www.backbodyclinic.com
info@backbodyclinic.com

487 Crockett Drive, Lewisville Texas 75057

Phone: 972-436-9785
Fax: 972-436-6068

CASE HISTORY & PATIENT INFORMATION

Date: _____

Name: _____ SS#:_____ Age: _____ Birth Date:_____

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? _____

HISTORY OF PRESENT ILLNESS:

Major symptom(s) or purpose of this appointment and date it appeared:_____

_____

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 pain? _____

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? _____

Are there any other current conditions that may be related to your major symptom?_____

TELL 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: > > > >

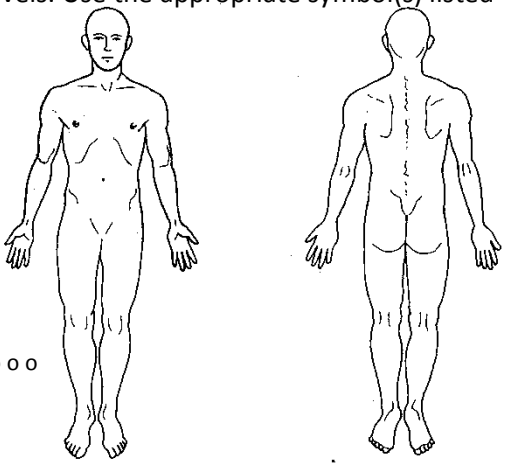
Numbness: = = = =

Burning: x x x x

Stabbing: / / / /

Throbbing: # # # #

Pins & Needles: o o o o



FOR OFFICE USE ONLY		
BP	PULSE	
HEIGHT	O2	
WEIGHT		

AUTO INSURANCE INFORMATION:

Were you the driver of the vehicle in which you were injured? ☐Yes ☐No If no, who was the driver of the vehicle? _____

Your insurance company: _____ Insurance adjustor's name: _____

Policy number: _____ Claim number: _____

Amount of personal injury protection: $_____ Have any charges been filed against your PIP? ☐Yes ☐No If yes, how much? _____

Have you retained an attorney? ☐Yes ☐No If yes, please provide their name, address and phone number: _____

_____

AUTO ACCIDENT INFORMATION:

Date of accident: _____ Time of accident: _____ Please explain in detail how your accident happened: _____

_____

_____

_____

Where did you feel the pain/symptoms immediately after the accident? _____

_____

What is the make/model of your vehicle? _____

What way was your vehicle heading? ☐ North ☐South ☐East ☐West on what road? _____

Where were you seated in the vehicle? ☐Driver ☐Passenger ☐Rear-seat ☐Other: _____

Which way was your head facing at the time of impact? ☐Straight ☐Left ☐ Right ☐ Up ☐ Down ☐Unsure

Were you aware of the approaching collision prior to impact? ☐Yes ☐No Were you knocked unconscious ☐ Yes ☐No

Were you wearing a seat belt? ☐ Yes ☐No Did your airbag deploy? ☐Yes ☐No Was your car totaled? ☐ Yes ☐No ☐Unsure

What were the road conditions like? ☐ Dry ☐Wet ☐Ice ☐ Snow ☐ Other _____

What was the estimated speed of your vehicle at impact? _____ What part of your vehicle was struck? _____

What is the make/model of the other vehicle? _____

What way was the other vehicle heading? ☐ North ☐South ☐ East ☐West on what road? _____

What was the estimated speed of the other vehicle at impact? _____ What part of the other vehicle was struck? _____

Were the police notified? ☐Yes ☐ No If yes, is there a police report? ☐ Yes ☐ No Were you treated by EMS/Paramedics? ☐Yes ☐ No

Were you taken by ambulance anywhere after the accident? ☐Yes ☐No If yes, where were you taken? _____

Was a doctor consulted? ☐ Yes ☐No If no, please disregard the following questions.

What was the diagnosis? _____

What tests were performed? _____

What treatment was performed? _____

Were medications prescribed? ☐Yes ☐No If yes, what medications were prescribed (include dosage and frequency)? _____

_____

MEDICAL HISTORY

Have you ever been diagnosed as having or have had any of the following?

