAY HWY | SAN ANTONIO, TX 78231| 210-342-3507

OFFICE HOURS

THERAPY & ADJUSTMENT		
MONDAY	9:00 AM-12:00 PM	2:00-5:00
TUESDAY	9:00 AM-12:00 PM	2:00-5:00
WEDNESDAY	9:00 AM-12:00 PM	2:00-5:00
THURSDAY	9:00 AM-12:00 PM	2:00-5:00
FRIDAY	9:00 AM-1:00 PM	CLOSED

MASSAGE	
MONDAY	9:00 AM- 5:00 PM
TUESDAY	9:00 AM- 5:00 PM
WEDNESDAY	9:00 AM- 5:00 PM
THURSDAY	9:00 AM- 5:00 PM
FRIDAY	9:00 AM- 1:00 PM
SATURDAY	9:00 AM- 1:00 PM

IF YOU ARE GOING TO BE LATE OR NEED TO CANCEL, PLEASE GIVE US A COURTESY CALL!

MASSAGE THERAPIST (MT)
SATURDAYS ARE ONLY FOR MASSAGES AND THERAPY, NO ADJUSTMENTS.

CANCELLATIONS:
WE REQUIRE A 24 HOUR NOTICE CALL FOR ALL CANCELLATIONS. FAILURE TO DO SO WILL RESULT IN A **$30 CANCELLATION/NO SHOW-NO CALL FEE.**

This must be collected before you schedule another massage. The collected fee will go directly to the massage therapist for the inconvenience.