

Realigning the Soul Chiropractic

1842 Snake River Rd. Katy, TX 77449

281-206-2348 www.realigningthesoul.com



Congratulations on choosing to improve your quality of life and health!

When you begin Chiropractic care, you will be exploring the incredible healing power of your own body, your own INNATE HEALING potential. During this process, Dr. Marlene Tellez will be your healing coach. You will have the opportunity to gain a stronger, healthier and more flexible spine and to develop long-term strategies for reclaiming your power for your health! Taking responsibility is at the core of health and peace!

Your initial visit will include a complete history and consultation along with your first gentle chiropractic adjustment. A second visit will also be arranged for your report of findings to review exam results, discuss recommendations for care, and answer your questions. By the end of this second visit you will have all the information you need to make an informed decision about continuing care.

To prepare for your initial visit, please follow this checklist:

- **Call** the office to set up a special appointment time **281-206-2348**
- Visit www.realigningthesoul.com for new patient forms.
- Please **READ & SIGN** the “*Inform Consent Form*”.
- **Thoroughly complete** the “*Patient Initial Questionnaire*”.
- **Thoroughly complete** the “*Life History Form*”.
- **Thoroughly complete** the “*Privacy Notice Agreement*”.
- Plan to spend one hour in the office for your 1st visit.
- Please **arrive 10 minutes prior** to your scheduled appointment time!

Your healing begins with gentle, honoring, light force adjustments to reduce abnormal spinal cord tension and increase your spinal awareness. As your body begins to re-awaken and heal, you may observe many changes in your physical, mental, and emotional sub-systems. Whether you have come to us for help with physical pain and symptoms, to strengthen your spine and body, to increase your present state of awareness or to increase the flexibility of your nervous system and improve your quality of life. I am honored to be with you on this journey as we realign the soul to your full potential. Congratulations, you are in the right place and on your way to a better life!

With Love,

Dr. Marlene Tellez

Inform Consent Form

I hereby request and consent to receiving spinal care, including wellness education in this office by a chiropractor. A low force technique is utilized along with the use of the arthrostim, percussor, and activator. I may use one or all of these during a treatment. My technique consists of gentle touch contacts along the spine and body to achieve greater communication between the brain and body and new sensory and motor strategies.

The nature of the adjustment:

I will use our hands or a mechanical device upon your body in such a way as to move your joints and the adjacent soft tissue. That may cause an audible “pop” or “click” as you have experience when you crack your knuckles. You may feel or sense movement.

The material risks inherent to the chiropractic adjustment:

As with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including muscle strain, possible bruising, fracture, stroke, and/or release of emboli. Some patients will feel stiffness and soreness following the first few days of treatment.

Probability of risks occurring:

Any type of complication is very rare and generally results from some underlying weakness of the bone, which we check for during history taking and examination. Since even that risk should be avoided if possible, we employ tests in our examination, which are designed to identify if you may be susceptible to that kind of injury.

By signing below, I state that I have weighed the risk involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. I acknowledge that no guarantee of assurance as to the results that may be obtained from this treatment have been given to me. I hereby give my consent to Dr. Marlene Tellez to perform examination and treatment as deemed necessary for my care.

As a female, I understand that if I am currently pregnant, Dr. Tellez will not be using the percussor on or around the fetus. _____

If eligible for Medicare, I understand that the services I receive are **not** covered under Medicare. _____

PRINTED NAME OF PATIENT

PRINTED NAME OF WITNESS

SIGNATURE OF PATIENT

SIGNATURE OF WITNESS

DATE

Treatment and Services Policy Agreement

Welcome!

I am delighted that you're here, and am committed to providing you with quality care. Trust and openness are essential for effective treatment.

Payment is due at time of service. Checks should be made payable to Dr. Marlene Tellez or Realigning the Soul Chiropractic. For your convenience, I also accept credit and debit cards.

If you find that you are unable to keep an appointment, please call and leave a message. I would appreciate a 24 hour notice. There will be a charge for missed appointments and those not cancelled 24 hours in advance.

I look forward to working with you,
Dr. Marlene Tellez

I have read and understand this agreement regarding services and policies. I understand that I may have a copy of this agreement for future references. I agree to be responsible for all charges for myself/ my spouse/ my children.

PRINTED NAME OF PATIENT

SIGNATURE OF PATIENT

DATE

PATIENT INITIAL QUESTIONNAIRE

Name: _____ Date: ____/____/____

Your quality of life is our concern. Please complete this form by listing your health concerns (in order of priority) and rate the severity of each from 1-10 with 10 being the worst.

I. Chief Physical Complaints

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

II. Chief Emotional Complaints

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

III. Please list any other concerns that you would like the doctor to know about:

IV. What would you like to accomplish from your healing process in our office?

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Life History Form

The intent of this form is to assist you in your healing process by initiating a thoughtful recognition of your life experiences. Life is a cumulative process; use this form to increase your understanding and appreciation of your own life process and accumulation of stressors, both positive and negative.