Aids/HIV		Depression		High Blood Pressure		Miscarriage		Rheumatic Fever	
Alcoholism		Diabetes		High Cholesterol		Mononucleosis		Rheumatoid Arthritis	
Allergies		Drug Addiction		Kidney Disease		Multiple Sclerosis		Seizures/Convulsions	
Anemia		Emphysema		Liver Disease		Osteoarthritis		STI	
Anxiety		Epilepsy		Loss of Memory		Osteoporosis		Sleeping Disorder	
Arthritis		Glaucoma		Loss of Smell		Pacemaker		Stomach Problems	
Asthma		Goiter		Loss of Taste		Parkinson's Disease		Stroke	
Bleeding Disorders		Gout		Low Blood Pressure		Pneumonia		Suicide Attempt	
Cancer		Heart Disease		Low Blood Sugar		Prostate Problems		Thyroid Problems	
Cataracts		Hepatitis		Measles		Prosthesis		Tuberculosis	
Chronic Vaginal Infections		Hernia		Migraines		Psychiatric Care		Whooping Cough	

Please check if you have had any of these preventative procedures:

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	

Have you had any major injuries, falls, auto accidents, or surgeries? Please list type and date:_____

_____

_____

Please check if you have experienced any of these symptoms within the last month:

Neurological		**Cardiovascular**		**Respiratory**		**Skin**		**Energy**	
Headaches		Anemia		Chest Congestion		Brittle Nails		Decreased Libido	
Migraines		Chest Pain		Cough		Easy Bruising/Bleeding		Fatigue	
Numbness/tingling		Palpitations		Recurrent Infections		Eczema		Hyperactivity	
Ringing in Ear		Swelling in Extremities		Shortness of Breath		Hair Loss		Problems Sleeping	
Slurring of Speech		**Gastrointestinal**		Wheezing		Lesions		Restlessness	
Ear/Nose/Throat		Abdominal Pains		**Genitourinary**		Rashes		**Mental**	
Altered Taste/Smell		Bloating/Gas		Blood in Urine		Redness		Anxiety	
Ear Ache		Blood in Stool		Difficulty Urinating		Swelling		Depression	
Nose Bleeds		Constipation		Discharge		Wound		Memory Loss	
Sinus Congestion		Diarrhea		Pelvic Pain		**Weight**		Mood Swings	
Sore Throat		heartburn		Prostate Problems		Appetite Changes		Stress	
Visual Disturbance		Nausea or Vomiting		Sexual Dysfunctions		Weight Gain		Suicidal Thoughts	
				Testicular Problems		Weight Loss			

Please list any other health problems you have, no matter how insignificant they may be: _____

_____

If you already have one, who is your medical provider? _____ When providers work together, it benefits you. May we have your permission to update your provider regarding your care at this office? ☐Yes ☐No

Have you been treated by a Chiropractor before? ☐ Yes ☐ No If yes, please give details (such as the doctor's name, your last adjustment and any treatment information): _____

_____

Do you have any medicinal, environmental, or food allergies? ☐ Yes ☐ No If yes, describe:_____

_____

_____

What medications or nutritional supplements are you currently taking?

NAME	STRENGTH	FREQUENCY

NAME	STRENGTH	FREQUENCY

Pharmacy name and crossroads: _____

FAMILY HISTORY

Please check if your family has ever been diagnosed by these diseases:

Father

☐	Alcoholism	☐	Blood Clots	☐	Diabetes 1 or 2	☐	Kidney Disease	☐	Osteoporosis
☐	Anemia	☐	Cancer	☐	Heart Disease	☐	Liver Disease	☐	Stroke
☐	Arthritis	☐	COPD/Emphysema	☐	High Blood Pressure	☐	Lung Disease	☐	Thyroid Disorder
☐	Asthma	☐	Dementia	☐	High Cholesterol	☐	Mental Illness	☐	Tuberculosis

Mother

☐	Alcoholism	☐	Blood Clots	☐	Diabetes 1 or 2	☐	Kidney Disease	☐	Osteoporosis
☐	Anemia	☐	Cancer	☐	Heart Disease	☐	Liver Disease	☐	Stroke
☐	Arthritis	☐	COPD/Emphysema	☐	High Blood Pressure	☐	Lung Disease	☐	Thyroid Disorder
☐	Asthma	☐	Dementia	☐	High Cholesterol	☐	Mental Illness	☐	Tuberculosis

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 ☐ ½ pack/day ☐ 1 pack/day ☐ 1-2 packs/day ☐ More than 2 packs

Do you 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: _____

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
- **No refunds on credit balances are issued until all treatments are completed** and the patient has been released for 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- Effective March 01, 2005, we no longer accept Worker's Compensation cases. If you feel your injury may be work-related in any way, please let us know so that we may refer accordingly.

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 chiropractic 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 chiropractic procedures. In most cases, 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. 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 (including manipulations) 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 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

CHIROPRACTIC
It is important to acknowledge the difference between the healthcare specialties of chiropractic, osteopathy, and medicine. Chiropractic healthcare seeks to resolve health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic healthcare services.

ANALYSIS
A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative power. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS
Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS, and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concerns as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

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 WAVER
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.

RESULTS
The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases, 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 that do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

I have read and understand the foregoing. I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in my case. I further authorize the doctor 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.

_____ _____

Signature Date

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PATIENT HEALTH INFORMATION CONSET 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 chiropractic 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 chiropractic 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, the chiropractic physician 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 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