The Back & Body CLINIC

Southwestern Health Resources
Texas Health Resources | UT Southwestern Medical Center

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571 W. MAIN ST. SUITE 100, Lewisville Texas 75057
Phone: 972-436-9785
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# CASE HISTORY & PATIENT INFORMATION

Date: _____

Name: _____ SS#: _____ Age: _____ DOB: _____

Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Phone Number: _____ ☐ Cell ☐ Home

Occupation: _____ Employer: _____

Race: ☐African American ☐American Indian ☐Asian ☐White ☐Other _____ Ethnicity: ☐African ☐ American ☐ Hispanic ☐Indian ☐Other_____

Gender: ☐Female ☐Male Marital Status: ☐Single ☐ Married ☐Widowed ☐Divorced Spouse: _____

Names and Ages of children: _____

Emergency Contact Name and Number: _____

How were you referred to our office? _____

## REASON FOR VISIT: _____

_____

_____

## DESCRIBE YOUR SYMPTOMS (IF NOT APPLICABLE, CONTINUE ON NEXT PAGE):

Which describes your pain? ☐ Achy ☐ Burning ☐Dull ☐Sharp ☐Stiff ☐Throbbing ☐Tingling ☐Numbness ☐ Sore ☐Other _____

How would you rate your pain level? ☐0 ☐1 ☐ 2 ☐3 ☐ 4 ☐5 ☐6 ☐7 ☐ 8 ☐ 9 ☐10

How frequent is your pain? ☐ Constant ☐Frequent ☐ Intermittent ☐Occasionally

What makes the problem worse? _____

What helps relieve the problem?_____

What does this prevent you from doing or enjoying? _____

Have you missed any work due to this condition? ☐Yes ☐ No If yes, how many days: _____

Have you ever had the same or a similar condition? ☐Yes ☐No If yes, when was the first time you noticed the problem and how did it originally occur? _____

## SHOW US WHERE YOU HURT

**PLEASE READ CAREFULLY:** Mark the areas on your body where you feel your problem. Include all affected areas. If your symptoms radiate, draw an arrow from where they start to where they stop. Please extend the arrow as far as the problem travels. Use the appropriate symbol(s) listed below.

Ache: > > > >

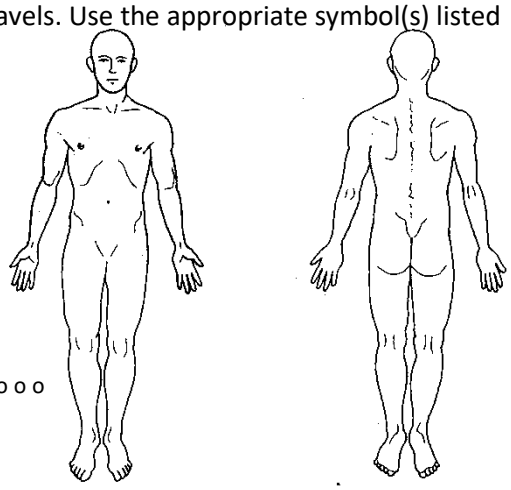
Numbness: = = = =

Burning: x x x x

Stabbing: / / / /

Throbbing: # # # #

Pins & Needles: o o o o



| FOR OFFICE USE ONLY | | |
|---|---|---|
| BP | PULSE | |
| | | |
| HEIGHT | O2 | |
| | | |
| WEIGHT | | |
| | | |
| | | |
| | | |

