

CONFIDENTIAL PATIENT INFORMATION

AUSTIN SKYE WELLNESS CENTER 9070 Research Blvd. #105, Austin, TX 78758
ATTENDING DOCTOR OF RECORD: Chris Barras, DC

PATIENT DATA

Name _____ M ___ F ___ Marital Status _____
Email _____
Home Phone _____ Work Phone _____ Cell Phone _____
Address _____ Apt # _____ City _____ Zip _____
Social Security # _____ - _____ - _____ Date of Birth _____ Age _____
Is your condition related to Work or Auto Accident? _____ If yes, date of accident: _____

INSURANCE INFORMATION: *Please provide the front desk with all your applicable insurance cards. If you do not have your insurance card, then you will need to pay full price for services until it can be obtained and verified.*

Name of insurance company: _____
Name of Insured: _____ Relationship: _____
Member Id#: _____ Group #: _____
Insured Date of Birth: _____

What concerns bring you in to see us today?

POLICY AGREEMENT: I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me, and as a courtesy to me this office will submit bills for my services to my insurance carrier on my behalf. ***Charges will be submitted to my insurance carrier no more than one time, and that this office will not enter into a dispute with my insurance company.*** Furthermore, I understand that this office gives my insurance company 60 days from an incurred charge to pay their portion. If for any reason they do not pay within 60 days, then the balance becomes my responsibility and is due payable upon receipt. I understand and authorize this office to prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I authorize this office to disclose any necessary medical records to the insurance company for payment. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also consent and authorize exams, x-rays, and/or any other procedures deemed necessary by this office. As always I agree to pay for serviced at the time Services are rendered.

CONSENT TO TREATMENT : I hereby authorize the Doctor's to treat my case as they deem appropriate through the use of physical therapy, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, acupuncture and diagnostic testing. I realize the goal of holistic healthcare is to strengthen the patient's body in order to heal themselves. A patient coming to the doctor provides him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor will not provide specific healthcare services, if known or to learn through health care procedures or diagnostics, that the symptoms from whatever he/she is suffering from are related to latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. It is understood and agreed the amount paid the clinic for x-rays is for interpretation and only the x-ray negatives will remain the property of this office, being on file. The patient also agrees that he/she is responsible for all bills incurred at this office.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: I understand and have been provided with a *Notice of Information 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, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

Patient's Signature _____ Date _____

Spouse/Guardian _____ Date _____

Witness _____ Date _____

Austin Skye Wellness
ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

I, the undersigned, do hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries or illnesses, past or present ("condition") to pay directly to, and exclusively in the name of AUSTIN SKYE WELLNESS ("Dr. Chris Barras, DC" and/or Chris Barras, DC, P.C.) such sums as may be owing to Austin Skye Wellness for charges incurred by me including, but not limited to charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the office ("charges"). I further grant a contractual lien to Austin Skye Wellness with respect to my charges applicable to all payers. For the purposes of this Agreement, "benefits" shall include, but shall not be limited to: proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payment benefits, personal injury protection, uninsured motorist coverage, third-party liability distributions, and any other benefits or proceeds payable to me for the purposes stated herein.

In the event that I retain one or more attorneys to represent me in this matter, I hereby direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of Austin Skye Wellness. I further direct each attorney to provide immediate notice to Austin Skye Wellness regarding any funds received by the attorney relating to my accident, injuries, cause of action or claim, to promptly pay out of such funds, and to provide a full accounting of such funds to Austin Skye Wellness upon request, provided that such funds are for medical charges.

I hereby direct all payers to release to Austin Skye Wellness any information regarding any coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize Austin Skye Wellness to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct Austin Skye Wellness to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers.

I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our address upon request in writing to the physician/facility named above.

I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at his clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

This Agreement shall not be modified or revoked without the mutual written consent of Austin Skye Wellness and myself. I hereby revoke any previous signed authorizations, whether executed at this office or any other to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every treatment under this Agreement was reasonable and necessary at the time and place it was rendered. Should any provision of this Agreement be found to be invalid, illegal, or unenforceable, or for any reason cease to be binding on any party hereto, all other portions of this Agreement shall, nevertheless remain in full force and effect.

A photocopy of this instrument shall serve as original.

Signature of patient and/or responsible party: _____ Date: _____

Patient Name (Please Print): _____ Relationship to Patient: _____

Witness: _____ Date: _____

PATIENT INTAKE FORM

NAME: _____

DATE: _____

Please complete all information.

