



Holistic Chiropractic and Wellness, Inc.

Dr. Blair Spiller, D.C.

Dr. Amanda Ming Ulloa, D.C.

Dr. Jen Dufala, D.C.

2251 Double Creek Dr, Suite #501 Round Rock, TX 78664  
512-246-0220, ext. 2

**Welcome to our office!** PLEASE PRINT AND COMPLETE ALL SECTIONS

Appointment Date: \_\_\_\_\_ Referred By: \_\_\_\_\_  
 Name (first, middle, last) \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Marital Status: M S W D Name of Spouse: \_\_\_\_\_  
 Names and Ages of children \_\_\_\_\_  
 Email: \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_

**TELL US ABOUT ALL PRESENT AND PAST CONDITIONS:**

Please mark, in front of each statement ANY that apply to you. Place and "X" for any **present conditions** and, "O" for any **past conditions** that are no longer an issue. **If it does not apply to you, please leave it blank.**

Extremities	Respiratory	Other Conditions	Male
___ Hip Pain or Stiffness R/L	___ Asthma	___ Headaches/Migraines	___ Impotence
___ Foot Pain Stiffness R/L	___ Chest Pain	___ Trouble Sleeping	___ Prostate Problems
___ Wrist Pain or Stiffness R/L	___ Difficulty Breathing	___ Excessive Sweating	<b>Female</b>
___ Elbow Pain or Stiffness R/L	___ Lung Problems	___ Cancer Type: _____	___ Menopausal Problems
___ Shoulder Pain or Stiffness R/L	<b>Digestion</b>	___ Emotional/Mental Disorders	___ Menstrual Cycle Problems
___ Pubic Bone Pain	___ Heartburn	___ Learning Disability	<b>Urinary Tract</b>
___ Jaw Pain or Clicking or Popping R/L	___ Digestion Problems	___ Nervous/Irritable	___ Kidney Trouble
___ Knee Pain or Stiffness R/L	___ Gallbladder Problems	___ Loss of Memory	___ Frequent Urination
<b>Spine</b>	___ Colon Trouble	___ Dizziness/Loss of Balance	___ Bedwetting
___ Head/Shoulders Feel Heavy/Tired	___ Diarrhea/Constipation	___ Arthritis	___ Other:
___ Neck Pain or Stiffness R/L	___ Hemorrhoids	___ Epilepsy/Convulsions	<b>Organ Problems/Dysfunction</b>
___ Upper Back Pain or Stiffness R/L	<b>Immune</b>	___ Knocked Unconscious	___ Diabetes
___ Mid Back Pain or Stiffness R/L	___ Skin Problems	___ Frequent Ear Infections	___ Liver Trouble
___ Low Back Pain or Stiffness R/L	___ Sinus / Allergies	___ Ringing in Ear R/L	___ Hepatitis
___ Pain with cough/sneeze or strain	___ Frequent Colds/Flu	___ Hearing Loss R/L	___ High/Low Blood Pressure
___ Difficulty with (circle all that apply) Standing/Walking/Sitting/Bending/Lifting/Twisting	___ Anemia	___ Trouble Concentrating	___ Heart
<b>Numbness/Tingling or Pain in:</b>	___ Other:	___ AIDS/HIV	
___ Arms/ Hand/Fingers R/L		___ Fracture/Dislocation of Bones: _____	
___ Legs / Feet / Toes R/L		___ Other:	