Date: _____/_____/_____

PATIENT’S FULL NAME:

“Nick Name” or name you like to be called if different:

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Would you like to subscribe to our Email Newsletter? Yes No Email Appointment Reminders? Yes No

Date of Birth: _____/_____/_____ Age: _____ Sex: M F Relationship Status: _____

Spouse or Partner’s Name: _____ Number of Children: _____

REFERRAL SOURCE: The majority of our practice members come from direct in house referrals.

Were you referred by a patient of ours? Yes No Patient’s Name: _____

Were you referred by the internet? Yes No If so, any particular directory or site? _____

Were you referred by: Other: _____

Primary Contact: Self Spouse Other _____

Employment Status: Full time Part time Retired Unemployed Other _____

Employer _____ Work Phone: _____

Occupation: _____ Financially Responsible Party: Self Spouse

Parent Other _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HEALTH HISTORY:

Have you ever received any form of Chiropractic Care? Yes No

Do you know what type of adjustments the chiropractor performed, or what technique(s) or methods he or she used?

When was your last visit? _____ If you stopped, why did you stop? _____

Were you pleased with his or her service? Yes No Somewhat _____

Has anyone ever taken x-rays of your spine? Yes No When? _____

If yes, who would you need to contact for copies of your x-rays? _____

Does anyone in your immediate family receive chiropractic adjustments? Yes No _____

The practice of chiropractic is based upon the location and adjustment of Vertebral Subluxations. Spinal Subluxations are caused by any stress your body can not properly perceive, adapt to or recover from. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL/MENTAL in nature.

GENERAL - PHYSICAL STRESS: Next to each potential cause of vertebral subluxation is a check box. Please check 'P' for Past, 'C' for Current (or both if they apply) under the level of trauma severity.

	MILD		MODERATE		EXTREME			MILD		MODERATE		EXTREME	
	P	C	P	C	P	C		P	C	P	C	P	C
Falls from crib, bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sports Impacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falls down/up steps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Fights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falls on ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Armed services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Have you ever been knocked unconscious? Yes No Date: _____

Comments: _____

Have you ever used crutches, a walker, or cane? Yes No Date: _____

Comments: _____

Have you ever broken any bones? Yes No Date: _____

Comments: _____

Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? Yes No

Date: _____ Comments: _____

Have you had extensive dental or orthodontial work done? Yes No Date: _____

Comments: _____

Have you served in the military? Yes No Date: _____ to _____ Were you involved in combat? Yes No

During the day, I: sit stand walk drive do desk work phone work mechanical work heavy lifting

I exercise: daily weekly monthly List Details: _____

AUTOMOBILE ACCIDENTS: Have you (even as a passenger and even if you do not think you were hurt) been involved in a vehicular collision or near collision? Please list approximate dates and severity (Mild, Moderate, Severe or Extreme)?

Automobile: _____

Bus, bicycle, motorcycle, train, airplane, mo-ped, or other vehicles: _____

MEDICAL TREATMENT: Have you ever been hospitalized? Yes No When? And Why

Have you ever had surgery? Yes No If yes, please explain: _____

Do you still have all your body parts? Yes No If no, please explain: _____

Have you had: a spinal tap spinal injections physiotherapy neck collar spinal brace traction
heel lift radiation treatments corrective shoes or bars on shoes extensive diagnostic x-rays
acupuncture chemotherapy blood transfusion bone in a cast or immobilized?

GENERAL - CHEMICAL STRESS: Are you now taking any drug (prescription, over-the-counter or recreational) regularly?

Drug: _____ Date Prescribed: _____ Reason: _____

Drug: _____ Date Prescribed: _____ Reason: _____

Drug: _____ Date Prescribed: _____ Reason: _____

Drug: _____ Date Prescribed: _____ Reason: _____

Are these drugs being prescribed by a physician? Yes No Last visit: _____

If you were previously taking any other medication regularly, please describe: _____

Do you or did you work with any chemical, fume, dust, powder, or smoke for prolonged periods? Yes No

Please explain: _____

Is there anything else you wish to share, which has not been discussed, that may help us to better understand you and why you have chosen to see the doctor in this office? _____

Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

The **Realigning the Soul Chiropractic (RSC)** is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition and the care and treatment you receive from us. The creation of a record detailing the care and services you receive helps this clinic to provide you with quality health and wellness care. This Privacy Notice details how your PHI may be used and disclosed to third parties and also details your rights regarding your PHI.