## MEDICAL HISTORY

Please check if you've ever been diagnosed as having any of the following? **If you have not, please select none.**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Aids/HIV | | Cataracts | | Hepatitis | | Miscarriage | | Seizures/Convulsions | |
| Alcoholism | | Depression | | Hernia | | Mononucleosis | | Sex Transmitted Dz | |
| Allergies | | Diabetes | | High Blood Pressure | | Multiple Sclerosis | | Skin Disorders | |
| Anemia | | Drug Addiction | | High Cholesterol | | Osteoarthritis | | Sleeping Disorder | |
| Anxiety | | Emphysema | | Kidney Disease | | Osteoporosis | | Stomach Problems | |
| Arthritis | | Epilepsy | | Liver Disease | | Pacemaker | | Stroke | |
| Asthma | | Fractured Bone | | Loss of Memory | | Parkinson's Dz | | Suicide Attempt | |
| Atrial Fibrillation | | Glaucoma | | Loss of Smell | | Pneumonia | | Thyroid Problems | |
| Bleeding Disorders | | Goiter | | Loss of Taste | | Prostate Problems | | Tuberculosis | |
| Blindness | | Gout | | Low Blood Pressure | | Prosthesis | | Vaginal Infections | |
| Blood Clotting Disorders | | Hearing Loss | | Low Blood Sugar | | Miscarriage | | | |
| Cancer-Type:_____ | | Heart Disease | | Migraines | | Mononucleosis | | | |
| ☐ None | | | | | | | | | |

If you have had any of these preventative procedures, please write approximate date of occurrence in the space provided. **If you have not, please select none.**

| | | | |
|---|---|---|---|
| Physical with labs (annual) | | Pneumonia Shot (once for 65+) | |
| Pap Smear (every 3–5 years for women 21-65) | | Shingles Shot (once for 65+) | |
| Mammogram (every 1-2 years for women 40+) | | Tetanus Shot (every 10 years) | |
| Prostate Cancer Screening (annual for men 40+) | | Bone Marrow Density (annual for women 65+) | |
| Colonoscopy (every 10 years for 50+) | | Tuberculosis Screening | |
| ☐ None | | | |

Have you had any surgeries, major injuries, falls, or auto accidents? Please list all and approximate date **or select none.** ☐ None

_____

_____

Please check if you have experienced any of these symptoms within the last month. **If you have not, please select none.**

| **Neurological** | | **Cardiovascular** | | **Respiratory** | | **Skin** | | **Energy** | |
|---|---|---|---|---|---|---|---|---|---|
| Concussion | | Anemia | | Chest Congestion | | Brittle Nails | | Decreased Libido | |
| Headaches | | Chest Pain | | Chronic Infections | | Easy Bruising/Bleeding | | Fatigue | |
| Migraines | | Palpitations | | Cough | | Eczema | | Hyperactivity | |
| Numbness/tingling | | Swelling in Extremities | | Shortness of Breath | | Hair Loss | | Restlessness | |
| Ringing in Ear | | **Genitourinary** | | Wheezing | | Lesions | | Problems Sleeping | |
| Slurring of Speech | | Blood in Urine | | **Gastrointestinal** | | Rashes | | **Mental** | |
| **Ear/Nose/Throat** | | Difficulty Urinating | | Abdominal Pains | | Redness | | Anxiety | |
| Altered Taste/Smell | | Discharge | | Bloating/Gas | | Swelling | | Depression | |
| Ear Ache | | Pelvic Pain | | Blood in Stool | | Wound | | Decrease Memory | |
| Nose Bleeds | | Prostate Problems | | Constipation | | **Weight** | | Mood Swings | |
| Sinus Congestion | | Sexual Dysfunctions | | Diarrhea | | Appetite Changes | | Stress | |
| Sore Throat | | Testicular Problems | | Heartburn | | Weight Gain | | Suicidal Thoughts | |
| Visual Disturbance | | Urinary Tract Infection | | Nausea or Vomiting | | Weight Loss | | None | |

Please list any other health problems you have, no matter how insignificant they may be, **or select none.** ☐ None

_____

Who was your medical provider before? Please list provider and practice name **or select none.** ☐ None

_____

Who was your chiropractor before? Please list provider and practice name **or select none**. ☐ None

_____

**Do you have any medicinal, environmental, or food allergies?** ☐ Yes ☐ No **If yes, list allergy, severity, and reaction:**

_____

_____

Are you taking any medications or nutritional supplements? **If no medications or supplements, please select none.**

| MEDICATION/SUPPLEMENT | STRENGTH | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| MEDICATION/SUPPLEMENT | STRENGTH | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

☐ None

Pharmacy name and crossroads: _____

## FAMILY HISTORY

Please check all boxes that apply **or select none.**

**Father** ☐ None Other: _____

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcoholism | | Auto Immune Disorders | | Dementia | | High Cholesterol | | Mental Illness |
| Anemia | | Blood Clots | | Diabetes 1 or 2 | | Kidney Disease | | Osteoporosis |
| Arthritis | | Cancer-Type:_____ | | Heart Disease | | Liver Disease | | Stroke |
| Asthma | | COPD/Emphysema | | High Blood Pressure | | Lung Disease | | Thyroid Disorder |