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TELL US ABOUT YOUR PRESENT AND PAST HEALTH CONDITION(S)**

1. Primary Complaint(s): \_\_\_\_\_
2. Secondary Complaint(s): \_\_\_\_\_
3. Tertiary Complaint(s): \_\_\_\_\_
4. Have you become discouraged about handling this problem?  Yes  No
5. Does this problem interfere with the following areas of your life?  
Family:  Yes  No If yes, please explain: \_\_\_\_\_  
Work:  Yes  No If yes, please explain: \_\_\_\_\_  
Hobbies:  Yes  No If yes, please explain: \_\_\_\_\_  
Life:  Yes  No If yes, please explain: \_\_\_\_\_
6. How much older does this problem make you feel: \_\_\_\_\_
7. On a scale of 1 to 10, with 10 being the most, rate your commitment level in helping us solve this problem:  
\_\_\_\_\_
8. Tell us about your past medical history: What? When? Results?  
Surgeries: \_\_\_\_\_  
Hospitalizations: \_\_\_\_\_  
Major Illness: \_\_\_\_\_
9. Are you currently taking anti-coagulant medication/therapy?  Yes  No
10. When did you last see a chiropractor? \_\_\_\_\_ Dr. Name: \_\_\_\_\_  
For what reason? \_\_\_\_\_  
What spinal maintenance programs were you given to maximize the stability of your spine?  
\_\_\_\_\_  
Did you follow the Doctor's recommendations?  Y  N If no, Why not? \_\_\_\_\_  
Why are you changing chiropractors? \_\_\_\_\_

**IF YOU'RE PREGNANT, PLEASE PROVIDE THE FOLLOWING INFORMATION**

1. How many weeks prenatal are you? \_\_\_\_\_
2. OB/GYN or midwife name: \_\_\_\_\_ Practice name: \_\_\_\_\_
3. Delivering at: \_\_\_\_\_
4. Due date: \_\_\_\_\_
5. Baby name: \_\_\_\_\_  Female  Male
6. Gestational diabetes?  Yes  No
7. Pre-eclampsia?  Yes  No
8. Placenta is:  Anterior  Posterior
9. I need more education in prenatal anatomy:  
 Sacrum  SI Joint  Round Ligament  Psoas  Piriformis

*I verify that all of my information is correct and that I have completed all questions with as much information as is possible.*

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Detailed Information - Primary Complaint

1. What is your **PRIMARY** complaint? \_\_\_\_\_
2. How long have you suffered with this? \_\_\_\_\_
3. How did your primary complaint start? \_\_\_\_\_
4. Please circle or describe what your primary complaint feels like:  
Aching    Tight    Burning    Sharp    Numbing    Tingling    Dull    Weak    Shooting  
Other: \_\_\_\_\_
5. How often does your complaint occur?                      Constant                      Intermittent                      Occasional
6. How would you rank your primary complaint on a pain scale from 1 to 10; 10 being the most painful: \_\_\_\_\_
7. Does your complaint ever radiate to any other areas?  Yes  No    If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
8. Currently, what makes it better? \_\_\_\_\_
9. Currently, what makes it worse? \_\_\_\_\_
10. Please circle all that you have done so far to help with your primary complaint:  
Massage      Medicine      Physical Therapy      Exercise      Rest    Ice    Heat    Herbal Remedy  
  
Chiropractic Adjustments    Yoga    Surgery      Psychiatrist/Psychologist/Counseling      Nothing
11. What medication(s), if any, are you taking for your primary complaint? \_\_\_\_\_
12. If you have had surgery regarding this complaint, please describe it: \_\_\_\_\_  
\_\_\_\_\_
13. Do you feel your symptoms are a result of domestic violence within the home? \_\_\_\_\_
14. Do you need more information about how to get help with human trafficking? \_\_\_\_\_

## Detailed Information - Secondary Complaint

1. What is your **SECONDARY** complaint? \_\_\_\_\_
2. How long have you suffered with this? \_\_\_\_\_
3. How did your secondary complaint start? \_\_\_\_\_
4. Please circle or describe what your secondary complaint feels like:  
Aching    Tight    Burning    Sharp    Numbing    Tingling    Dull    Weak    Shooting  
Other: \_\_\_\_\_
5. How often does your complaint occur?                      Constant                      Intermittent                      Occasional
6. How would you rank this complaint on a pain scale from 1 to 10; 10 being the most painful? \_\_\_\_\_
7. Does your complaint ever radiate to any other areas?  Yes  No    If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
8. Currently, what makes it better? \_\_\_\_\_
9. Currently, what makes it worse? \_\_\_\_\_
10. Please circle all that you have done so far to help with your secondary complaint:  
Massage      Medicine      Physical Therapy      Exercise      Rest    Ice    Heat    Herbal Remedy  
  
