Kulow Chiropractic and Wellness Center, PLLC

2305 Becker Dr., Suite F
Brenham, TX 77833
Phone 979-830-7055

464 East Guadalupe St.
La Grange, TX 78945
Phone 979-968-6400

Patient Information

Name: _____ e-mail:_____ Date: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home/Cell Phone: _____ Work Phone: _____
Date of Birth: _____ (optional) Race:_____ Ethnicity: _____
Marital Status: M/S/D/W/Sep Spouse's Name: _____ # of Children: _____
Referred By: _____ Age Range of Children: _____
Employer: _____ Occupation: _____
Emergency Contact: _____ Relationship: _____
Phone: _____ Home/Work/Cell.
Primary Care Physician: _____ Phone: _____
(For Minors Only)Parent Name: _____
Parent Address: _____ City: _____ State: _____
Zip Code: _____ Phone #: _____

PATIENT INITIALS: _____ Informed Consent to Chiropractic Treatment – **The nature of chiropractic treatment:** The doctor will use his/her hands or a mechanical device(s) in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cricked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy 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, dislocation 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 or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

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". **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.**

Health Insurance Information

Medicare _____
VA _____
Self Pay _____

PATIENT INITIALS: _____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. The provider will explain the purpose of every procedure. The provider will supply you with documents you'll need for filing a claim with your insurance company. Please note that some of our services may not be reimbursable under your policy. I accept financial responsibility for my care.

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. I account is not paid within 30 of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient/Guardian Signature: _____ Date: _____

Kulow Chiropractic and Wellness Center

Reason for Visit:
New Injury Old Injury Chronic Pain Wellness

Vitals: **B/P:_____ Ht:_____ Temp:_____**
P:_____ Wt:_____ O2:_____
Resp: _____

Describe your pain (*circle)*

Headache	sharp	dull	ache	radiating	numbness	cramping	burning	throbbing	deep	tight	stiff	sore
Neck Pain	sharp	dull	ache	radiating	numbness	cramping	burning	throbbing	deep	tight	stiff	sore
Upper Back	sharp	dull	ache	radiating	numbness	cramping	burning	throbbing	deep	tight	stiff	sore
Mid-back Pain	sharp	dull	ache	radiating	numbness	cramping	burning	throbbing	deep	tight	stiff	sore
Low Back Pain	sharp	dull	ache	radiating	numbness	cramping	burning	throbbing	deep	tight	stiff	sore
Shoulder Pain (R L)	sharp	dull	ache	radiating	numbness	cramping	burning	throbbing	deep	tight	stiff	sore
Arm Elbow Wrist Hand Pain (R L)	sharp	dull	ache	radiating	numbness	cramping	burning	throbbing	deep	tight	stiff	sore
Hip Pain (R L)	sharp	dull	ache	radiating	numbness	cramping	burning	throbbing	deep	tight	stiff	sore
Leg Knee Ankle Foot Pain (R L)	sharp	dull	ache	radiating	numbness	cramping	burning	throbbing	deep	tight	stiff	sore
Jaw Ear (R L)	sharp	dull	ache	radiating	numbness	cramping	burning	throbbing	deep	tight	stiff	sore

Grade pain level (*circle*)

Headache	*no pain*	0	1	2	3	4	5	6	7	8	9	10	*extreme pain*
Neck Pain		0	1	2	3	4	5	6	7	8	9	10	
Upper Back		0	1	2	3	4	5	6	7	8	9	10	
Mid-back Pain		0	1	2	3	4	5	6	7	8	9	10	
Low Back Pain		0	1	2	3	4	5	6	7	8	9	10	
Shoulder Pain (R L)		0	1	2	3	4	5	6	7	8	9	10	
Arm Elbow Wrist Hand Pain (R L)		0	1	2	3	4	5	6	7	8	9	10	
Hip Pain (R L)		0	1	2	3	4	5	6	7	8	9	10	
Leg Knee Ankle Foot Pain (R L)		0	1	2	3	4	5	6	7	8	9	10	
Jaw Ear (R L)		0	1	2	3	4	5	6	7	8	9	10	