**Mother** ☐ None Other: _____

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcoholism | | Auto Immune Disorders | | Dementia | | High Cholesterol | | Mental Illness |
| Anemia | | Blood Clots | | Diabetes 1 or 2 | | Kidney Disease | | Osteoporosis |
| Arthritis | | Cancer-Type:_____ | | Heart Disease | | Liver Disease | | Stroke |
| Asthma | | COPD/Emphysema | | High Blood Pressure | | Lung Disease | | Thyroid Disorder |

## SOCIAL HISTORY

**WOMEN: Are you pregnant or is there any possibility you may be pregnant?** ☐ Yes ☐ No ☐ Not Sure

Who do you live with? _____

How often do you drink alcohol? ☐ Never ☐ Rarely ☐ Occasionally ☐ Moderately ☐ Frequently ☐ Excessive

How much do you smoke? ☐ Never ☐ Former smoker (quit date: _____) ☐ ½ pack/day ☐ 1 pack/day ☐ <1 pack/day

Do you vape or use any other tobacco products? ☐ Yes ☐ No If yes, please list:_____

How much caffeine do you consume? ☐ None ☐ 1 to 3 drinks/day ☐ 3 to 6 drinks/day ☐ 6 or more drinks/day

How often do you exercise? ☐ Never ☐ 1 to 2 times/week ☐ 2 to 3 times/week ☐ 4 to 5 times/week ☐ Daily

Do you use any recreational drugs? ☐ Yes ☐ No If yes, please list drug and frequency of use: _____

_____

**Patient's Signature:** _____ **Date:** _____

**Guardian's Signature Authorizing Care:** _____ **Date:** _____

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# OFFICE POLICY

Welcome to The Back & Body Clinic. We appreciate the confidence you have shown by allowing us to be involved with your healthcare. It is our goal to do everything possible to make your care here as trouble-free as possible.

Because everyone prefers to "know the rules" in the beginning, we have attempted to set forth guidelines in regard to payment procedures. If you have any questions **at any time** in regard to your account, please do not hesitate to ask.

- **Payment in full is required** at the time services are rendered unless other arrangements are made
- There is a **$25.00 fee for returned checks**
- Copies of **medical records require an advance notice of 3-5 business days** and **pre-payment is required.**
    - Please note that these are usually requested by the insurance company and/or attorneys, and they are usually the ones to pay for these services. Any additional forms required from your insurance company (i.e. disability reports, questionnaires, etc.) or requests for medical records by other entities not directly related to the coordination of care will be charged as follows:
        - 1st form- Free
        - Any additional forms: $25 + ¢50/page over 20 pages
- **No refunds on credit balances are issued until all treatments are completed** and the patient has been released from care, unless other arrangements are made with the billing department.
- Any changes in address, phone numbers, employment, and/or insurance needs to be given to the front desk so that our records may be kept current. **It is the patient's responsibility to notify us of any changes**, and the patient agrees to be responsible for any balances that may be incurred due to these changes.

**PATIENT TYPE**

**Insurance**:

Patients who have insurance coverage will be expected to pay their co-payment or co-insurance in full every visit, unless prior arrangements are made with the billing department. Please remember that the insurance contract is between the insured and his/her insurance company. If payment has not been received from the insurance company within **60 days**, the patient will be responsible for the unpaid balance and will be given any necessary paperwork for him/her to obtain reimbursement from the insurance company.

**Time of Service Discount:**

Patients who do not have insurance coverage, or choose not to use their insurance will be considered time of service discount patients. Payment is expected in full every visit, unless prior arrangements are made with the billing department

**Medicare:**

We accept Medicare assignment and are a participating provider. **Government policy requires all offices to file claims** for any services rendered to a Medicare patient. The services covered by Medicare and the supplementary or secondary insurance benefits vary. Our staff will be happy to verify coverage and discuss any specific information.