Chiropractic Adjustments    Yoga    Surgery      Psychiatrist/Psychologist/Counseling      Nothing
11. What medication(s), if any, are you taking for your secondary complaint? \_\_\_\_\_
12. If you have had surgery regarding this complaint, please describe it: \_\_\_\_\_  
\_\_\_\_\_
13. Do you feel your symptoms are a result of domestic violence within the home? \_\_\_\_\_

## Detailed Information - Tertiary Complaint

1. What is your **TERTIARY** complaint? \_\_\_\_\_
2. How long have you suffered with this? \_\_\_\_\_
3. How did your tertiary complaint start? \_\_\_\_\_
4. Please circle or describe what your tertiary complaint feels like:  
Aching    Tight    Burning    Sharp    Numbing    Tingling    Dull    Weak    Shooting  
Other: \_\_\_\_\_
5. How often does your complaint occur?                      Constant                      Intermittent                      Occasional
6. How would you rank this complaint on a pain scale from 1 to 10; 10 being the most painful? \_\_\_\_\_
7. Does your complaint ever radiate to any other areas?  Yes  No    If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
8. Currently, what makes it better? \_\_\_\_\_
9. Currently, what makes it worse? \_\_\_\_\_
10. Please circle all that you have done so far to help with your tertiary complaint:  
Massage    Medicine    Physical Therapy    Exercise    Rest    Ice    Heat    Herbal Remedy  
Chiropractic Adjustments    Yoga    Surgery    Psychiatrist/Psychologist/Counseling    Nothing
11. What medication(s), if any, are you taking for your tertiary complaint? \_\_\_\_\_
12. If you have had surgery regarding this complaint, please describe it: \_\_\_\_\_  
\_\_\_\_\_
13. Do you feel your symptoms are a result of domestic violence within the home? \_\_\_\_\_

## RELEASE AND CONSENTS

### AUTHORIZATION FOR DIAGNOSIS AND TREATMENT

I authorize Dr. Blair Spiller, D.C., Dr. Jen Dufala, D.C., and/or Dr. Amanda Ming Ulloa, D.C. to administer diagnoses and treatment. I also authorize the provider(s) to release any information required to process insurance claims.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

### CONSENT TO X-RAY EXAMINATIONS

If and when deemed necessary, I do hereby consent to X-ray examination, to be performed at an outside facility.

Females: I will notify the doctors if I believe that I could be pregnant so that the proper precautions will be taken.

Last Menstrual Period Date \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HIPAA**

**Consents** Name of Practice: Holistic Chiropractic and Wellness, Inc.

Address: 2251 Double Creek Dr, Suite #501  
Round Rock, TX 78664

Privacy Contact: Dr. Blair Spiller, D.C.

Telephone: 512-246-0220

\* I hereby authorize Holistic Chiropractic and Wellness, Inc to release periodic status reports from the medical records of the patient listed below. The reports may be released to other physicians or facilities participating in my care.

\* I understand my records are confidential and cannot be disclosed without my written authorization, except otherwise provided by law.

\* I understand that records pertaining to the diagnosis and/or treatment of HIV/AIDS testing, psychiatric illness and alcohol or chemical abuse dependency will not be released unless I have given my specific consent to release this information.

\* I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it and that this authorization will automatically expire on one year from date signed.

\* I understand that a photocopy or facsimile of this authorization is as valid as the original.

\* I authorize the release of any medical billing or other information necessary to process claims on my behalf.

\* I agree to be fully responsible for all lawful debts incurred by myself (or dependents under care) for services received from Holistic Chiropractic and Wellness, Inc.

\* I understand that any verbal consent or intent to use photographs or social media network sharing by the patient or provider is protected as valid written consent when patient, other patient, or provider agreed on photographed educational testimonies.

\*\* I understand that I do not have to sign this authorization in order to receive treatment from this practice, but when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I acknowledge that I was provided with the Notice of Privacy Practices of the Chiropractic Practice named at the top of this page.

