Welcome.

Thank you for trusting us with your health.

PARKER UNIVERSITY
Chiropractic Clinics

Welcome to the Parker Chiropractic Clinics!

We are so glad that you have chosen us as your partners in your journey towards health and wellness.

You will come to know us as a group of passionate chiropractors who constantly pursue excellence. Our staff features doctors with advanced training in orthopedics, neurology, disability, rehabilitation, and functional science and the core essence of our care model has been presented in standard chiropractic education as well as chiropractic continuing education.

Our patients come from all walks of life but share one thing in common: They are ready to take charge of their health.

Our service for new patients begins with reviewing your answers to the questions in this packet and talking with you about your challenges, needs, and goals. This information will help us determine if we can help you and if you are a good candidate for our service.

If we believe we can help you, we will begin with the examination process that is appropriate for you.

This packet contains information that will explain more about our service and has questions related to your health. It will take approximately 10-15 minutes to review and complete. Let us know if you have any questions. We truly feel that helping our patients is a privilege.

Your Parker Team

We help more people through referrals made by our patients. If you know or see anyone who may need our help, please have them come in. Thank you for helping make Parker a leader in chiropractic healthcare that improves function and advances performance.



Quality Patient Care.



We are an education healthcare facility. Parker University, College of Chiropractic has a reputation as a premiere choice for students to receive their training towards their career as a doctor of chiropractic.

Since our care is aimed at helping patients and training future chiropractors, the flow of our service must accommodate both initiatives. All patient care is monitored by a licensed doctor of chiropractic and your relationship is with the doctor assigned to you. Your doctor will meet you and provide you with contact information so you can reach them if you have additional questions or concerns. Your service will be rendered by an intern. Interns are future chiropractors in training who have not completed their education. All of your service may be completed by one intern or you may receive service from different interns.

To begin, your intern or doctor will review your answers to the questions in this packet and spend some time getting an understanding about your health concerns. If they believe they can help you, they will recommend a physical and functional health examination. This is how they identify your condition, associated functional deficits, and resulting performance issues that are affecting the quality of your life.

Following your examination, your assigned intern and doctor will meet to discuss the examination results. If treatment makes sense, they will schedule a separate visit to explain what is going on and why they think it's occurring.

YOUR SECOND VISIT

Your intern and doctor will be prepared to report the findings of your examination during your second visit. They will answer your questions and explain why you are experiencing your health concern, what is likely causing it to happen, their plan to help you, how long your care may take, and the estimated cost of your care.

The initial treatment, usually consisting of spinal and/or extremity adjustments, soft tissue release, and therapeutic exercise will be done after your report of findings and your consent to care is given.

If you respond well to our care, your intern or doctor may provide you with home self-care instructions so you can promptly start conditioning your body to maintain your initial results.

FUTURE VISITS

Your intern or doctor should give you a complimentary follow up call within a day of your first treatment visit to see how you responded, answer questions about your home self-care, and confirm your follow up visit. During future planned visits, your intern or doctor will remeasure some of your initial exam tests to determine how you are responding so your care can address your specific needs. Additionally, your intern or doctor will discuss health maintenance and promotion information with you so you can make informed decisions involving your lifestyle habits.

Following a course of care, you will receive a progress examination and report that will guide future decision-making involving your care. If your initial concern improves and resolves, your intern or doctor will discuss wellness options available to you. If your initial concern does not respond to the course of care, an amended care plan may be presented to you or you may be referred to another type of health care provider.

HOW WE MEASURE QUALITY PATIENT CARE

The quality of the care you receive is important to Parker University and we utilize several methods to evaluate the quality of care rendered by our doctor-intern teams:

1. We test the customer service portion of our care by measuring and recording a sample population for patient check-in and wait times, treatment times, and check-out times. Our goal is to make sure that our on-time patients are checked-in with a friendly greeting immediately and the assigned intern is called within two minutes of patient check-in. You can routinely expect a wait time of 5-10 minutes until your intern greets you and about 30-40 minutes for your treatment visit. About 10 minutes of your visit is used by your doctor to discuss your care with the assigned intern and approve the service before it is rendered.

   Once care is completed, it usually takes 2-5 minutes to check-out and confirm your next visit date and time.

   Patients arriving early will be checked-in immediately but the associated intern will be called at the scheduled visit time, so a longer wait time should be expected by early patients.

