# CESAK CHIROPRACTIC
## NEW PATIENT CASE HISTORY

Today's Date _____

Patient's Name _____ SS# _____ Male ____ Female ____

Date of Birth _____ Married ____ Single ____ Divorced ____ Widowed ____

Primary Phone _____ ☐ Cell Provider ____ ☐ Home ☐ Other

Secondary Phone _____ ☐ Cell Provider ____ ☐ Home ☐ Other

How would you like to be reminded about your appointments? ☐ Text or ☐ Call

Address _____ Apt # _____

City _____ State _____ Zip _____ Personal Email _____
(Used to receive valuable coupons from us and other vendors)

Would you like a copy of our Health Newsletter (via E-mail) Yes ____ No ____

Employer _____ Occupation _____

Address _____

City _____ State _____ Zip _____ Phone # _____

Spouse's Name _____ Contact Number _____

Children's Name(s) & Age(s) _____

Emergency Contact ( If different from Spouse) _____ Contact # _____

Referred by: ___ Friend/Family _____ __Internet _____

___ Your Insurance Preferred Provider Directory __ Flyer/Mailer/Coupon _____

___ Sign On Memorial Dr. ___ Health Fair __Other _____

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Please circle the intensity of your pain today. 1-10

1-No PAIN
10-MOST INTENSE EVER FELT

Example Neck When Started? How Started?

1 2 3 4 5 6 7 8 9 10

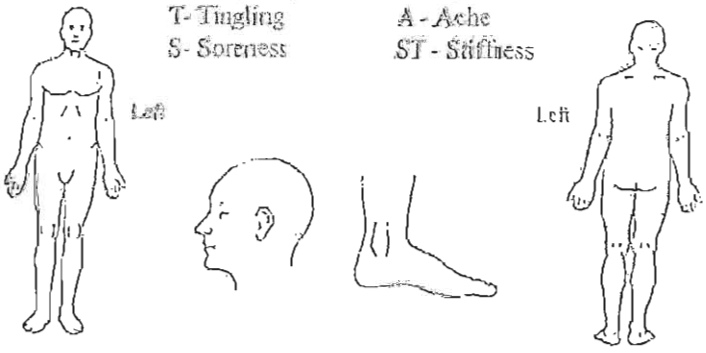
1. _____ _____
1 2 3 4 5 6 7 8 9 10

2. _____ _____
1 2 3 4 5 6 7 8 9 10

3. _____ _____
1 2 3 4 5 6 7 8 9 10

Please Mark the Body with your symptoms.

N - Numbness P - Pain
T- Tingling A - Ache
S- Soreness ST - Stiffness



## HABITS

- ☐ Smoking Packs/Day ____
- ☐ Drinking Alcohol ____
- ☐ Caffeinated beverages Cups/Day ____
- ☐ Recreational Drugs ____

## EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily

Type ____

## FAMILY HISTORY

| | Diabetes | Heart | Kidney | Cancer | Back | Stroke |
|---|---|---|---|---|---|---|
| Mother | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Father | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Brother, # of __ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sister # of __ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

N = Now P= Past

Please check if these symptoms or disease apply and explain on the space provided if Necessary

| N | P | MUSCLES & JOINTS (Explain if Necessary) |
|---|---|---|
| ☐ | ☐ | Arthritis ____ |
| ☐ | ☐ | Bursitis ____ |
| ☐ | ☐ | Foot trouble ____ |
| ☐ | ☐ | Low Back Pain ____ |
| ☐ | ☐ | Neck Pain/Stiffness ____ |
| ☐ | ☐ | Pain Between Shoulders ____ |
| ☐ | ☐ | Hernia ____ |
| ☐ | ☐ | Sciatica ____ |
| ☐ | ☐ | Spinal Curvature ____ |
| ☐ | ☐ | Swollen Joints ____ |
| ☐ | ☐ | Painful Tail Bone ____ |
| ☐ | ☐ | Headaches ____ |

| N | P | PAIN OR NUMBNESS IN... (Explain if Necessary) |
|---|---|---|
| ☐ | ☐ | Shoulders ____ |
| ☐ | ☐ | Arms ____ |
| ☐ | ☐ | Elbows ____ |
| ☐ | ☐ | Hands ____ |
| ☐ | ☐ | Hips ____ |
| ☐ | ☐ | Legs ____ |
| ☐ | ☐ | Rapid Heart ____ |
| ☐ | ☐ | Knees ____ |
| ☐ | ☐ | Feet ____ |

