New Patient Paperwork

ALLEN ADVANCED CHIROPRACTIC

Today's Date:_____

Name:_____

Phone Number:(Cell/Home)_____ Date of Birth:_____

Mailing address:_____

Email address:_____

Gender: ❑ Male ❑ Female

Marital Status:

- Single
- Married
- Child
- Other_____

Race:

- African American
- Asian
- Caucasian
- Latin American
- Native American
- Pacific Islander
- Other_____

Ethnicity:

- Hispanic
- Latino
- Non-Hispanic/Non-Latino

How did you hear about us?

- Internet Search
- Social Media
- Referral: _____
- Other:_____

Emergency Contact: Name _____Number _____

Relation: ❑ Spouse ❑ Parent ❑ Child ❑ Friend ❑ Other_____

Do you have insurance? ❑ Yes ❑ No Are you the primary policy holder?: ❑ Yes ❑ No

- Blue Cross Blue Shield
- United Healthcare
- Medicare Part B
- Aetna
- Cigna
- Ambetter
- Superior
- Baylor Scott & White
- Other

PLEASE PROVIDE THE OFFICE WITH A COPY OF YOUR INSURANCE CARD(s)

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No

If yes, what type? ❑ Auto ❑ Work ❑ Other_____

Has it been reported? ❑ Yes ❑ No If yes, to whom?_____

Review of Systems

Please indicate if you have experienced any of the following in the last month:

Neurological:
__Migraines
__Headaches
__Slurring of Speech
__Dizziness
__Blurred vision
__Light sensitivity
__Fever
__Fainting

Ear/Nose/Throat:
__Loss of Taste/Smell
__Night Blindness
__Sore Throat
__Nose Bleeds
__Jaw Problems

Cardiovascular:
__Chest pain
__Palpitations
__Swelling in hands/feet
__Anemia

Respiratory:
__Recurrent respiratory infections
__Asthma
__Chest congestion
__Wheezing
__Frequent Sneezing
__Allergies
__Shortness of breath

GI:
__Stomach pains or cramping
__Constipation
__Diarrhea
__Reflux or Heartburn
__Bloating
__Gas
__Nausea
__Vomiting

Musculoskeletal:
__Neck Pain
__Mid Back Pain
__Lower Back Pain
__Upper Joint Pain (shoulder/elbow/wrist)
__Lower Joint Pain (hip/knee/ankle)
__Arthritis
__Muscle Aches

Skin:
__Eczema
__Dermatitis
__Excessive sweating
__Rashes
__Brittle nails
__Hair loss
__Easy bruising
__Increased Bleeding
__Numbness/Tingling

Genitourinary:
__Uterine Fibroids
__Ovarian cysts
__Cancer (breast/ ovarian/ prostate/ uterine)
__Prostate problems

Emotional/Mental:
__Depression
__Anxiety
__Mood Swings
__Irritability
__Memory Loss
__Confusion

Energy:
__Fatigue
__Hyperactivity
__Restlessness
__Insomnia
__Decreased libido
__Stress

Weight:
__Decreased appetite
__Weight gain
__Weight loss
__Inability to lose weight
__Food cravings
__Binge eating
__Water retention

<u>Please indicate if you have ever had any of the following:</u>

__Aids/HIV
__Anemia
__Arthritis
__Bleeding Disorders
__Cancer
__Diabetes (Type 1 or 2)
__Emphysema
__Epilepsy
__Fractures
__Gout
__Heart Disease
__Hepatitis
__Hernia
__Herniated Disc
__High Blood Pressure
__High Cholesterol
__Kidney Disease
__Liver Disease
__Multiple Sclerosis
__Osteoporosis
__Pacemaker
__Parkinson's Disease
__Pinched Nerve
__ Rheumatoid Arthritis
__Stroke
__Venereal Disease
__Other_____

Are you currently under drug or medical care? ❑ Yes ❑ No
If yes, please explain:_____

Please list any medications and/or supplements you are currently taking (include dosage and frequency):