   We will make every attempt to see late-arriving patients but due to the volume of patients seen, it is sometimes necessary to reschedule. Late-arriving patients should expect a longer wait time.

2. We issue patient surveys three times each year to a sample population of our visiting patients. The survey records your opinion about your doctor's service, your intern's service, our front desk staff service, our scheduling system and available visit times, our facility, and fee structure.

3. The fee slip from each patient visit is reviewed the next business day. We check for twelve quality points including proper diagnosis, service matching, and fee assessment.

4. Each doctor receives routine file audits on a monthly basis. Our thorough process reviews over one hundred points of quality decision-making for each doctor every year. We double-check to make sure that the reason you initially came in is addressed by an accurate diagnosis and an effective treatment plan and service.

5. We listen to your comments and take necessary action. If you have a concern about your care or our service, please contact:
   - Your Doctor
   - Clinic Operations Manager, Elena Kissel – ekissel@parker.edu
   - Director of Compliance, Doug Sanford, DC – dsanford@parker.edu
   - Dean of Clinics, Leon Tom, DC - ltom@parker.edu



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CHIROPRACTIC CLINICS

Joint Notice of Privacy Practices Organized Health Care Arrangement of Parker University

This Joint Notice of Privacy Practices (NPP) describes how your medical information may be used and/or disclosed as well as your rights and how you may access the information. Please review the NPP carefully.

This Joint Notice is the required privacy practices notice of Parker University and Synapse: Human Performance Centers, Inc. for their Organized Healthcare Arrangement (OHCA). This notice applies to and will be followed by: (i) All employees, staff, volunteers, and other personnel of Parker and Synapse; (ii) The physicians and other practitioners who are not employed by Parker or Synapse but who perform services at Parker or its clinics and who are members of the OHCA.

The OHCA consists of separate legal entities that provide clinically integrated care (as defined under federal privacy rules) at Parker's clinics or the Synapse center (collectively, the Clinics). Parker, Synapse, and the practitioners need to share medical information freely to provide care to patients and to conduct health care operations for the Clinics. The OHCA and this NPP only cover information practices related to services rendered at the Clinics. **It does not cover the information practices of the individual practitioners in their separate practices, offices, or at other care settings. It does not alter the independent status of Parker, Synapse, and the practitioners or make Parker or Synapse and the practitioners jointly responsible for the clinical services either provides. In other words, neither Parker, Synapse, nor the practitioners are responsible for each other's negligence, mistakes, or violations of your privacy rights**.

Parker, Synapse, and other members of its OHCA are permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. The following provides explanations and examples of how the OHCA (often referred to herein as "we") may use or disclose your health information and will protect your health information.

"Protected Health Information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health, condition(s) and related health care services. We are required by law to maintain the privacy of PHI.

We are required to abide by the terms of this Joint Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Joint Notice of Privacy Practices when you call the office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Clinics will inform you in a timely manner if there is a case of a breach of unsecured health information.

1. Uses and Disclosures of Protected Health Information

Treatment: We may use and/or disclose PHI about you to provide, coordinate or manage your health care and related services. For example, your student intern will share medical information about you with the Clinic Faculty Doctor who supervises the intern.

Payment: Generally, we may use and give your medical information to others to bill and collect payment for the treatment and services provided to you by us or by another provider. For example, before you receive scheduled services, we may share information about these services with your health plan(s) to ask for coverage under your plan or policy and for approval of payment before we provide the services.

Healthcare Operations: We may use and/or disclose PHI in performing business activities called "health care operations". Examples of the way we may use or disclose PHI about you for "health care operations" include the following:

- *Appointment Reminders.* We may use and/or disclose health information to contact you as a reminder of your appointments.
- *Treatment Alternatives/Benefits.* The Clinic may contact you about a treatment alternative it offers, or other health benefits or services that may be of interest to you.
- *Reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you.*
- *Providing training programs for students, trainees, health care providers or non-health care professionals (for example, billing clerks or assistants, etc.) to help them practice or improve their skills.*
- *Cooperating with outside organizations that assess the quality of the care that the Clinics and others provide.* These organizations might include government agencies or accrediting bodies such as the Council on Chiropractic Education.
- *Reviewing activities and using or disclosing PHI in the event that we sell our business, property, or give control of our business or property to someone else.*
- *Note: Genetic information is protected by law and is not considered part of Health Care Operations.*
- *Fundraising – To the extent that the Clinics engage in fundraising activities (i.e. appeals for money, help, or event sponsorships), certain types of PHI may be disclosed for these purposes, unless you specifically 'opt out' of receiving notification. To 'opt out', call or email the Clinic to be excluded from fundraising campaigns.*

Written Authorization: Other uses and/or disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

Uses and/or Disclosures That Will Not Occur Without Your Expressed Written Authorization:

Marketing/Sales: We will obtain prior authorization before disclosing PHI in connection with marketing/sales activities in which financial remuneration is received.