Disclosure for Treatment, Payment, and Operations Purposes

RSC may use and/or disclose your PHI for the purposes of:

- (a) Treatment – In order to provide you with the health and wellness care you require, RSC will provide your PHI to those health care professionals, whether on RSC's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, another physician treating you for lower back pain may need to know the results of your latest examination by this office.*
- (b) Payment – In order to get paid for services provided to you, RSC will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, RSC may need to provide your PIP insurance with information about health and wellness care services that you received in this clinic so that we can be properly reimbursed. RSC may also need to tell your insurance plan about treatment you will receive so that it can determine whether or not it will cover the treatment expense.*
- (c) Health and wellness care operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for RSC to continue to provide quality and efficient care, it may be necessary for us to compile, use, and/or disclose your PHI. For example, RSC may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.*

NO CONSENT REQUIRED

RSC may use and/or disclose your PHI without a written Consent from you in the following instances:

- (a) De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.*
- (b) Business Associate – To a business associate if RSC obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists us in undertaking some essential function, such as a billing company or individual that assists the office in submitting claims for payment to insurance companies or other payers.*
- (c) Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health and wellness care.*
- (d) Emergency Situations –*
 - (i) for the purpose of obtaining or rendering emergency treatment to you provided that we attempt to obtain your Consent as soon as possible; or*
 - (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.*
- (e) Communication Barriers – If, due to substantial communication barriers or inability to communicate, we have been unable to obtain your Consent and we determine, in the exercise of our professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.*
- (f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.*
- (g) Abuse, Neglect or Domestic Violence - To a government authority if RSC is required by law to make such disclosure. If RSC is authorized by law to make such a disclosure, it will do so if we believe that the disclosure is necessary to prevent serious harm.*
- (h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.*
- (i) Judicial and Administrative Proceeding - For example, RSC may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.*
- (j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, we may disclose your PHI if we believe that your death was the result of criminal conduct.*
- (k) Coroner or Medical Examiner - RSC may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.*
- (l) Research - If RSC is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.*
- (m) Avert a Threat to Health or Safety - RSC may disclose your PHI we believe that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.*
- (n) Specialized Government Functions - This refers to disclosures of PHI that relate primarily to military and veteran activity.*

(o) National Security and Intelligence Activities – RSC may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.

(p) Military and Veterans – If you are a member of the armed forces, RSC may disclose your PHI as required by the military command authorities.

APPOINTMENT REMINDERS

RSC may, from time to time, contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. RSC may attempt to contact you by email or by telephone as an appointment reminder, or leave a message on your answering machine or with the individual answering the phone. RSC may also send you birthday cards or information pertinent to your condition, new research, or treatment options to the address provided by you for that purpose.

FAMILY/FRIENDS

RSC may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. We may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(a) If you are present at or prior to the use or disclosure of your PHI, we may use or disclose your PHI if you agree, or if we can reasonably infer from the circumstances, based on the exercise of professional judgment, that you do not object to the use or disclosure.

(b) If you are not present, we will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

 You have the right to:

(a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to Dr. Tellez (Privacy Officer for RSC) or to any of RSC's staff members, or

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, RSC is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to any RSC staff member. In your written request, you must inform RSC of what information you want to limit, whether you want to limit RSC's use or disclosure, or both, and to whom you want the limits to apply. If RSC agrees to your request,

We will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to Dr. Tellez, or any of RSC's staff members. RSC will accommodate all reasonable requests.

(d) Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to Dr. Tellez or any of RSC's staff members. RSC can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, RSC may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

(e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to Dr. Tellez. You must provide a reason that supports your request. RSC may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by RSC (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained

by RSC, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with RSC's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Dr. Tellez or any RSC staff member. The request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but RSC may charge you for the cost of providing additional lists. RSC will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Receive a paper copy of this Privacy Notice from RSC upon request to Dr. Tellez or any RSC staff member.

(h) Complain to Dr. Tellez or to the Secretary of Health and Human Services (HHS) if you believe your privacy rights have been violated. To file a complaint with RSC, you must contact the Dr. Tellez. All complaints must be in writing.

(i) To obtain more information on, or have your questions about your rights answered, you may contact Dr. Tellez at (281) 206-2348, or via email at info@realizingthesoul.com

RSC'S REQUIREMENTS

RSC:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing our legal duties and privacy practices with respect to your PHI.

(b) Is required to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law where state and federal laws conflict, and where state law is more stringent in the area of privacy.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE: This notice is in effect as of ___/___/___

Privacy Notice Agreement

Patient consent for use and/or disclosure of protected health information to carry out treatment, payment, and healthcare operations.

With my signature below, I give consent for Realigning the Soul (the Practice) to use and/or disclose information about me (or for whom I have legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and healthcare operations.

I have reviewed that Privacy Policy of this Practice prior to signing this consent. The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy by request.

I have the right to request restrictions on how my information is used and/or disclosed in order to execute treatment, payment, or healthcare operation. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The Practice may communicate confidential information to me including any invoices for services, reminder cards, birthday cards, newsletters, and the like, at the address/phone number/fax number/email address designated in my registration forms.

PRINTED NAME OF PATIENT

SIGNATURE OF PATIENT

DATE