Hendrick Wellness Center, P.C.

Blaine Hendrick, DC, FNP-C
Jana Hendrick, DC

Patient Information

Date_____ Patient SS #_____

Patient_____

Primary Address_____

_____
City State Zip

Secondary Address_____

_____
City State Zip

Sex: □ M □ F Age:_____ Birthdate:_____

Preferred Language_____ Race_____ Ethnicity_____

___Single ___Married ___Divorced ___Separated ___Widowed

Occupation_____

Employer_____

Employer address_____

_____
City State Zip Phone #

Spouse's name_____

Spouse's birthdate_____

Name/location of your primary physician:_____

_____

Pharmacy Name:_____

Address:_____ Phone #_____

How did you hear about us? □Insurance Co. □Web □Ads
□Friend/Family □Doctor referred me □Phone Book
□Other:_____ Referred by:_____

Insurance Information

Who is responsible for this account?_____

Relationship to patient_____

Insurance Co._____

Member #_____

Subscriber's name_____

Birthdate_____ SS#_____

Is the patient covered by additional insurance? ____Yes ____No

Insurance Co._____

Member #_____

ASSIGNMENT and RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Hendrick Chiropractic & Wellness Center, P.A. or Hendrick Wellness Center, PC** all insurance 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 insurance submissions. Refunds will be given to patient in same form as collected.

_____
Responsible party signature

_____ _____
Relationship Date

NOTICE OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review the document.

_____ _____
Signature Staff

Contact Information

Home #_____ Cell #_____

E-mail Address:_____
(for records, billing and general information)

Appointment Reminders: □ Text □ E-mail □ Call
IN CASE OF EMERGENCY, CONTACT:

Name_____ Relationship_____

Telephone #_____

Accident Information

Is condition due to an accident? ___Yes ___No Date_____

Type of accident: ____Auto ____Work ____Other

To whom have you made a report of your accident?
Auto insurance Employer Worker Comp Other

Name of Insurance/Workers Comp_____

Attorney name (if applicable)_____

Health History

Please mark any current or resolved conditions:

□ AIDS/HIV	□ Cataracts	□ Herniated Disk	□ Pinched Nerve
□ Alcoholism	□ Depression/Anxiety	□ High Blood Pressure	□ Prosthesis
□ Anemia/Bulimia	□ Diabetes	□ High Blood Cholesterol	□ Rheumatoid Arthritis
□ Anorexia	□ Emphysema	□ IBS	□ Seizures
□ Arthritis	□ Epilepsy	□ Kidney Disease	□ Stroke/Aneurysm
□ Asthma	□ Gastro- Esophageal Reflux	□ Liver Disease	□ Thyroid Disorder
□ Autoimmune Cond.	□ Glaucoma	□ Multiple Sclerosis	□ Scoliosis
□ Benign Tumors	□ Headaches	□ Osteoporosis	□ Ulcers
□ Bleeding Disorders	□ Heart Attack/Heart disease	□ Ovary/Uterus/Breast Cyst	□ Other: _____
□ Cancer	□ Hernia	□ Pacemaker/Any Device	

MEDICATIONS/SUPPLEMENTS

_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES

Latex □ Yes □ No

_____
_____
_____
_____
_____
_____

Date of your last:

Physical Exam: _____
Mammogram: _____
Pap Smear: _____
Prostate Exam: _____
Colonoscopy: _____

Height _____ Weight _____

Please list all surgeries, hospitalizations, & injuries (including motor vehicle collisions if injured):

	Date:		Date:

Smoking:
Never smoked: □
Current smoker: Packs/day_____ Years _____
Former smoker: Packs/day_____ Years _____ When? _____
Smokeless tobacco: □Yes, Years _____ □ No
Do you drink alcohol? Yes No Drinks/day _____
Are you pregnant? Yes No Due date or date of last menstrual period: _____

