ACTION CHIROPRACTIC

Pain, Injury and Rehab

GENERAL PATIENT INTAKE FORM and CHIROPRACTIC CARE AGREEMENT

Patient Information:

Today's Date: ____/____/____ Home Phone: _____
Name: _____ Cell Phone: _____
I prefer to be called: _____ Work Phone: _____
Address: _____ **E-mail**: _____
_____ Social Security No.: _____
_____ Date of Birth: ____/____/____ Age: _____
Sex: ❑ Male ❑ Female Height: ____'____" Weight: _____lbs
Occupation: _____ Marital Status: _____
Employer: _____ No. of Children: _____
Address: _____
If minor, name of parent or guardian: _____
Who should we contact in case of an emergency? _____
Relation: _____ Phone: _____
Address: _____
Primary Care Physician: _____ Phone: _____
How did you hear about office? _____
Have you ever been to a chiropractor before? ❑ Yes ❑ No If so, whom? _____
How do you prefer to receive communication from our office? ❑ Via Email ❑ Via Regular Mail

Insurance Information:

If you choose to use health insurance to help offset your financial responsibility, please give your card to the front desk for verification of benefits. Please list insurance provider: _____

Reason for Visit:

1. This visit is as a result of (Please circle): **wellness**, **sports**, **auto**, **trauma**, or **chronic condition.**
2. If this visit is for wellness visit or spinal checkup, please skip questions 3 through 10.
3. If this visit is due to pain, when did the symptoms begin? ____/____/____
4. Please explain what you are experiencing:

   _____
   _____
   _____
5. Is the condition getting worse? □ Yes □ No. Describe □ Constant □ Comes and goes
6. List activities that aggravate this condition(s) or inhibit this condition(s):

   _____
   _____
   _____
7. Have you had this or a similar condition in the past? □ Yes □ No
8. Have you been treated by a medical physician or other provider for this condition? □ Yes □ No
9. Are you taking any medications? Please include any vitamins or supplements. □ Yes □ No

If yes, please list:

_____
_____

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HEALTH HISTORY

Have you ever had any of the following diseases or conditions?

- ❑ Heart Attack or Stroke
- ❑ Congenital Heart Defect
- ❑ Alcohol/Drug Abuse
- ❑ HIV+/AIDS
- ❑ Frequent Neck Pain
- ❑ High/Low Blood Pressure
- ❑ Severe/Freq. Headaches
- ❑ Fainting/Seizure/Epilepsy
- ❑ Diabetes
- ❑ Lower Back Problems
- ❑ Heart Surgery or Pacemaker
- ❑ Mitral Valve Collapse
- ❑ Venereal Disease
- ❑ Shingles
- ❑ Emphysema
- ❑ Psychiatric Problems
- ❑ Kidney Problems
- ❑ Sinus Problems
- ❑ Difficulty Breathing
- ❑ Artificial Bones/Joints
- ❑ Heart Murmur
- ❑ Artificial Valves
- ❑ Hepatitis
- ❑ Cancer
- ❑ Anemia
- ❑ Rheumatic Fever
- ❑ Ulcers/Colonitis
- ❑ Asthma
- ❑ Tuberculosis
- ❑ Arthritis

Please list any other medical conditions that you have or have ever had.

_____

Please list any allergies.

_____

Please list previous surgeries and dates.

_____

Please list any past motor vehicle accidents or traumas and dates.

_____

Is there anything else about your health history or family health history that you feel is important to share?

_____

Do you have a pacemaker? □ Yes □ No
Do you exercise? □ Yes □ No
Are you on a special diet? □ Yes □ No
Do you smoke? □ Yes □ No How much? _____ How long? _____
Are you wearing: □ Orthotics □ Heel lifts □ Arch supports

For women:
Are you taking birth control? □ Yes □ No
Are you pregnant? □ Yes □ No How long? _____ Nursing □ Yes □ No

Patient/Legal Guardian Signature _____ Date: ____/____/____

INFORMED CONSENT

A patient, in coming to *Action Chiropractic*, gives the chiropractor permission and authority to care for the patient in accordance with the chiropractor's assessment of tests, diagnostic impressions, and conclusions. The chiropractic adjustment, as well as 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 render health care if he or she is aware that such care may be contra indicated. It is the patient's responsibility to make known any pathological defects, illnesses, or deformities that 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 as a specialist and is available to work with other types of providers in your health care regime.

Usually, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions, which do not respond to chiropractic care, may come under the control of other health care providers. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's 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 the doctor's office will be credited to my account on receipt. However, 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, all fees for professional services rendered to me will be immediately due and payable.

Please discuss any questions or problems with the doctor before signing this statement of policy.

_____ ____/____/____

Patient's Signature **Date**

CONSENT TO TREAT A MINOR

I, _____ hereby authorize Dr. _____ and whomsoever he or she may designate as assistants to administer care as deemed necessary to _____. My relationship to this minor is _____.

(Name of Minor)

_____ ____/____/____

Parent, Guardian, or Spouse's Signature Authorizing Care **Date**

CONSENT TO TREAT AN EMANCIPATED MINOR

By my signature below, I warrant that I am over the age of sixteen (16) years, and that I reside separate and apart from my parents, managing conservator, or guardian. I further warrant that I am managing my own financial affairs, and hereby consent to treatment by Action Chiropractic.

_____ _____ ____/____/____

Printed Name **Signature** **Date**

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ASSIGNMENT OF BENEFITS: ASSIGNMENT OF CAUSE OF ACTION: CONTRACTUAL LIEN

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to *Action Chiropractic* 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 adjuster for purposes of processing my claim for benefits and payment of 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, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to 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 *Action Chiropractic*, and to send all checks to 5400 E. Mockingbird Lane Suite 214, Dallas, TX 75206.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable directly to *Action Chiropractic*, and to send any and all checks to 5400 E. Mockingbird Lane Suite 214, Dallas, TX 75206.

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 ATTORNEY: I hereby grant to the physician/facility named above the 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 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. If my carrier is unable to provide said rejections in a timely manner, I instruct my carrier to pay up to available limits directly to physician/clinic named above, and to send any and all checks or financial instruments to 5400 E. Mockingbird Lane Ste 214, Dallas, TX 75206.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointment 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 that failure to do so may jeopardize my case.

_____ ____/____/____

Patient Signature **Date**