What have you done for the pain? *(circle*)
Seen another doctor pain killers ice
heat aspirin nothing

How long does the pain last? *(circle)*
constant comes & goes

What makes the pain better? *(circle)*
sitting standing laying down turning head
raising arms walking nothing

What makes the pain worse? *(circle)*
sitting standing laying down turning head
raising arms walking nothing

When did your condition/accident occur? ___/___/___

Where did your injury occur? _____

_____

Please explain what happened: _____

_____

Did your injury occur during:

o Work

o Sports/play

o Auto Accident

o Routine/Household activity

Is your condition interfering with your:

o Work If so, how: _____

o Sleep _____

o Daily Routine _____

Is your condition getting worse? Yes No

Has this or something similar happened in the past? Yes No

Explain: _____

Have you been treated by a Medical Physician for this condition? Yes No

If so, where? _____

Have you ever been treated by a chiropractor? Yes No

Clinic or Dr.'s name: _____

Clinic Phone #: _____

REVIEW OF SYSTEMS:

GENERAL APPEARANCE

□ Weight Loss □ Weight Gain □ Change in Sleeping Patterns □ Change in Activity Capacity

NEUROLOGICAL

□ Anxiety □ Headaches □ Depression □ Meningitis □ Paralysis □ Seizure □ Stroke □ Tingling □Tremors □ Memory Loss □ Fainting spells
□ Dizziness □ Head injuries □ Blackouts or near blackouts □ Change in sensation anywhere on your body □ Localized weakness or numbness

EARS, EYES, NOSE, & THROAT

□ Hay fever □ Glaucoma □ Polyps □ Allergy □ Cataracts □ Goiter □ Hoarseness □ Double vision □ Gum problems □ Eye problems
□ Ear Infections □ Glasses/contacts □ Hearing Loss □ Ear discharge/pain □ Frequent nosebleeds □ Ringing in your ears
□ Sinus infections □ Swollen glands

CARDIOVASCULAR

□ Angina □ Leg cramps □ Ankle swelling □ Awakening at night short of breath & getting out of bed □ Cardiac catheterization
□ Cold hands or feet □ Congenital heart defects □ Dizziness when standing up quickly □ Heart attacks □ Heart failure
□ High or low blood pressure □ Irregular heart rate □ Purple fingers or lips □ Leg pain that resolves with rest □ Heart palpitations
□ Varicose veins □ Chest pains □ Murmurs

RESPIRATORY

□ Asthma □ Breathlessness when lying flat □ Prolonged cough □ Coughing up blood □ Emphysema □ Shortness of breath
□ Tuberculosis □ Pneumonia □ Frequent infections (bronchitis) □ Wheezing □ Pleurisy

SKIN

□ Abscess □ Dandruff □ Acne □ Oily skin □ Boils □ Rashes □ Hives □ Dry skin □ Lumps □ Psoriasis □ Jaundice □ Athlete's foot
□ Excessive body odor □ Excessive sweating □ Fungal infections □ Nail problems □ Moles- irregular □ Moles - change/new

KIDNEYS & URINARY TRACT

□ Blood in urine □ Brown urine □ Dribbling after urination □ Painful urination □ Excessive thirst □ Involuntary urination/incontinence
□ Urinating frequently (day) □ Urinating frequently (night) □ Urine hesitancy □ Weak flow
□ Frequent bladder infections □ Kidney disease □ Kidney stone

ENDOCRINE

□ Diabetes □ Sickle cell □ Abnormal body hair □ Changes in skin texture □ Cold intolerance □ Heat intolerance
□ History of "borderline" diabetes