| N | P | GASTROINTESTINAL (Explain if Necessary) |
|---|---|---|
| ☐ | ☐ | Nausea ____ |
| ☐ | ☐ | Vomiting ____ |
| ☐ | ☐ | Constipation ____ |
| ☐ | ☐ | Diarrhea ____ |
| ☐ | ☐ | IBS ____ |
| ☐ | ☐ | Gall bladder trouble ____ |
| ☐ | ☐ | Liver problems ____ |
| ☐ | ☐ | Poor Appetite ____ |
| ☐ | ☐ | Abdominal Pain ____ |
| ☐ | ☐ | Excessive Hunger ____ |
| ☐ | ☐ | Hepatitis ____ |

| N | P | EARS, EYES, NOSE, THROAT (Explain if Necessary) |
|---|---|---|
| ☐ | ☐ | Asthma ____ |
| ☐ | ☐ | Cold/ Flu ____ |
| ☐ | ☐ | Deafness ____ |
| ☐ | ☐ | Dental Decay ____ |
| ☐ | ☐ | Ear Noises/ Tinnitus ____ |
| ☐ | ☐ | Hay Fever ____ |
| ☐ | ☐ | Sore Throat/Tonsillitis ____ |
| ☐ | ☐ | Sinus Infection ____ |
| ☐ | ☐ | Vision Problems ____ |

| N | P | CARDIOVASCULAR (Explain if Necessary) |
|---|---|---|
| ☐ | ☐ | High Blood Pressure ____ |
| ☐ | ☐ | Low Blood Pressure ____ |
| ☐ | ☐ | Pain over Heart ____ |
| ☐ | ☐ | Poor Circulation ____ |
| ☐ | ☐ | Rapid Heart Beat ____ |
| ☐ | ☐ | Slow Heart Beat ____ |
| ☐ | ☐ | Swelling of Ankles ____ |
| ☐ | ☐ | Stroke ____ |
| ☐ | ☐ | Heart Attack ____ |
| ☐ | ☐ | Heart Disease ____ |

| N | P | RESPIRATORY (Explain if Necessary) |
|---|---|---|
| ☐ | ☐ | Chest Pain ____ |
| ☐ | ☐ | Chronic Cough ____ |
| ☐ | ☐ | Difficulty Breathing ____ |
| ☐ | ☐ | Spitting Blood ____ |
| ☐ | ☐ | Spitting Phlegm ____ |
| ☐ | ☐ | Wheezing ____ |

| N | P | GENITO-URINARY (Explain if Necessary) |
|---|---|---|
| ☐ | ☐ | Blood in Urine ____ |
| ☐ | ☐ | Painful Urination ____ |
| ☐ | ☐ | Frequent Urination ____ |
| ☐ | ☐ | Incontinence (loss of bladder control) ____ |
| ☐ | ☐ | Prostate Trouble ____ |
| ☐ | ☐ | Kidney/Urinary Tract Infection ____ |

| N | P | OTHER (Explain if Necessary) |
|---|---|---|
| ☐ | ☐ | Diabetes ____ |
| ☐ | ☐ | Cancer ____ |
| ☐ | ☐ | Epilepsy ____ |
| ☐ | ☐ | Dizziness ____ |
| ☐ | ☐ | Anemia ____ |
| ☐ | ☐ | STD ____ |
| ☐ | ☐ | HIV ____ |
| ☐ | ☐ | Any Other Important Diagnoses ____ |

WOMEN ONLY

- Pregnancy ____ Births ____ Miscarriages ____
- ☐ Irregular Cycle
- ☐ Menopausal Symptoms
- ☐ Painful Menstruation
- ☐ Excessive Menstrual Flow
- ☐ Excessively Painful Cramps

OPERATIONS AND PROCEDURES
(Please fill in with month and year)

| DATE | DATE | DATE |
|---|---|---|
| _____ Back Operation | _____ Appendectomy | _____Heart |
| _____Neck Operation | _____Female Organs | _____Brain/Stroke Surgery |
| _____Arm Operation | _____Tonsillectomy | _____ Stomach/Intestinal/Colon |
| _____Leg Operation | _____Gall Bladder | _____Other_____ |
| _____I have never had any operation(s)/surgery | | _____Other_____ |