Specially Protected Information: Certain types of information such as psychotherapy notes, HIV status, substance abuse, mental health, and genetic testing information require their separate written authorization for the purposes of treatment, payment, or healthcare operations.

Uses and/or Disclosures That May Be Made With Your Consent, Authorization, or Opportunity to Object:

We may use and/or disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use and/or disclosure of the PHI, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use and/or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens, we shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment.

Communication Barriers: We may use and disclose your PHI if an intern or another health care provider in the Clinic attempts to obtain consent from you but is unable to do so due to substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and/or Disclosures That May Be Made Without Your Consent, Authorization, or Opportunity to Object:

We may use or disclose your PHI in the following situations without your consent or authorization.

Required By Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to an appropriate government agency that is authorized by law to receive reports of abuse or neglect of a child, an elderly person or a disabled person. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in response to a subpoena, discovery request or other lawful process, subject to certain conditions.

Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. Individuals have the option to 'opt out' of certain types of research activities.

De-identified Information: We may use and/or disclose your PHI after it has been altered so that it does not identify you.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities.

Workers' Compensation: Your PHI may be disclosed by us to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your health care provider created or received your PHI in the course of providing care to you.

Business Associate: We may use or disclose your PHI to a business associate, who is someone we contract with to provide service necessary for your treatment, payment for your treatment, and/or health care operations (e.g., billing service, or transcription service). We will obtain satisfactory written assurance, in accordance with applicable law, that the business associate and their subcontractors will appropriately safeguard your PHI.

Treatment Coordination/Marketing: Face to face communications directly with the patient, treatment and coordination of care activities, refill reminders, or promotional gifts of nominal value do not require authorization as long as we receive no financial remuneration for making the communications.

Required Uses and Disclosures: If required by law, but such uses or disclosure will be made in compliance with the law and limited to the requirements of the law.

2. Your Rights

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to revoke any authorization, in writing, any time.

You have the right to inspect and copy your PHI. With limited exceptions, you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your health care provider and the Clinics use for making decisions about you. You must submit a request in writing. We may deny the request. We may charge a fee for processing costs.

You have the right to request a restriction of your PHI. You may ask us to place additional restrictions on the use or disclosure of any part of your PHI. We are not required to agree to a restriction that you may request. The request must be submitted in writing.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the reason for the request. Please make this request in writing.

You have the right to ask us to amend your PHI. You may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. The request must be submitted in writing.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. You may request a list of disclosures we have made of your PHI. Your request may cover disclosures for up to six years prior to the date on which you make a the request. This list does not include disclosures for treatment, payment, or healthcare operations, disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. The request must be submitted in writing. We may charge a fee for processing costs.

You have the right to obtain a paper copy of this notice from us, upon written request, even if you have agreed to accept this notice electronically.

Your have the right to restrict disclosures to your health plan when you have paid out-of-pocket in full for health care items or services provided by the Clinics. The requested restriction must be submitted in writing.

3. Complaints

Please contact the Clinic HIPAA Contact Officer (Doug Sanford, DC / (972) 438- 9355) if you have any questions or concerns referenced in this Joint Notice of Privacy Practices. Additionally, if you believe your privacy rights may have been violated by the Clinics, please file a written complaint with Doug Sanford, DC. We will not retaliate or treat you any differently for filing a complaint. Another resource that you may contact is the Secretary of Health and Human Services.

This notice was revised, published, and became effective on **October 01, 2021**.



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CHIROPRACTIC CLINICS

PARKER UNIVERSITY
Igniting Passion. Transforming Lives.