PAST HISTORY:

Please indicate any prior medical problems:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Back/Neck problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Chemical Dependence	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gynecologic problems
<input type="checkbox"/> Gastrointestinal problems	<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Injuries
<input type="checkbox"/> Lupus	<input type="checkbox"/> Migraines/Headaches	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Previous Auto Accidents	<input type="checkbox"/> Major Sports Injuries		
<input type="checkbox"/> Other _____		Or circle	NONE

DO YOU : Smoke? _____ If so, how much? _____
Consume Alcohol? _____ If so, How much/how often? _____
Consume coffee, tea, colas or sodas? _____
Have a Primary Care Physician? _____ His/Her Name _____

HAVE YOU EXPERIENCED ANY KIND OF ABUSE (Emotional, Verbal, Sexual)? Y / N _____

SURGERY: Or circle NONE

List all surgeries that you have had:

ALLERGIES: NONE

List all drugs to which you are allergic, and your reaction to them:

MEDICATIONS: NONE

List all medications , vitamins, supplements, herbs & dosages that you are currently taking or have taken within the last two months:

FAMILY HISTORY:

Please list any conditions that run in your family:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Back/Neck problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Chemical Dependence	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gynecologic problems
<input type="checkbox"/> Gastrointestinal problems	<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Injuries
<input type="checkbox"/> Lupus	<input type="checkbox"/> Migraines/Headaches	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Previous Auto Accidents	<input type="checkbox"/> Major Sports Injuries		
<input type="checkbox"/> Other _____		Or circle	NONE

PLEASE DESCRIBE ANY OTHER CONCERNS YOU HAVE:

Do you have a Living Will and/or Advanced Directives that our office needs to be aware of? Y / N

If Yes, please provide details and supporting documents) Please inform our receptionist or the doctor if you would like more information regarding a Living Will and/or Advanced Directives.

Please circle if you have or have had in the last three months any of the following.

General:	Poor Appetite	Poor Sleeping	Fatigue	Fevers
Chills	Night Sweats	Cravings	Change in Appetite	Poor Balance
Bleed/Bruise Easily	Localized Weakness	Weight Loss	Weight Gain	Peculiar Tastes
Desire Hot Food	Desire Cold Food	Strong Thirst	Sudden Energy Drop	

Skin & Hair:	Rashes	Ulcerations	Hives	Itching
Eczema	Pimples	Dandruff	Dry Skin	Recent Moles
Hair Loss	Purpura	Change in Hair or Skin Textures		Other: _____

Musculoskeletal:	Joint Disorders	Muscle Weakness	Muscle Pain	Tremors
Sprain of Joint	Cold Hands/Feet	Swelling Hands	Swelling Feet	Back Pain
Spinal Curvature	Hernia	Numbness	Tingling	Paralysis
Neck Tightness	Neck Pain	Shoulder Pain	Hand/Wrist Pain	Hip Pain
Knee Pain	Other: _____			

Head, Eyes, Ears, Nose, & Throat:	Dizziness	Concussions	Migraines
Glasses/Contacts	Eye Strain	Color Blindness	Night Blindness
Cataracts	Blurry Vision	Earaches	Poor Hearing
Poor Vision	Cataracts	Seeing Spots	Nose Bleeding
Sore Throat	Grinding Teeth	Teeth Problems	Jaw Clicks
Sores on Lips	Sores on Tongue	Difficulty Swallow	Other: _____

Cardiovascular:	High BP	Low BP	Chest Pain	Palpitations
Fainting	Phlebitis	Irregular Heartbeat	Rapid Heartbeat	Varicose Veins
Other: _____				

Respiratory:	Cough	Coughing Blood	Wheezing	Difficulty
Breathing	Pneumonia	Chest Pain	Phlegm	Other: _____

Gastrointestinal:	Nausea	Vomiting	Diarrhea	Constipation
Gas	Belching	Black Stools	Bloody Stools	Indigestion
Bad Breath	Rectal Pain	Hemorrhoids	Abdominal Pain	Abdominal Cramps
Gallbladder Issues	Parasites	Ulcers	Other: _____	

Neuro-psychological:	Loss of Balance	Lack of Coordination	Concussions	Depression
Anxiety	Stress	Bad Temper	Bi-polar	Other: _____

Genito-urinary:	Pain when Urination	Frequent Urination	Bloody Urine	Urgent urge to Urinate
Kidney Stones	Leaky Bladder	Dribbling	Pause of flow	Frequent UTI
Pain in genitalia	Genital itching	Other: _____		

FEMALE ONLY:	Vaginal Infection	Pelvic Infection	Endometriosis	Vaginal Discharge
Fibroids	Ovarian Cysts	Irregular Periods	Clots	Pain/Severe
Cramps	Breast Lumps	Fertility Problems	Hot Flashes	PMS
Pregnancy # _____	Live Births # _____	Miscarriages # _____	Abortions # _____	Premature Births # _____
Cesareans # _____	Difficult Delivery # _____	Age 1st Menstrual _____	1 st date last period _____	
Method of Birth control: _____ How long have you been using this method? _____				

MALE ONLY:	Prostate Problems	Discharge	Impotence	Fertility Problems
Ejaculation Problems	Painful Testicles	Swollen Testicles	Frequent Seminal Emissions	
Other: _____				

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

Print

Signature

Date