SPRING CREEK – COIT CHIROPRACTIC AND PHYSICAL MEDICINE & First Health Group

PATIENT INFO

Name: _____
(LAST) (MI) (FIRST)

Address: _____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

DOB: / / Soc. Sec #: - -

Driver's License #: _____ State: _____

Marital Status: S M W Spouse's Name: _____

You're Employer: _____ Occupation: _____

Employer Address: _____
(STREET) (CITY) (STATE) (ZIP)

Referred By: _____ Primary Care Physician: _____

Or how did you find us? _____

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name: _____

Member #: _____ Group #: _____

Insurer's Name (If Different From Patient): _____ Relationship to Patient: _____

Insurer's DOB: / / Insurer's Soc. Sec #: - -

Insurer's Employer: _____

Person responsible for account: _____

Do you have a Health Savings or Spending Account? _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that I will also be responsible for all collection and interest fees of 10% and/or attorney fees for nonpayment of account.

Patient/Guardian Signature **Date:**

_____ _____

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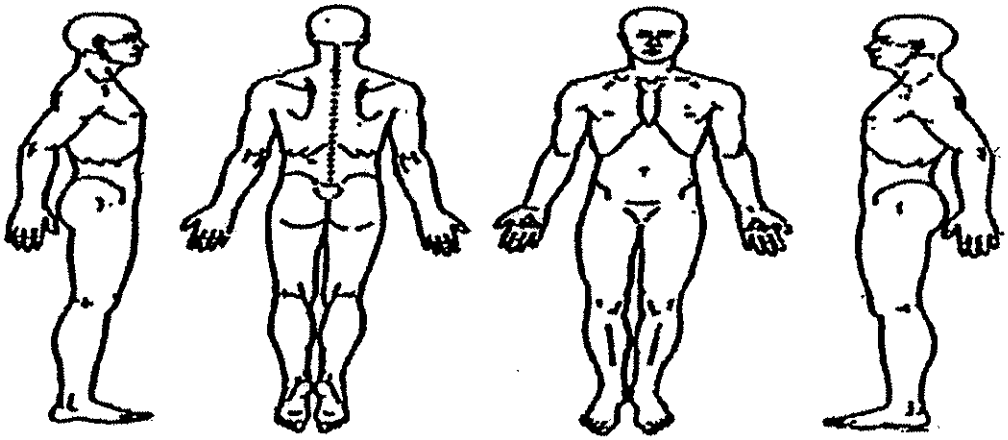
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Today's problem will be filed as: □ Insurance/ Self Pay □ Auto Accident

2. What is your primary area of concern/ pain? _____

3. Indicate on the drawings below where you have pain/symptoms:



4. How would you describe the type of pain?

□ Sharp
□ Dull
□ diffuse
□ Achy
□ Burning
□ Shooting
□ Stiff
□ Numb
□ Tingly
□ Sharp with motion
□ shooting with motion
□ stabbing with motion
□ Electric-like with motion
□ Other: _

5. How long have you had this problem? _____

6. How do you think your problem began? _____

7. How often do you experience your symptoms?

□ Constantly (76-100% of the Time)
□ Frequently (51-75% of the Time)
□ Occasionally (26-50% of the Time)
□ Intermittently (1-25% of the Time)

8. On a scale from 0-10 (10 being the worst), how would you rate your pain?

0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

9. What aggravates your problem? _____

10. What alleviates your problem? _____

11. How are your symptoms changing with time?

□ getting worse □ staying the same □ getting better

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Patient Name: _____ **Date:** _____

12. What is you're: **Height** _____ **Weight** _____ **Date of Birth** _____

Occupation _____

13. How would you rate your overall health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

14. Rate your level of exercise activity:
□ Strenuous □ Moderate □ Light □ None

15. Indicate if you suffer from or have immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

16. For the conditions listed below, please check the "past" column if you have had the condition in the past; if you presently have a condition listed below, please check the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ mid Back Pain	□	□ Stroke	□	□ Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		