MUSCULOSKELETAL

□ Anemia □ Arthritis □ Back pain □ Neck pain □ Bursitis □ Gout □ Joint aches □ Tendinitis □ Abnormal Blood Counts
□ Blood clots in legs/lungs □ Bone Marrow Biopsy □ Easy Bleeding □ Easy bruising □ Joint swelling □ Morning stiffness
□ Muscle aches

GASTROINTESTINAL

□ Diarrhea □ Reflux □ Ulcers □ Hepatitis □ Abdominal pain □ Anal fissures □ Black tarry stools □ Vomiting blood
□ Constipation □ Nausea □ Problems swallowing □ Hiatal Hernia □ Intestinal obstruction □ Liver disease □ Hemorrhoids
□ Red blood after bowel movements □ Gallstones □ Vomiting □ Heartburn □ Indigestion

MALE & FEMALE

□ Painful sexual intercourse □ Loss of sexual interest □ Unprotected sex □ Groin itching □ Sexually transmitted diseases

MALES ONLY

□ Hernia □ Sterility □ Bloody ejaculation □ Inability to complete intercourse □ Lump on testicle □ Penile discharge
□ Problems maintaining or keeping an erection □ Prostate disease □ Sores on penis or warts □ Testicular pain □ Testicular swelling

FEMALES ONLY

□ D & C □ Hot flashes □ Hernia □ Fibroids □ Abnormal bleeding between cycles □ Abnormal pap smear
□ Bleeding after intercourse □ Complications w/ pregnancy □ PMS □ Endometriosis □ Heavy bleeding during cycles □ Discharge from breast
□ Ovarian cysts □ Pelvic Inflammatory Disease □ Postmenopausal symptoms □ Vaginal discharge □ Vaginal Dryness
□ Vaginal warts

List any Medications you are taking:

o _____

o _____

o _____

o _____

o _____

o _____

o _____

o _____

Please List anything that you may be allergic to:

_____

Do You: Take Supplements or Vitamins? Yes No

Do You: Exercise? Yes No

Are you on a special diet? Yes No How Long? ____

For Women: Are you taking Birth Control? Yes No

Are you Pregnant? Yes No How far along? _____

Are you Nursing? Yes No

Date of Last Menstrual Period: _____

Please List previous illnesses you've had in your life:

_____

List previous surgeries/ treatments with dates:

_____

List any past serious accidents or broken bones with dates:

_____

Family Health History:

Associated health problems of relatives *(circle)*: Cancer Heart Diabetes Other_____

Deaths or Health Problems in immediate family:

Mother Cancer Heart Diabetes Other_____

Father Cancer Heart Diabetes Other_____

Sibling Cancer Heart Diabetes Other_____

Do you smoke? Y N

How much? _____ How long? _____

Are you wearing:

o Heel Lifts

o Sole Lifts

o Inner Soles / Arch supports

What is the age of your mattress? _____

Is it comfortable? Y N

Comprehensive Medical History

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Kulow Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

ICD- 10 CODES:

A_____ B_____ C_____ D_____ E_____ F_____

G_____ H_____ I_____ J_____ K_____ L_____

NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (**IIHI**). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

How we may us and disclose your IIHI

Your privacy rights in your IIHI

Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Kulow Chiropractic and Wellness Center
Kellie Kulow, D.C., Privacy officer
2305 Becker Dr, Suite F
Brenham, TX 77833
Kkdoc5@aol.com
979-830-7055

C. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to – may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.

8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death, we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices

In response to a warrant, summons, court order, subpoena or similar legal process

To identify/locate a suspect, material witness, fugitive or missing person

In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organs and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation in you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for worker's compensation and similar programs.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents:

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sur Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ **Any of the Above**
☐ Text Message ☐ **None of the above** (opt out)
☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

_____ It was emergency treatment _____ The patient was unable to sign because _____

_____I could not communicate with the patient _____ Other (please describe) _____

_____The patient refused to sign _____ _____

Signature of Privacy Officer