List any accidents, falls, and car accident dates:_____

List any broken bones (fractures) or dislocations:_____

Ever on Crutches? Yes No Why?_____

Have you ever had any spinal taps or spinal injections? Yes No

Were you ever knocked unconscious ? Yes No

Have you ever seen a chiropractor? Yes No When?_____ Who?_____

Why?_____

Have you ever had X-rays taken? Yes No When?_____ Why:_____

Have you ever had MRIs taken? Yes No When?_____ Why:_____

Have you ever had CTs taken? Yes No When?_____ Why:_____

Where were these tests taken?_____

Do you suffer from any condition other than that for which you are now consulting us?

_____

Are you presently taking any medications, minerals, or vitamins? Yes No

What prescription medications?_____

Do you have any allergies?_____

I agree the above information or data related to my case to be used for future research/statistical purpose. Any personal identifying information from my case will be strictly confidential and my personal privacy will be protected. I understand that occasionally visiting doctors and or staff to the clinic may be present for the observation of my case. I also state that the above information is accurate to the best of my knowledge.

Signature_____ Date_____

Guardian Signature (if necessary)_____ Date_____


14441 MEMORIAL DR. #24
HOUSTON, TX 77079
P. 281-589-2225
F. 281-589-2227

## AUTHORIZATION AND ASSIGNMENT OF BENEFITS

In consideration of Cesak Chiropractic Family Wellness Center (CCFWC) undertaking to treat me, I agree to the following:

1. CCFW is authorized to release any information deemed appropriate concerning my health to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me at Cesak Chiropractic. In addition, I hereby authorize you to release any of my health information with other doctors as needed to ensure better patient care.

2. In the event any insurance company obligated to make payment to me or CCFW for charges made for services rendered, and has refused to make such payment upon demand by CCFW, I hereby assign and transfer to CCFW the cause of action that exists in my favor against any such company. I also authorize CCFW to prosecute said action either in my name or your name as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts CCFW does not collect from insurance proceeds (whether it be all or part of what is due) I personally owe CCFW.

3. I waive the Statute of Limitations regarding my doctor's right to recover.

## AUTHORIZATION TO PAY DIRECTLY TO DOCTOR

TO: _____/_____

Patient Name — Name of Insurance Company(s) / attorney (if applies) (if applies)

In consideration of the services rendered and to be rendered, I authorize and assign the direct payment to Dr. Brian Cesak any sum I now (or hereafter) owe him by my attorney out of the proceeds of any settlement of my case and/or by any insurance company obligated for the charges for his services or otherwise obligated to make payment to me or him whether based in whole or in part upon the charges made for services rendered by him.

Signature _____ Date _____

CESAK
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WE'VE GOT YOUR BACK!

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**Insurance Patients:** You are responsible for any co-pay, coinsurance, deductible or any other cost not covered by your insurance benefits. Payment is required on the same day services are provided.

The following things are not covered by insurance:

1. Decompression
2. Electrodes (used for muscle stimulation therapy) = $22
   (Electrodes usually last about 1 year so only 1 set usually necessary)
3. Any vitamin supplements, pillows, exercise equipment, biofreeze, etc…

The following treatment may not be covered by insurance:

1. Massage- Every 15 minutes = $22 is our cash price

**Cash Patients:** Cash, check or credit card are accepted payments. Payment is required on the day the services are provided (We DO NOT accept Discovery or American Express). A list of cash prices for our services is available at any time. Please ask someone at the front desk for a copy.

**Auto Accident Patients:** A letter of protection from lawyer or the information to bill your auto insurance (PIP or Personal Injury Protection) is required on the first date of service. If the third party (i.e. you were not responsible for the accident and are seeking medical care) accepts our assignment of benefits (AOB) then we can see you without payment upfront with the understanding that the insurance will reimburse us directly. If your third party does not accept our AOB then you must pay cash at time of service. We will supply you with an itemized bill for you to submit your claims to the third party's insurance.

Special Offers:

1. For patients needing financial help we do offer a great service called Care Credit which provides a no interest credit card if paid within 12 months. Normal credit card rates apply to balances after the 12 month grace period.
2. Cesak Chiropractic offers discount treatment packages, wellness maintenance packages, and massage packages. Ask one of our staff or Dr. Cesak if you're interested in these plans.