Family History

F = Father M = Mother S = Sibling GP = Grandparent

High Blood Pressure	F	M	S	GP	Cancer	F	M	S	GP	Arthritis	F	M	S
Heart Disease	F	M	S	GP	Stroke	F	M	S	GP	Alzheimers	F	M	S
Circulation Problems	F	M	S	GP	Osteoporosis	F	M	S	GP	Back Problems	F	M	S
Autoimmune Disorders	F	M	S	GP	Headaches	F	M	S	GP	Seizures-Convulsions	F	M	S

Patient Condition

Today's Date: _____ Reason for visit: _____

When did your symptoms begin? _____

Is this condition getting worse? ___ yes ___ no Rate your current pain: 0 1 2 3 4 5 6 7 8 9 10
0= no pain 10= maximum possible pain

Type of Pain: Aching, Throbbing, Dull, Tingling, Burning, Numbness, Shooting, Stiffness, Tightness, Swelling, Sharp/Stabbing, Cramps

The pain occurs: □ Constantly (76%-100% of the time) □ Frequently (51%-75% of the time)
□ Occasionally (26%-50% of the time) □ Intermittently (0%-25% of the time)

Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation

Painful positions/activities: □ Sitting □ Standing □ Walking □ Bending □ Lying Down □ Twisting

Treatments already received for your condition: □ Medication □ Physical Therapy □ None □ Chiropractic

Have you recently experienced: □ Dizziness □ Fainting □ Nausea □ Night Sweats □ Unexplained weight loss or gain

Other doctor(s) who have treated you for your condition: _____

_____

_____

_____

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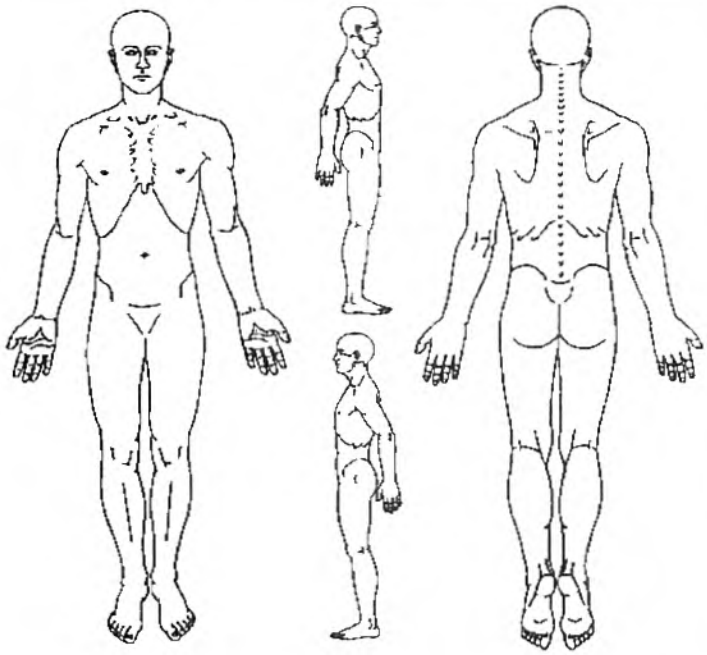

CIRCLE the LOCATION of your symptoms.

LABEL each symptomatic area with the following letters:

A=ache
B=burning
N=numbness
S=sharp/stabbing
T=tingling
O=other

DISCLOSURE AND CONSENT

Medical and Chiropractic Procedures

TO THE PATIENT*: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I/we voluntarily request Dr. ___Blaine Hendrick, DC, FNP-C_____ and/or _____Dr. Jana Hendrick, DC___ to serve as my health care provider(s).

