Hortman Family Chiropractic
15949 Hwy 105 W Ste 52A
Montgomery, TX 77356

PATIENT INFORMATION

PATIENT Name

Last Name _____ First Name _ _____ Middle _____

Gender: M F Date of Birth ____ / ____ / ____ Marital Status: ____ W____ S____ M____ D SS# _____

Home Address _ _____ Apt #_____

City _____ State_ _____ Zip_____

Home Phone # _____ Cell Phone #_____

Employer Name _ _____ Occupation_ _____

Employer Address _____ Apt#_____

City _____ State_ _____ Zip_____

SPOUSE or GUARDIAN

Last Name _____ First Name _ _____ Middle _____

Employer Name _ _____ Work Phone # _____

Date of Birth ____ / ____ / ____

EMERGENCY Name and address of nearest relative or friend not living with you.

Last Name _____ First Name _ _____ Middle _____

Home Phone # _____ Work Phone # _____

Relation to Patient _____

Assignment of Benefits & Authorization

I authorize the **release** of any medical or other information necessary to process my claims to any insurance company and/or attorney for treatment, payment, and health care operations. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that any amount authorized to be paid directly to **Hortman Family Chiropractic** will be credited to my account on receipt. However, I clearly understand and agree that any services rendered to me are charged directly to me and I am personally responsible for payment. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Texas. This is a permanent authorization that I may revoke at any time by written notice.

x _____

Signature of patient or person acting on patient's behalf Date

Hortman Family Chiropractic
15949 HWY 105 W Ste 52A
Montgomery, TX 77356
OFFICE: 936-588-5008 FAX: 936-588-1011

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **Hortman Family Chiropractic**.

I understand that the Notice describes the uses and disclosures of my protected health information by **Hortman Family Chiropractic** and informs me of my rights with respect to my protected health information.

_____ _____
Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____
Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____ _____
Employee Name *Today's Date*

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Consent to Chiropractic Services

1. I authorize **Dr. Scott A Hortman** the performance upon myself of the following procedures:

   1) Chiropractic manipulative therapy to restore joint motion and function.

   2) Prescribed physiotherapies, electrical, ultrasonic, myotherapeutics, hot and cold applications, traction, muscle rehabilitation, and re-education.

2. I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions. That the above named doctor, associates or assistants, may consider necessary or advisable in the course of my health care.

3. The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to me by the above named doctor or associate.

4. I acknowledge that the doctor or associate has given no guarantee or assurance as to the results that may be obtained from the procedures.

Signed:_____

Dated:_____

Patient Health Questionnaire

Name:_____ Date:_____

Describe your symptoms:_____

When did your symptoms start?_____

How did they begin?_____

Indicate the intensity of your pain: 0 1 2 3 4 5 6 7 8 9 10

NONE UNBEARABLE

Who have you seen for these symptoms?_____

What is your occupation?_____

What is your recreation?_____

Other health problems?_____

Medications:_____

Are you pregnant? Yes or No Not Sure

Patient Signature:_____ Date:_____