NEW PATIENT INTAKE PAPERWORK

LAST NAME		FIRST NAME		MIDDLE INITIAL
PREFERRED NAME		ADDRESS		
CITY	STATE	ZIP	PHONE NUMBER	
EMAIL			PREFERRED METHOD OF CONTACT: ☐PHONE ☐EMAIL ☐TEXT	
DATE OF BIRTH:	AGE:		SEX ASSIGNED AT BIRTH:	

EMERGENCY CONTACT NAME:	PHONE #:
RELATIONSHIP TO PATIENT:	INFORMATION ALLOWED TO BE RELEASED: ☐ALL ☐OTHER:

I AM: ☐SINGLE ☐PARTNERED ☐MARRIED ☐DIVORCED ☐WIDOWED			
I AM CURRENTLY LIVING WITH: ☐SELF ☐PARTNER ☐SPOUSE ☐FAMILY ☐OTHER:			
PARTNER/SPOUSE (IF APPLICABLE)	FIRST	LAST	PHONE #

EMPLOYER NAME:	OCCUPATION:	
ADDRESS:	CITY/ STATE:	PHONE #

PRIMARY CARE PHYSICIAN NAME:	CLINIC NAME:
PHONE NUMBER:	CITY/ STATE:

Who referred you to Parker University Clinics? _____

Are you here because you were involved in an auto collision? ☐Yes* ☐No

Are you here because you were injured at work? ☐Yes* ☐No

Are you here because you were injured on someone else's property? ☐Yes* ☐No

*If YES to any of the above, are you considering OR have you already filed a claim? ☐Yes ☐No

INTERN/ID:_____PATIENT FILE #: _____DATE:_____

NEW PATIENT INTAKE PAPERWORK

CHIEF COMPLAINT

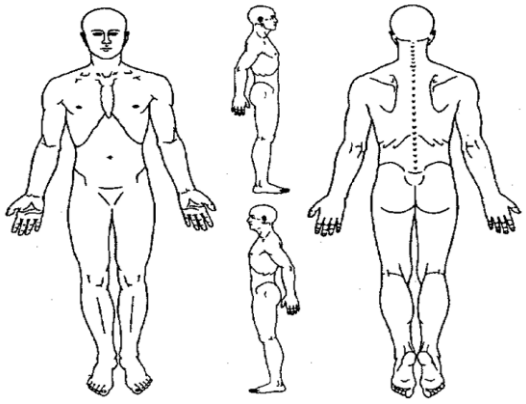
What is the reason(s) for your visit?

COMPLAINT 1:

COMPLAINT 2:

COMPLAINT 3:

Please mark on the diagram the areas of concern that you are seeking care for today. Include any descriptors or comments you feel are important.



Using the chart below, mark the intensity of your complaint(s) for each category below. In order to make the most appropriate determination of your care, please make sure to refer to the severity definitions for each category.

MILD → **MODERATE** → **SEVERE**



0	1	2	3	4	5	6	7	8	9	10
No Symptoms	Hardly notice the symptoms	Slight discomfort	Does not affect activity	Affects personal activities	Prevents personal activities	Limits my work schedule	Prevents all working activities	Prevents all activity	Keeps me bedridden	Worst pain imaginable

QUADRUPLE VISUAL ANALOG SCALE (QVAS)

Mark the severity of your complaint as it is **right now.**

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Mark the severity of your complaint as it is **on average.**

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Mark the severity of your complaint as it is **at its best.**

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Mark the severity of your complaint as it is **at its worst.**

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

COMPLAINT 1:_____ COMPLAINT 2:_____ COMPLAINT 3:_____

INTERN/ID:_____PATIENT FILE #: _____DATE:_____

NEW PATIENT INTAKE PAPERWORK

REVIEW OF SYSTEMS

To ensure you are receiving attention and the best care for your overall health and wellbeing, please review the following conditions and mark if you currently, or have in the past, suffered from any of the following issues:

General:	Current	Past	Never
Fatigue/tired	☐	☐_____	☐
Fever/chills	☐	☐_____	☐
Headache	☐	☐_____	☐
Weight loss	☐	☐_____	☐
Weight Gain	☐	☐_____	☐
Other:			

Skin, hair, Nails:	Current	Past	Never
Bruising	☐	☐_____	☐
Hair Loss	☐	☐_____	☐
Nail Problems	☐	☐_____	☐
Rash	☐	☐_____	☐
Skin Changes	☐	☐_____	☐
Other:			

Musculoskeletal:	Current	Past	Never
Back Pain	☐	☐_____	☐
Joint Pain	☐	☐_____	☐
Muscle Pain	☐	☐_____	☐
Swelling	☐	☐_____	☐
Other:			

Respiratory:	Current	Past	Never
Cough	☐	☐_____	☐
Shortness of Breath	☐	☐_____	☐
Wheezing	☐	☐_____	☐
Use of Inhalers	☐	☐_____	☐
Other:			