_____

_____

_____

_____

Please list any surgeries and/or hospitalizations you have had (type & date):

_____

_____

_____

Please list any allergies:

_____

_____

Family History:

__Heart Disease __Cancer __Other_____

__Diabetes __Arthritis

Do you exercise: ❑ Never ❑ 1-2 days a week ❑ 3-4 days a week ❑ Daily

Type of exercise: ❑ Walking ❑ Running ❑ Swimming ❑ Other_____

Does your work mostly include: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Weekly consumption:

Caffiene_____cups/day Cigarettes_____packs/day Recreational

Alcohol_____drinks/week Vape_____puffs/day drugs_____times/month

I certify that the above questions were answered accurately and I understand that providing false information can be dangerous to my health.

Signature_____Date_____

X-Ray Questionnaire: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name:_____

- There is a possibility that I may be pregnant at this time.
- Yes, I am definitely pregnant.
- No, I am definitely not pregnant at this time.
- I request that x-rays not be taken because: _____

Date of last menstrual period:_____

Signature:_____Date:_____

Neurological/ MRI/ Vascular Patient Questionnaire

for any YES answer, please provide an explanation

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES

Comment: _____

2. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES

Comment: _____

3. Do you suffer from headaches? If yes, how often, how severe, what has been tried? NO YES

Comment: _____

4. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES

If yes: When? For how long? What kind? _____

5. Have you had any recent imaging such as X-Rays or MRIs? NO YES

If yes: When? Who ordered it? What was it ordered for?

_____

6. Have you used any splint or braces or other prescribed treatment by an MD? NO YES

If yes: When? What kind? Who ordered it?_____

7. If you have tried any treatment or medications, did this make your problem better? NO YES

Comment: _____

Neurological/ MRI/ Vascular Patient Questionnaire

Name_____Date_____

for any YES answer, please provide an explanation

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
Comment: _____
8. Do our legs or feet fall asleep regularly? NO YES
Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
Comment: _____
10. Do you suffer from cold hands or feet? NO YES
Comment: _____
11. Do have frequent falls or find that you trip over your feet while walking? NO YES
Comment: _____
12. Do you suffer from headaches? If yes, how often, how severe, what has been tried? NO YES
Comment: _____
13. Have you tried any medications such as anti-inflammatory? NO YES
If yes, what kind of medication_____

14. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
If yes: When? For how long? What kind? _____
15. Have you had an MRI? NO YES If yes: When? Who ordered it? What was it ordered for?
_____
_____
16. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
If yes: When? What kind? Who ordered it?_____
17. If you have tried any treatment or medications, did this make your problem better? NO YES
Comment: _____

Treatment Consent Form

To the Patient:

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:
The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will be using spinal manipulative therapy as your treatment. I may use my hands or a mechanical instrument to help move your joints. This can create the same “pop” or “click” sound you would hear when you “crack” your knuckles. You may also feel a sense of movement.

Analysis / Examination / Treatment
As a part of the analysis, examination and treatment, you are consenting to the following procedures:
The material risks inherent in chiropractic adjustment:
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to, fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, costovertebral separations and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck. This can lead to or contribute to serious complications including stroke. Some patients will feel some stiffness and/or soreness following the first few days of treatment. The doctor will make every reasonable effort during the examination to screen for contraindications that could affect your care; however, if you have a condition that would otherwise not come to the Doctor’s attention, it is your responsibility to inform the Doctor.
The probability of those risks occurring:
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history, examination and/or X-Ray/MRI. Stroke and/or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a casual relationship at all it is extremely rare and remote. Unfortunately, there is not a recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.
The availability and nature of other treatment options:
Other treatment options for your condition may include:
• Self-Administered, over-the-counter analgesics and rest
• Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers.
• Hospitalization
• Surgery
If you choose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.
The risks and dangers attendant to remaining untreated:
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor providing my treatment and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I hereby give my consent to treatment.

Patient Signature or Guardian: _____ Date: _____

Patient’s Name: _____ Date: _____

Consent for Use & Disclosure of Protected Health Information

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and my plans for future care or treatment.

