Chad Williams, D.C.
206 N. Dove Rd., Grapevine, TX 76051
817-410-2225 PHONE
817-251-1509 FAX

Welcome

Welcome to the office of Chad Williams, D.C. where we have been proudly serving patients from across the DFW metroplex since 2009. Our mission is "to enable people to live healthier, more fulfilling lives as a result of our care." Our philosophy is old-fashioned; excellence, compassion and integrity. We would like to thank you for inviting us to participate in your health and wellness. We look forward to providing you and your family the finest health care possible.

First, we will do everything we can to address the reasons that brought you to our office, educate you about your health and wellness and provide you with every opportunity to reach your optimum level of health and wellness. We expect you to be an active participant on that road to health so please read all enclosed information and we will welcome all questions you might have – we achieve the best results when doctor and patient are working towards the same goal.

Policy and Procedure

Please thoroughly complete all enclosed forms. We must have these complete forms in order to see you for your first appointment
APPOINTMENTS- Your first visit will take about an hour and subsequent appointments will take about 15 minutes. The treatment plan will be recommended specifically for you so that you achieve the best results possible. We recommend that you do not miss appointments and we will do our best to make your appointments for days and times that will ensure that. _____Initial
CANCELLATION POLICY – If you are unable to keep a scheduled appointment we kindly ask that you give us a 24-hour notice or you will be charged for the appointment. Remember, if you are late it affects everyone scheduled after you. Therefore, if you are 10 minutes late for an appointment it will be considered a missed appointment – you will be charged and asked to reschedule. We encourage everyone to be at least 5 minutes early for all appointments. _____ Initial
PAYMENT – Payment is due at the time services are rendered. We accept check, cash, Visa, MasterCard, and HSA debit cards. Budget payment plans can be arranged if necessary and we will require that you leave a credit card on file for this arrangement. _____ Initial

INSURANCE- We do not bill insurance for services. We will provide you with the necessary documents so that you can file a claim with your insurance company if you chose to do so.
My signature below indicates that I understand that this office does not accept benefits from insurance companies, and any and all fees are my sole responsibility.
Patient/guardian signature _____ Date _____

Your attitude about your health is as important to us as the reason you have consulted our office. Please check which health attitude most closely reflects your personal values:

___ **Treatment Only:** I only consult a doctor when I have an ache or pain and stop care as soon as it is cleared up
___**Prevention:** In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring
___**Maintaining Health:** I am conscious of my health, diet, exercise, etc and actively pursue these because I feel better, perform better, and it maximizes my potential

Patient Information

___**Family Health:** I take an active part in assisting, informing, and maintaining health, with my family. I am concerned with the long term affects of good health.

Name _____ Date of Birth _____ Date _____

Address _____ City_____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____ (please circle the best contact number)

___ Married _____ Widowed _____ Divorced Spouse Name _____

Number of children and ages _____

Who may we thank for referring you to our office? _____

Have you ever received chiropractic care __ No __ Yes who/where/when _____

Please check reason for consulting our office:

___ Continuing ongoing care from another chiropractor
___Concerned about my health and looking for answers
___ I have a specific condition. Explain _____
___ Interested in wellness and natural healthcare
___ I want to improve my immune function

Your Health History

The human body was designed to be healthy – that is the natural state. Throughout life , various stressors occur that damage your body's ability to express its health potential. The information will help us determine the layers of damage to your nervous system and the reason for your current ill health. Based on this information, your chiropractor will outline a course of treatment to correct these layers of damage and recover your natural health potential

Please check all that apply to your health history

	No	Yes	**PLEASE GIVE EXPLANATION AND LIST DATES**
Broken Bones	_____	_____	_____
Been hospitalized	_____	_____	_____
Auto Accident	_____	_____	_____
Sprains/strains	_____	_____	_____
Struck unconscious	_____	_____	_____
Surgery	_____	_____	_____

Please check all that apply to you or a blood relative. Mark X for you and O for family member (parent, grandparent or sibling)

__ AIDS Alcoholism Cancer Crohn's Diabetes

Stress Test: Chemical/Physical/Emotional Stressors

In addition to factors in your health history, the following areas of stress can cause misaligned vertebrae called subluxations. Please complete according to your life style choices