Neurological:	Current	Past	Never
Dizziness	☐	☐_____	☐
Fainting	☐	☐_____	☐
Memory Loss	☐	☐_____	☐
Numbness	☐	☐_____	☐
Weakness	☐	☐_____	☐
Other:			

Head, Eyes, Nose, Ears Throat:	Current	Past	Never
Dry mouth	☐	☐_____	☐
Hearing problem	☐	☐_____	☐
Hoarseness	☐	☐_____	☐
Lumps/swelling in neck	☐	☐_____	☐
Trouble Swallowing	☐	☐_____	☐
Difficulty seeing	☐	☐_____	☐
Other:			

Gastrointestinal:	Current	Past	Never
Vomiting	☐	☐_____	☐
Abdominal Pain	☐	☐_____	☐
Blood in stool	☐	☐_____	☐
Bowel/Bladder changes	☐	☐_____	☐
Constipation	☐	☐_____	☐
Heartburn	☐	☐_____	☐
Loss of appetite	☐	☐_____	☐
Nausea	☐	☐_____	☐
Other:			

Mental Health:	Current	Past	Never
Anxiety	☐	☐_____	☐
Depression	☐	☐_____	☐
Difficulty sleeping or Concentrating	☐	☐_____	☐
History of Physical or Mental Abuse	☐	☐_____	☐
Mood Swings	☐	☐_____	☐
Stress	☐	☐_____	☐
Suicidal Thoughts	☐	☐_____	☐
Other:			

Chronic Disease History:	Current	Past	Never
Stroke	☐	☐_____	☐
Heart Attack	☐	☐_____	☐
Diabetes	☐	☐_____	☐
High Blood Pressure	☐	☐_____	☐
High Cholesterol	☐	☐_____	☐
Cancer	☐	☐_____	☐
Other:			

Cardiac (Heart):	Current	Past	Never
Chest Pain	☐	☐_____	☐
Irregular heartbeat	☐	☐_____	☐
Pain with walking	☐	☐_____	☐
Shortness of Breath	☐	☐_____	☐
Swelling in feet/ankles	☐	☐_____	☐
Other:			

INTERN/ID:_____PATIENT FILE #: _____DATE:_____

NEW PATIENT INTAKE PAPERWORK

REVIEW OF SYSTEMS CONTINUED

Reproductive Health	Current	Past	Never		Current	Past	Never
Blood in urine	☐	☐_____	☐	Breast Discomfort	☐	☐_____	☐
Difficulty achieving erection	☐	☐_____	☐	Post-menopausal bleeding	☐	☐_____	☐
Pain in testicles	☐	☐_____	☐	Irregular bleeding	☐	☐_____	☐
Trouble urinating	☐	☐_____	☐	Painful intercourse	☐	☐_____	☐
Foul odor in urine	☐	☐_____	☐	Pregnant/Breast feeding	☐	☐_____	☐
Last Menstrual Cycle Start Date:				Contraception type:			

RECENT TESTS/HEALTH MAINTENANCE

Please indicate if you have had any recent (within the past 2 years) tests by marking YES. In the line provided, please put the date the test was performed.

	NO	**YES**			**NO**	**YES**	
Bone Density	☐	☐	_____	Colonoscopy	☐	☐	_____
Eye Exam	☐	☐	_____	Pap Smear	☐	☐	_____
Mammogram	☐	☐	_____	Prostate Exam/Labs	☐	☐	_____
Physical	☐	☐	_____	Lab Work	☐	☐	_____
Imaging	☐	☐	_____	Diabetic Foot Exam	☐	☐	_____

Current evidence shows that pain is multifactorial and constantly influenced by our emotional health, social structures, and more. To better support your individual needs, please complete the following with as much honesty as you can:

DO YOU HAVE ANY OF THE FOLLOWING CONCERNS?	DO YOU HAVE EASY ACCESS TO THE FOLLOWING?
☐ INABILITY TO MEET BASIC NEEDS (FOOD, SHELTER)	☐ SAFE WALKABLE AREAS
☐ LACKING STRONG SUPPORT SYSTEM	☐ PARKS
☐ WORKPLACE DISSATISFACTION	☐ FRESH PRODUCE
☐ FEELING UNSAFE AT HOME AND/OR WORK	☐ RELIABLE TRANSPORTATION

INTERN/ID:_____PATIENT FILE #: _____DATE:_____

NEW PATIENT INTAKE PAPERWORK

HEALTH HISTORY

List all of the prescription medications you are currently taking:

List all of the over the counter (OTC) medications or supplements you are currently taking:

List all of the surgical procedures/hospitalizations/ER and Urgent Care visits that you have had:

List all significant past traumas that you have had:

Do you currently or have you ever used nicotine/tobacco products (e.g. cigarettes, vaping, chewing)? Please describe which and for how long.