17. List all prescription and over-the-counter medications you are currently taking:

_____

_____

18. List all nutritional supplements you are currently taking:

_____

_____

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Patient Name: _____ **Date:** _____

19. List all surgical procedures you have undergone:

_____

_____

20. What activities do you do at work?

Sit	□ Most of the day	□ Half of the day	□ A little of the day
Stand	□ Most of the day	□ Half of the day	□ A little of the day
Computer Work	□ Most of the day	□ Half of the day	□ A little of the day
On the Phone	□ Most of the day	□ Half of the day	□ A little of the day
Drive	□ Most of the day	□ Half of the day	□ A little of the day
Other Activities	□ Perform manual labor	□ Read a lot	□ Travel frequently

21. What activities do you enjoy outside of work?

_____

22. Have you ever been hospitalized? □ Yes □ No

If yes, why? _____

23. Have you had past trauma such as car accidents (ever?), falls, sports injuries, etc.? □ Yes □ No

If yes, what and when? _____

24. Is there anything else you wish to let the doctor know about your visit today? □ Yes □ No

If yes, what? _____

Patient Signature _____ **Date** _____

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Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the physician's hands or with the use of a machine. Frequently, adjustments create a "popping" or "clicking" sound/sensation in the areas being treated.

In this office, we use trained assistants who may assist the physician with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. On the occasion when your physician is unavailable, your care may be handled by another physician or trained assistant.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The chiropractic adjustment that is related to the vertebral artery stroke is called Extension-Rotation-Thrust Atlas Adjustment. We DO NOT use this type of adjustments on our patients. Other type of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractic would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disk Herniation's: Disk herniation's that create pressure on a spinal nerve or the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustment, traction, etc. This includes both in the neck and back. Yet, occasionally, chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely, surgery may cause a disk problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment (or treatment) may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

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Rib Fractures: The ribs are found only in the thoracic spine or mid-back. They extend from your back to your front chest area. Rarely, a chiropractic adjustment will crack a rib bone and this is referred to as a fracture. This occurs only on patients who have weakened bones from conditions such as osteoporosis. Osteoporosis can be detected on your x-rays. We adjust all patients very carefully, and especially with those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform your physician.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always provide you with the best care and if results are not acceptable, we will refer you to another health care provider who we feel may assist your condition.

If you have any questions on the above information, please ask your physician. Once you have a full understanding, please sign and date below.

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Secondary Number: _____

Patient Name (Printed)_____Date _____

Patient Signature _____

Parent/Guardian Signature _____

Staff Signature _____Date _____

SPRING CREEK – COIT CHIROPRACTIC AND PHYSICAL MEDICINE & 1rst Health

HIPAA Disclosure

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

All Patient Medical Records

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

Spring Creek - Coit Chiropractic and Physical Medicine and/or 1rst Health

Expiration Date of Authorization
This authorization is effective through unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize Spring Creek - Coit Chiropractic and Physical Medicine Manager to use my protected information for the listed reasons:

_____

Patient Name (Printed)_____Date _____

Patient Signature _____

Parent/Guardian Signature _____

Staff Signature_____Date _____

SPRING CREEK – COIT CHIROPRACTIC AND PHYSICAL MEDICINE & 1rst Health Group

Assignment of Benefits

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, grants and conveys for deferred payment to 1rst Health Group, a lien and assignment against the proceeds of the patient's insurance settlement with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to 1rst Health Group, and to 13601 Preston Road, Suite 550E Dallas, TX 75238.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Spring Creek - Coit Chiropractic and Physical Medicine, and to send any and all checks to 4105 W. Spring Creek Pkwy, Suite 510, Plano, TX 75024

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORYEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

By my signature be it known that I have read and fully understand the above contract.

Patient Name (Printed)_____Date _____

Patient Signature _____

Parent/Guardian Signature _____

Staff Signature_____Date _____

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Insurance Verification Disclosure/Agreement

As a courtesy, Spring Creek - Coit Chiropractic and Physical Medicine & 1rst Health will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Office Manager _____ Date _____

PHONE 972.599.9200 FAX 972.599.9833
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