I understand that this information services as:

A basis for planning my care and treatment.

A means of communication among the many healthcare professionals who contribute to my care.

A source of information for applying my diagnosis and information to my bill.

A means by which a third-party payer can verify that services billed were actually provided.

A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand I have the right to:

· Object to the use of my health information for directory purposes.

· Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that the organization is not required to agree to the restrictions requested.

I understand I have the right to request a copy of Nortex Medical Group's Notice of Privacy Practices.

Patient Name: _____ Date: _____

Patient Signature/ Legal Guardian: _____ Date: _____

Authorization to Communicate via Text or Email

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from the automated outreach and messaging system when necessary.

Patient Name: _____Date:_____

Patient Signature/Legal Guardian: _____Date: _____

Disclosure of Physician Ownership and Financial Interest

State and Federal guidelines may require that physicians who may have an affiliation or ownership interest in or with the in and out of network facilities/services to which the physician refers we must disclose this information. In the interest of providing our patients with complete information, we are providing the names of the out of network facilities where NorTex Spine & Joint Institute may have an ownership interest/affiliation

1. Southern Hills Anesthesia
5999 Custer Road, Suite 110-506, Frisco, TX 75035

2. Frisco Anesthesia Associates
5999 Custer Road, Suite 110-514, Frisco, TX 75035

3. DFW Pain Institute, PLLC
981 State Hwy 121 Bld. D, #4150, Allen, TX 75013

4. Texas General Surgery Center
2023 West McDermott Drive, Suite 240, Allen, TX 75013

5. Allen Advanced Chiropractic
981 State Hwy 121 Bld. D, #4150, Allen, TX 75013

6. Nortex Spine & Joint Institute
981 State Hwy 121 Bld. D, #4150, Allen, TX 75013

7. Advanced Spine & Joint
6550 Naaman Forest Boulevard Suite 3-100, Garland, TX 75044

During your course of treatment at Allen Advanced Chiropractic, you may be referred to one of these facilities for medical services. These in and out of network facilities or provider may bill the patient for services not covered by your benefit plan. You have the right to choose the facility where you receive medical treatment/services, including the right to choose a facility/service other than the ones listed above.

By signing below, I acknowledge receipt of the above disclosure information and have a right to a copy of this form.

Patient Name: _____Date:_____

Patient Signature/Legal Guardian: _____Date: _____

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations(§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals.

I may request a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Patient Name: _____Date:_____

Patient Signature/Legal Guardian: _____Date: _____

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Patient Name: _____Date:_____

Patient Signature/Legal Guardian: _____Date: _____

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

Explanation and Assignment of Benefits

The following is a legal agreement between you and NorTex Medical Group Doing Business As Advanced Spine & Joint (the "Facility"), in which you will grant certain rights to the Facility to seek, receive, and/or compel payment from your health insurer. Health insurance is a contract between you and your insurer. In order for the Facility to collect money from your insurance company, you must assign that right to the Facility. By signing this document, you grant the Facility various rights to seek, receive, and/or compel payments on your behalf from your insurer (or other responsible party). The assigned rights include, among others, the right to collect payment, the right to process appeals for denied payments, and the rights to pursue legal action if your insurer (or other responsible party) fails to pay. Please carefully read the following and sign below to indicate your acceptance.

_____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA, AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the Facility, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the Facility, regardless of its managed care network participation/status. I understand that I am financially responsible for all charges, regardless of any applicable insurance or benefit payments. I hereby authorize the Facility to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or settlement information upon written request from the Facility or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the Facility any legal or administrative claim or chose in action arising under any group health plan, employee benefits plan, health insurance, or Tort-feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medication I received from the Facility provider (including any right to pursue those legal or administrative claims or chose in action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the Facility all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the Facility, including rights to any settlement, insurance, or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (the Facility) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statement about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefits plan, health care benefits plan, or plan administrator. The Facility as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator, or insurance
company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare, and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I have read and fully understand this agreement.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____