__Smoke or Chew Tobacco (servings/day) _____
__Use Artificial Sweetener (servings/day) _____
__ Consume Caffeine (servings/day) _____
__ Poor Sleep
__Repetitive Lifting/Bending
__ No/little exercise
__ excessive sitting/standing
__Consume Alcohol (servings/day) _____
__Drink Soda(servings/day) _____
__Eat "fast food" (servings/day) _____
__Extensive computer work
__ Excessive weight loss or gain

Describe your diet: _____

__Take over the counter meds (type and frequency) _____

__Take Prescription meds (please list) _____

Occupation: _____ Employer _____ hours worked per day/week _____
Rate your stress level (0=none 10=excessive) Professional _____ Personal _____

Stressors have led to Current Condition/Symptoms

Please mark on the diagram where your current condition is. For all other questions , please circle the answers that best describe your condition

When and how did this condition begin? _____

Did it start: suddenly or gradually Is the pain: constant or come and goes

Please rate intensity of your pain: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain ever)

Does the pain radiate __no __yes where?_____

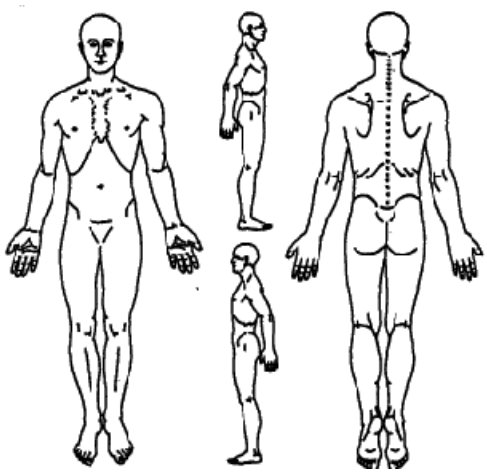
What makes your condition worse:
Sitting standing bending lifting walking ice heat other _____

What makes it better:
Sitting standing bending lifting walking ice heat massage medication other _____

What time of day is your condition better: morning midday night does not matter

Does condition interfere with: sleep work daily routine other _____

Is condition getting: better worse no change



Other healthcare professionals seen for this condition? Who, Where, When?
_____ _____

What type of treatment did you get and what kind of results? _____ _____

Home treatments? _____

Any other questions or concerns ? _____

_____ _____

INFORMED CONSENT & TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have a right, as a patient, to be informed about the conditon of your health and the recommended care and treatment to be provided so that you may make decisions whether or not to undergo chiropractic care after after being advised of the benefits and alternatives.

C*hiropractic* is a science and art which concerns itself with the realtionship between structure (primarily the spine) and function (primarily thenervous system) as that relationship may affect the restoration and preservation of health. *Health* is a state of optimal physical, mental, and social well being, not merely and absence of infirmity.

One disturbance to the nervous sytem is called a *vertebral subluxation.* This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An *adjustment* is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjusments of the spine. Adjustments are usually done by hand or with hand held instruments. In addition, ancillary procedures such as physiotherapy and rehabilitative procedures may be included.

We do not offer to diagnose or treat any disease or condition (pain) other that the vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Our only objective is to eliminate a major interference to the expression of your body's optimum health potential. Our method is with specific adjustments to correct vertebral subluxations. However, we may use other procedures or give other recommendations to help you achieve wellness.

I have read and fully understand the above statements. I therefore accept chiropractic care on this basis.

Signature _____ Date _____

CONSENT TO TREATMENT OF MINOR

I _____ being the parent or legal guardian of _____have read and fully understand the above terms of acceptance. I authorize Dr. Williams and staff to give chiropractic care, perform diagnostic tests and other forms of treatment.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICE SUMMARY

- Chad Williams, D.C. uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.
- Chad Williams, D.C. will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.
- Chad Williams, D.C. may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.
- Chad Williams, D.C. may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, and the patients have a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.
- Chad Williams, D.C. must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.
- If you have any questions or complaints please contact Chad Williams, HIPAA Compliancy Officer for Chad Williams, D.C. at 817-410-2225 .

Patient/guardian Signature _____