Printed Name of Patient: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

**For Personal Representative of the Patient (only if applicable)**

Print Name of Personal Representative: X \_\_\_\_\_

Relationship (parent, guardian, etc.): X \_\_\_\_\_

Signature of Personal Representative: X \_\_\_\_\_

Reason Patient unable to sign: \_\_\_\_\_

\_\_\_\_\_  
Practice Employee

\_\_\_\_\_  
Date

**ALL PATIENTS PLEASE PROVIDE THE FOLLOWING**

May we release appointment, billing and medical information to anyone other than you? \_\_\_YES \_\_\_NO

Name(s) of the person(s) we may release your information to: \_\_\_\_\_

**Please initial one box below:**

If our office attempts to contact you and a message is taken by an answering machine/voicemail or another person, it is appropriate to leave a:

\_\_\_ Detailed message regarding condition, appointments, or payments.

\_\_\_ Message to call Round Rock Health & Wellness Center

## NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

Revised According to New HIPAA Regulations September 23, 2013

Holistic Chiropractic and Wellness, Inc. is committed to protecting your protected health information.

"Protected Health Information" (PHI) may include such items as: medical notes from your doctor, a claim from your provider listing your diagnosis, a medical treatment that you received, or laboratory/diagnostic test results. This notice about protecting your PHI is required by law. It tells you about your rights and how we use and disclose your health information.

### YOUR HEALTH INFORMATION RIGHTS

- Request a restriction on certain uses and disclosures of your PHI; however, we are not required to approve your request.
- Request that we notify you about your PHI in a way or at a location that will help you keep your information confidential.
- Receive a list of certain disclosures we have made of your PHI. This is a list of disclosures made by us during a specified period of up to six years *except for disclosures made*:
  - For treatment, payment, and healthcare operations
  - For use in or related to a facility directory
  - To family members or friends involved in your care
  - To you directly
  - Pursuant to an authorization of you and your personal representative
  - For certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes)
  - Before April 14, 2003
- In writing at any time, withdraw your permission for us to disclose your PHI, except for the information that we disclose before you stopped your permission.
- Review and obtain a copy of your own PHI.
- Ask us to change your PHI if you believe it is incorrect or incomplete. We may deny your request and, if so, will give you the reason(s) why the request was denied.
- Receive a paper or electronic copy of this Notice of Privacy Practices upon request.

HOW Holistic Chiropractic and Wellness, Inc. MAY USE OR DISCLOSE YOUR PHI: The examples included with each category do not list every type of use or disclosure that may fall within that category. FOR TREATMENT: We may use and disclose your PHI to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use and disclose your PHI to obtain payment for services we provided to you. HEALTHCARE OPERATIONS: We may use and disclose your PHI in connection with chiropractic operations, including quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

REQUIREMENTS BY LAW: We may use and disclose your PHI when required to do so by law. We may also use or disclose your PHI to public health authorities or other authorized persons to carry out certain activities related to public health, including the following:

- To prevent or control disease, injury or disability.
- To report disease, injury, birth or death.
- To report child abuse or neglect.
- To report reactions to medications or problems with products or devices regulated by the federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA regulated products or activities.
- To locate and notify persons of recalls of products they may be using.
- To notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease.
- To report to your employer, under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance.

We may also use and disclose your PHI under certain circumstances for the following purposes where the disclosure is:

- About a suspected crime victim if, under certain limited circumstances, we are unable to obtain a person's agreement because of incapacity or emergency.
- To alert law enforcement of a death that we suspect was the result of criminal conduct.
- In response to a court order, warrant, subpoena, summons, administrative agency request, or other authorized process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- About a crime or suspected crime committed at the workplace.
- In response to a medical emergency not occurring at the workplace, if necessary to report a crime, including the nature of the crime, the locations of the crime or the victim, and the identity of the person who committed the crime.

HEALTH OVERSIGHT ACTIVITIES: We may disclose your PHI to government health agencies for health oversight reasons, such as program audits or licensure reviews.

RESEARCH: We may use your PHI for approved research purposes, such as for study to cure a disease. SPECIAL GOVERNMENT FUNCTIONS: We may, such as protection of public officials or reporting to various branches of the armed services, require the use or disclosure of your PHI.