I/we understand that Dr. Blaine Hendrick, DC, FNP-C is currently licensed by the State of Texas as a Family Nurse Practitioner and is authorized to provide medical and prescriptive services, under the laws of the Texas Board of Medicine and the Texas Board of Nursing. I/we further understand that the Provider also holds a Doctor of Chiropractic license issued by the Texas Board of Chiropractic Examiners and authorized to provide any service(s) within the scope of practice of chiropractic. I/we understand that the Provider may be called upon to provide one or more chiropractic or medical procedures, such as a spinal and/or other joint manipulation, in his capacity as a licensed doctor of chiropractic and nurse practitioner. I/we agree that the Provider and such associates, technical assistants and other health care providers, may utilize these procedures, as they may deem necessary to treat my condition.

I/we understand that Dr. Jana Hendrick, DC holds a Doctor of Chiropractic license issued by the Texas Board of Chiropractic Examiners and is authorized to provide any service(s) within the scope of practice of chiropractic. I/we understand that the Provider may be called upon to provide one or more chiropractic procedures, such as a spinal and/or other joint manipulation, in her capacity as a licensed doctor of chiropractic. I/we agree that the Provider and such associates, technical assistants and other health care providers, may utilize these procedures, as they may deem necessary to treat my condition.

I/we understand that the following medical, chiropractic and/or diagnostic procedures are planned for me and I/we voluntarily consent and authorize these procedures as needed:

___chiropractic manipulation, heat/cold therapy, electric stimulation, ultrasound, cold laser therapy, exercises, soft tissue manipulation, and possibly pharmacologic intervention. __

I/we understand that the Provider may discover other or different conditions which require additional or different procedures than those planned. I/we authorize the Provider, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I/we understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, chiropractic and/or diagnostic procedures planned for me. I/we realize that common to the type of medical,

chiropractic and/or diagnostic procedures to be employed by the Provider is the potential for infection, blood clots in veins and lungs, hemorrhage, bruising or broken bones, strains/sprains, soreness, allergic reactions, and even death.

I/we have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I/we believe that I/we have sufficient information to give this informed consent.

I/we certify this form has been fully explained to me/us, that I/we have read it or have had it read to me/us, and that I/we understand its contents.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required)

SIGN:_____ **DATE:** _____

PRINT NAME: _____

For Office Personnel:

Staff initials :_____ **ADDRESS:** 5403 & 5403-A N. McColl Rd, McAllen, TX 78504

Hendrick Wellness Center, P.C.

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Dr. Jana Hendrick, DC
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T: 956.630.2255 F: 956.630.5228
www.**McAllen**Health**Center**.com

Insurance Patients

Regarding your deductible, coinsurance, and/or copay:

We will try to collect the correct amount at the time of your visit. The exact amount varies per insurance company and per plan, and it changes at various times throughout the year. It is difficult to know exactly what you will owe at the time of your visit to our office. Therefore, we typically collect from you a ***rough estimate*** of what you will owe. This is usually not the full amount, but is very close. We will receive information from your insurance company ("EOB" Explanation of Benefits) in 2 or more weeks after your visit. Once we receive the EOB, we will know exactly what amount you owe for that visit. If you owe a little more, we will bill you for the rest. If we owe you some money back, we will send it to you.

> ***For example***, we may collect $ 60 (rough estimate) for a session at the time of the visit. Your insurance may say that you owe $ 64.36, in which case you will then be billed the remaining $ 4.36.
>
> a. You paid $ 60 at the time of your visit.
> b. Your insurance responds in an EOB saying you owed $ 64.36 total.
> c. We will bill you $ 4.36.
>
> If the EOB says you owe less than what you already paid us, then we will gladly return the extra money.

Please understand that we are trying our best to tell you the exact amount due, or at least a rough estimate, when you are in our office. It is very difficult to know exactly what you owe because each insurance plan is different, and they change throughout the year.

Questions? Please call us **(956) 630-2255** or our billing company at **(866) 602-6822**.

**I understand that I may owe more or less after my insurance company confirms the charges in the Explanation of Benefits (EOB). The amount I am paying at the time of the visit is a rough estimate.

_____ _____

Patient Name Date

_____

Print Name