**Personal Injury:**

**Whenever personal injury protection (PIP) is available, we will file claims to the patient's auto insurance**. If the PIP benefits have been exhausted, we will file claims to the patient's major medical insurance, or the patient will pay cash and seek any reimbursement available from the insurance company/companies. We typically do not accept 3rd party insurance as a form of payment, but consider it on a case by case basis.

**Veterans**:

We are in network with the veterans choice program and accept authorizations from TriWest. Visits that are not covered by your authorizations will be charged to you with our time of service discount, or billed to your private insurance company.

**Workman's compensation**- We are in-network with most Workman's Compensation networks.

**FINANCIAL POLICY**

**All financial arrangements must be made through the billing department**. I understand, agree and acknowledge that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. **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 understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable. Furthermore, balances that are outstanding for >90 days may be turned over to a collection agency. If your account is turned over to collections, an additional administration fee will be added to your balance.

Due to the complexities of nature, no doctor can promise you specific results. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the results of your care. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same treatments. Because of this, **I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment even if I am not satisfied with the results of my care**.

Some insurance companies have recently begun to determine that some charges are not "medically necessary". They have done this in spite of the fact that benefits were correctly verified and even after payment has been issued on these same services for prior dates of service. Therefore, we have found it necessary to add the following statement to our office policy. Please be aware that should this happen, you will be charged the time of service discount rate for these charges, and we will work with you any way that we can.

**"Should my insurance company determine that any treatment I receive at this office is not medically necessary or not covered by my policy and states in writing before the service or supply was given, I hereby agree to be financially responsible for those charges."**

I do understand that the above referenced office will release my Protected Health Information to insurance carriers and other health care providers for the purpose of treatment, payment and/or health care operations. This document shall act as my written authorization for this act of disclosure of my Protected Health Information. Without written authorization, information may be disclosed according to Texas law that overrides HIPPA rules regarding: child abuse, neglect, domestic violence, or other accidents under Texas law, workers compensation cases, or an emergency.

I further authorize Matthew W. Gilbert, D.C. and/or The Back & Body Clinic, its authorized agents and employees to endorse any and all checks, drafts, or money orders which are made payable to the undersigned alone or to the undersigned and the said office of The Back & Body Clinic at the request or within the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Please sign and date below acknowledging that you have read, understand, and agree with the policies stated above.

_____ _____

**Patient Signature** **Date**

_____ _____

**Witness Signature** **Date**

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# INFORMED CONSENT

**TO THE PATIENT: You have the right to be informed about 1) your condition, 2) the recommended medical care or surgical procedure, and 3) the risks related to this care/procedure. This disclosure is designed to provide you this information, so that you can decide whether to consent to receive this care/procedure. Please ask your health care provider any remaining questions you have before signing this form.**

**INFORMED CONSENT TO TREAT**
I hereby authorize employees and agents of The Back & Body Clinic (including physicians, physician assistants, nurse practitioners, chiropractors, and other employees and staff members) to render medical evaluations and care to the patient indicated below. I understand that in connection with the patient's treatment, photos or videos may be taken. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of emergency.

**INFORMED CONSENT FOR CHIROPRACTIC CARE**
In coming to the doctor of chiropractic, a patient gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or healthcare if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through healthcare procedures the condition from which he is suffering: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regimen.

**PREGNANCY WAIVER**
In the event that X-Rays are needed, I hereby acknowledge that The Back & Body Clinic has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own violation that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

**ACKNOWLEDGEMENT**
I have read and understand the foregoing. I hereby authorize and release the providers and whomever they may designate as assistants to administer medical treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that they deem necessary in my case. I further authorize the providers to disclose all or any part of my patient records to any person or corporation which is or may be liable under a contract to the office, the patient or to a family member or employer of the patient for all or part of the clinic's charges, including and not limited to, hospital or medical services companies, insurance companies, workers compensation carries, welfare funds, or the patient's employer.

_____

**Patient Printed Name**

_____ _____

**Patient Signature** **Date**

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# PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only to be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, this office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

**Patient Printed Name**

_____ _____

**Patient Signature** **Date**

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# ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

**AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay The Back & Body Clinic as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

**Signed this _____ day of _____, 20 ____.**

_____ _____

**Patient Signature** **Date**