OTHER USES: We may use and disclose your PHI to your family member, close friend, or any other person identified by you if that information is directly relevant to the person's involvement in your care or payment for your care.

OBLIGATIONS OF Holistic Chiropractic and Wellness, Inc.

- Maintain the privacy of your PHI.
- Provide you with the Notice of its legal duties and privacy practices with respect to your PHI.
- Obtain your written authorization to use or disclose your PHI for reasons other than those listed in this Notice and permitted by law.
- Abide by the terms of this Notice that are currently in effect.
- Notify you if we are unable to agree to requested restriction on how your PHI is used or disclosed.
- Allow reasonable requests you may make to notify you about your PHI in a way or at a location that will help you keep your PHI confidential.

Holistic Chiropractic and Wellness, Inc. reserves the right to change its information practices. The new provisions will be effective for all PHI that Holistic Chiropractic and Wellness, Inc. maintains. Revised notices will be made available to you by written notices.

### COMPLAINTS:

If you have a complaint about how Holistic Chiropractic and Wellness, Inc. handles your PHI, or if you otherwise believe that your privacy rights have been violated by Holistic Chiropractic and Wellness, Inc., your complaint should be directed to:

Holistic Chiropractic and Wellness, Inc., 2251 Double Creek Dr, Suite #501 Round Rock, TX 78664 (512) 246-0220

Attention: Privacy Contact

If you are not satisfied with the manner in which Holistic Chiropractic and Wellness, Inc. handles a complaint, you may submit a formal complaint to the U.S. Secretary of Health and Human Services in Washington, D.C. There will be no retaliation by Holistic Chiropractic and Wellness, Inc. if you file a complaint.



## OFFICE POLICIES

### TO OUR VALUED PATIENTS:

Thank you for choosing Round Rock Health & Wellness Center for your care. We are committed to providing you with the best possible service. Please review our financial policy below. If you have any questions, please ask one of our staff to assist you with an explanation.

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### TIME OF SERVICE PAYMENT

**Payment is required at the time services are rendered** unless other arrangements have been made in advance by you and/or your insurance carrier. This includes applicable and estimated co-insurance and copayments under your insurance policy, deductible amounts under your insurance policy, and non-covered services. If there is a remaining balance due after your insurance carrier pays, you have **30 days** to make payment on the invoice. We urge you to keep your account current to avoid any misunderstandings with our office or cumulative buildup of your balance. RRHWC accepts cash, money orders, and most credit cards.

### INSURANCE

As a courtesy to you, we will bill your insurance company for chiropractic services. It is your responsibility to provide us with information regarding the insurance we will be billing. If you do not have your insurance card(s) with you, your account will be considered "self-pay" until you provide us with the appropriate documents. Insurance coverage is a contract between you and your insurance carrier. **You are ultimately responsible for full payment of services rendered and knowing what your insurance will or will not pay.** Our front office staff will do their best to give you an **estimate** of what you'll owe each visit. Please be sure to inform the front office staff of any changes in your policy or information, and we will be happy to verify your benefits for you.

### REFERRALS

Your insurance may require a prior authorization for some services before you can be seen by a chiropractor. It is your responsibility to make sure RRHWC has this authorization on file at the time of your visit. If the authorization is not provided, you may be asked to reschedule or pay for your visit at the time of service until the required documents are provided for submission to your insurance carrier.

### FORMS REQUESTS

We are happy to provide you with hard copies or PDFs of any documentation you may need. If you need a flex receipt, superbill, letter of medical necessity, or any other documentation, please allow up to 48 hours for our office to complete.

### NO-SHOW POLICY AND FEE

A missed appointment leaves an empty slot that could have been used by a patient in need of medical care. We therefore request that patients who are unable to keep their scheduled appointments notify us in advance so the time might be made available to someone else. To avoid any late cancellation fees, we require a minimum notice of one business day (or before 1pm on Saturday for a Monday appointment). Appointments that are cancelled without advanced notice, including same day cancellations, will be subject to a fee of \$25 for the first cancellation and up to the full service cost for repeated incidents.