Alternative Health Management

Patient Information

Patient's Full Name:	Cell Phone # Work#
Email Address:	Date of Birth:
Address:	Gender: Male Female
City: St: Zip:	Marital Status: Single/Married/Divorced/Widowed
Emergency Contact:	Referral Source:
Reason for Visit (Major Complaint):	When Did Symptoms First Start?
Medications Currently Taking:	Supplements Currently Taking:
Allergies (Drug, Food, or Other)	Diagnosed Conditions (Current or Past)
Any Hospitalizations or Surgeries:	Any Family History of Health Conditions:
Any Additional Details you would like the Dr. to know:	

Alternative Health Management
952 Echo Ln. Ste 115
Houston, TX 77024
Phone 713-722-2580 Fax 713-722-0055
AlternativeHealthManagement@yahoo.com

CHIROPRACTIC INFORMED CONSENT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff 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 or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations 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, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I, _____ have read and fully understand the above statements.
(Print Name)

_____ _____
(Signature) *(Date)*

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above statements and hereby grant permission for my child to receive chiropractic care.

_____ _____
(Signature) *(Date)*

Alternative Health Management

Patient Information

Financial Agreement

I understand that all services rendered on a cash, check, or credit card basis and are to be paid at the time of service for any services or any products I wish to purchase. I also agree to the $25 returned check charge in the event that my check is returned.

Patient's Initials _____

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operation

Patient's Initials _____

Missed Appointment Policy (No Call/No Show)

I understand that I will be charged a fee if I miss my scheduled appointment time without giving a 24hr notice of cancellation. No Call/ No Shows are subject to the entire amount of the service they are scheduled. Same day cancellations will be subject to $35 cancellation fee. My scheduled time is set aside for me, therefore, another patient cannot be scheduled during that period on that day. I also understand that if I am late for my scheduled appointment or do not have the new patient paperwork complete in its entirety I may be asked to wait allowing the next patient to be seen, or may have to reschedule.

Patient's Initials _____

30 Day Return Policy

I understand the nutritional supplements; homeopathic remedies and/or other supplies are available for purchase. Any product brought in for a refund or exchange must be within the 30 days of the original purchase date. Seals cannot be broken on any packaging and must be in the original boxes if applicable. Returns are subject to a 10% Restocking fee.

Patient's Initials _____

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Phone 713-722-2580 Fax 713-722-0055
AlternativeHealthManagement@yahoo.com

CREDIT CARD AUTHORIZATION FORM

To Schedule an appointment this form must be returned to our office no later than 12:00pm (noon) the day before your scheduled appointment. You may fax or email this form to: Alternativehealthmanagement@yahoo.com or 713-722-0055 (fax)
If you have already provided us with your credit card information by phone, please simply sign and date the form, and write "Card on File" Across the credit card account number area and you may bring the form in with you to your scheduled appointment. *

Please note that your debit/credit card will not be charged to hold this appointment.

However, if you **DO NOT** show for your appointment or cancel within 24 hours, your account will be charged for the length of your scheduled appointment time ($85-$150)

Patient paperwork needs to be **COMPLETELY** filled out prior to your scheduled appointment time. If upon arriving your paperwork is not complete, we may need to reschedule your appointment and you will be charged for the time your appointment was scheduled.

Your appointment is very important to Dr. Howell and the staff of Alternative Health Management. Dr. Howell makes every effort to stay on schedule, so you are not inconvenienced by delays. Thank you for your compliance.

Name on Card: _____

Visa_____ Mastercard____ American Express____

Account Number: _____

Expiration Date: _____/_____

Security Code: _____

Billing Address:_____

Phone Number: _____

By Signing this form, you authorize Alternative Health Management to charge your card for any missed appointment fees that you incur if you do not contact their office within 24hrs of your appointment.

Print Name: _____

Sign: _____ Date:_____/_____/_____

HIPAA SHORT FORM NOTICE OF PRIVACY PRACTICES

We understand that health information about you is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us because we need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all the records of your care generated by this office, whether made by your personal doctor, or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by law
- To avert a serious threat to health and safety
- As required by the military or Veterans' and workers' compensation organizations
- Public health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National security and intelligence activities

Your rights regarding Health Information about you:

- Right to inspect and copy records
- Right to amend records
- Right to an accounting of disclosures
- Right to request restrictions
- Right to request confidential communication, electronically or by paper
- Right to a paper copy of this Notice *(full Notice is available upon request)*

Changes to this Notice:
We reserve the right to change this Notice. We will post a copy of the current Notice in our facility with the current effective date.

Complaints:
If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please address all complaints to:

Alternative Health
Management
952 Echo Lane Ste. #115
Houston, Texas 77024

We will request that you acknowledge your receipt of this notice on the demographics form you complete for us. This acknowledgement will become a part of your records. This acknowledgement provides that you have declined to accept the Complete Notice and instead reviewed this Short Form. We post a copy of the Current Complete Notice of Privacy Practices in our facility and you may also ask for a copy from the receptionist.