FAMILY HISTORY

Please read the following conditions and mark any that have been diagnosed in your family (Immediate family including aunts, uncles, and grandparents). Please use the space provided to write in what family member(s) are affected.

☐ Substance abuse (alcohol, drugs, etc.)	☐ Allergies/Eczema
☐ Autoimmune (lupus, RA, etc.)	☐ Cancer
☐ Depression/Mental illness	☐ Heart disease/High blood pressure/High cholesterol
☐ Kidney stones	☐ Neurodegenerative disease (including dementia, Parkinson's, etc.)
☐ Migraine/Seizures	☐ Stroke
☐ Osteoporosis	☐ Endocrine (thyroid, diabetes, etc.)
☐ Other:	

INTERN/ID:_____PATIENT FILE #: _____DATE:_____

NEW PATIENT INTAKE PAPERWORK

FITNESS AND LIFESTYLE

Are you currently using any recreational drugs?

What healthy activities are you interested in beginning (if any):

How committed are you to performing activities that will enhance your healthy habits?

Not Committed at all — Fully Committed

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Which of the following activities do you do on a weekly basis, if any? Please provide frequency next to each marked activity.

☐ Running/walking	☐ Cycling
☐ Swimming	☐ Lifting weights
☐ Yoga	☐ Other:

How many servings of fruits & vegetables do you eat a day?	☐0	☐1-2	☐3-4	☐5-6	☐>7
How many glasses of water do you drink a day?	☐0	☐1-2	☐3-4	☐5-6	☐>7
How many sugary beverages do you drink a day?	☐0	☐1-2	☐3-4	☐5-6	☐>7
How many alcoholic beverages do you drink a week?	☐0	☐1-2	☐3-4	☐5-6	☐>7
How many caffeinated beverages do you drink a day?	☐0	☐1-2	☐3-4	☐5-6	☐>7

What are your ideas, concerns, expectations and/or goals regarding your chief complaint?

What are your ideas, concerns, expectations and/or goals regarding receiving care from us?

Do you have anything to share about yourself, lifestyle or beliefs that could influence how we render your care?

INTERN/ID:_____PATIENT FILE #: _____DATE:_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

PATIENT OR GUARDIAN INITIALS

I acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of Parker and the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by Parker.

In addition, I authorize Parker to communicate protected health information through the use of phone, voice mail, text messages, and personal communication, . . birthday cards, thank you notes, etc., as well as including electronic communication such as announcements or newsletters.

This acknowledgement will expire six (6) years from the date of my last visit to Parker.

RELEASE OF HEALTH INFORMATION & ASSIGNMENT OF BENEFITS

PATIENT OR GUARDIAN INITIALS

I authorize Parker to use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, replying to requests from my insurance company, evaluating the quality of services provided, communicating with my referring physician, and any other administrative operations related to treatment or payment as noted in Parker's Notice of Privacy Practices.

I understand that benefits quoted from my insurance carrier to Parker are only an estimate and not a guarantee of payment. I assign Parker all benefits payable to me under my insurance policies and health benefit plans. I shall be personally responsible for any unpaid balance.

THIS IS AN EDUCATIONAL HEALTHCARE FACILITY

PATIENT OR GUARDIAN INITIALS

I acknowledge that I was informed about Parker's operational procedures and methods of assessing the quality of patient care. I understand that a licensed doctor of chiropractic will be overseeing my care, my relationship is with that doctor, one or more interns will be delivering my chiropractic services under the direction of my doctor, and my care may be observed by directly or by way of observational portals so interns may be assessed during the delivery of my care.

I understand that my first visit is for the purpose of obtaining a history of my health concern(s) and delivering necessary examination tests. Once my doctor has approved the work completed, I will receive a report of findings during my second visit and and if I am a candidate for care I will receive treatment following my report.

I will receive future assessments as necessary to evaluate my response to care and any new health concerns.