All copies of your medical bills (itemized bills) can be made available to you 2-3 business days after your last visit upon request.

ATTENTION: If your check is returned unpaid, you expressly authorize Cesak Chiropractic and its processing center to electronically debit your account, or generate a paper draft/substitute check against your account for the face value of the returned check and the maximum allowable state fee. Your use of a check as payment is your acknowledgement and acceptance of this policy and its terms. If applicable, collection fees will automatically be charged to patient's accounts

I, _____ ____, acknowledge that I have read and
(Printed name)
will adhere to the policies outlined above.

_____ / _____
Signature Date

_____ / _____
Signature (Guardian if necessary) Date

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## HIPAA NOTIFICATION
## PERMISSION TO RELEASE MEDICAL INFORMATION

I, _____ I have been informed that Cesak Chiropractic's HIPAA policies are available for me to read at any time, in the reception area. I have been advised to read those policies by the staff upon my arrival. I understand my privacy rights as they pertain to my medical information at this office. I give Cesak Chiropractic permission to share my medical/insurance information with all medical professional offices that I am referred to for imaging and/or additional care.

Furthermore, I give Cesak Chiropractic permission to share any of my medical information with these personal contacts listed below. These contacts are unrelated to my insurance or lawyer's office. I understand that I can amend this list at any time by contacting the office and that the contacts will have access to my medical information from today's date on, unless I opt to remove them at a later date. I further understand that I have the option to leave this blank and that will automatically leave my information private to personal contacts.

Non-medical persons allowed access to my medical information:

Contact 1 _____

Contact 2 _____

Signature_____ Date_____

Signature (guardian if necessary)_____ Date_____

## CONSENT FOR CHIROPRACTIC TREATMENT AND X-RAY

I, _____, do hereby give my consent to Cesak Chiropractic and/or its representatives to perform all necessary treatments including spinal manipulation, decompression, traction, muscle stimulation/interferential therapy, thermal/cryotherapy, massage therapy, therapeutic exercise and other physical therapies as deemed appropriate by the examining Doctor of Chiropractic. I also give permission for the doctor to order X-rays/MRIs/CT/Ultrasound etc. I understand the risks and benefits of the above noted procedures/therapies or they have been thoroughly explained to me and I wish to proceed with treatment.

Signature_____ Date_____

Signature (guardian if necessary) _____ Date_____

Women Only
I declare that to my knowledge I am not pregnant.

Signature_____ Date_____

If you are pregnant or may be pregnant you should tell your doctor before or during the exam.

# MASSAGE CANCELLATION POLICY

All appointments for 30 minutes or greater massages at Cesak Chiropractic Family Wellness Clinic requires a minimum 24-hour notice of cancellation. These appointment times are blocked off especially for you and, as such, are made unavailable to other patients. Additionally the massage therapists are generally required to come in early or stay late to provide this service and are happy to do so when appointments are kept. Please inform us at least 24 hours in advance if you are unable to keep your appointment so that we may make that time available to other patients in need of massage.

Since these massage services are by appointment only, a major credit card is required to hold your appointment. You will not be charged until massage services are rendered, unless you fail to cancel within 24 hours and/or no-show (see below) your appointment! We understand that family or business "emergencies" can arise from time to time so we provide the following generous policy regarding missed appointments. If you are unable to give us 24 hours advance notice you will be charged:

| | Base Rate |
|---|---|
| 1st offense: No Charge | 30 minutes - $44 |
| 2nd offense: 50% of base rate | 60 minutes - $88 |
| 3rd offense + : full charge of base rate | 90 minutes - $132 |

Please keep in mind that this fee cannot be billed to your insurance company and will be your responsibility to pay. If you are scheduled for a Monday massage appointment and will be unable to make it, then leaving a voice mail by Sunday mid-day will be sufficient.

No-shows

Anyone who fails to show up for a scheduled massage appointment or does not provide a minimum 24 hours cancellation notice, will be considered a "no-show" and will be charged as mentioned above.

Late Arrivals

Out of respect and consideration to your therapist and other customers, please plan accordingly and be on time. If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the "full" session.

We thank you in advance for your courtesy.

_____ _____

Patient's Name Date

_____ _____

Signature Credit Card Information