CONSENT FOR FIRST VISIT EXAMINATION AND TREATMENT

PATIENT OR GUARDIAN INITIALS

I acknowledge that I have received, reviewed, understand and agree to Parker's new patient procedure and consent and authorize Parker to perform evaluation and management procedures for the purpose of identifying a differential diagnosis, formulating and performing an examination, and delivering treatment.

The patient examination process includes important tests that require movement, exertion, and balance control and may result in worsening of symptoms, muscle strain, and falling. I accept these risks and agree that I will provide correct answers and information and I will notify Parker if there has been a change in any of my answers and information.

PATIENT NAME PRINTED

PATIENT OR GUARDIAN SIGNATURE

DATE

PARKER UNIVERSITY
Chiropractic Clinics

Assignment of Benefits and Release of Information

I hereby irrevocably acknowledge full financial responsibility for all services provided to me by Parker University Chiropractic Clinics as consideration for such provider services. I hereby irrevocably assign Parker University Chiropractic Clinics any and all benefits payable by or from any insurance or health care plan(s) coverage maintained by me as consideration for the total fee for those charges incurred by patient as a result of those services rendered by Parker University Chiropractic Clinics. I hereby assign Parker University Chiropractic Clinics: (i) any and all benefits payable by or from any automobile medical payment coverage maintained by me or any party under whose policy of insurance patient may have a lawful right of recovery, (ii) any and all benefits payable by or under any third party liability insurance coverage to which I may have a right of recovery due to the injuries for which I have sought provider's health care services, and (iii) a "common law lien interest" in, and all contractual rights and claims to, any and all future insurance proceeds I have against any insurance company, health care benefits plan, or any other party contractually liable to me for payment of all or any portion of the health care services rendered by Parker University Chiropractic Clinics, and the resultant charges therefore, to me as a result of the injuries sustained by me. This irrevocable assignment of benefits, conveyance of lien interest and contractual rights to and for those charges attributable to Parker University Chiropractic Clinics health care services shall extend to, but not be limited to, provider's entitlement to any and all insurance proceeds remitted as a result of any insurance claim for damages by me which has given rise to the above referenced health care services provided by Parker University Chiropractic Clinics.

_____ _____

Patient Name (printed) Date

_____ _____

Minor's Parent/Guardian Name (printed) Patient/Parent/Guardian Signature

Parker University Chiropractic Clinic
2600 Electronic Lane, Dallas, TX 75220 111 S. Delaware, Irving, TX, 75060
(972) 428 - 9355

AUTHORIZATION FOR TEXT MESSAGING (SMS COMMUNICATIONS)

Patient Name _____ Date of Birth: _____

I understand that:

- Text messages are inherently unsecure because they are transmitted over a public network onto a personal telephone and as such there are inherent risks in using this type of communication. Information texted to me could be received and read by an unauthorized third party.
- It is my responsibility to keep my mobile number up to date with Parker University Chiropractic Clinics
- I should not send PHI or ePHI to Parker University Chiropractic Clinics in a text message because of the unsecure nature of text messages.
- I may be charged for text messages by my wireless carrier.
- This Authorization is voluntary, and I have the right to refuse to sign it.
- Treatment will not be conditional on whether I sign this Authorization.
- By signing this form, I am allowing Parker University Chiropractic Clinics to send text messages to the following mobile number: _____ for the following:
    - Notify me of appointment confirmations, reminders or missed appointments.
    - Informing me that results are back (actual results will NOT be sent)
    - Marketing (surveys, newsletter, promotions, etc.)
    - Other _____

- Parker University Chiropractic Clinics will not send PHI or sensitive PHI in a text message.
- If I sign this authorization, I may revoke (cancel or opt out) it later, at any time, by notifying Parker University Chiropractic Clinics via e-mail (askparkerclinics@parker.edu), or calling 972-438-9355 ext. 7552.

Signature(s)

Patient signature _____ Date _____

Sign below if you are a personal representative of the patient.

Representative signature_____ Date _____

Print Name _____ Relationship to Patient _____

Definitions:

Protected Health Information (PHI): PHI means information about a patient, including demographic information that may identify a patient, that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services.

Sensitive Protected Health Information (SPHI): SPHI means Protected Health Information that pertains to particularly sensitive information, as defined by state law, such as (i) an individual's HIV status or treatment of an individual for an HIV-related illness or AIDS, or (ii) an individual's substance abuse condition or treatment of an individual for mental illness.