COWBOY SPINE & Performance Center

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830-714-0006
830-714-0007

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Marital Status: _____ Age: _____ Birthdate: _____

Cell: _____ Email: _____

Primary Care/Family Doctor: _____

Employment/Job Title: _____

Spouse/Guardian/Emergency Contact: _____

Relationship: _____ Phone Number: _____

INSURANCE COVERAGE (not applicable if you are filing PIP or represented by an attorney due to motor vehicle collision)

Primary Insurance Company	Primary Ins ID#	Primary Ins Group#
Secondary Insurance Company	Secondary Ins ID#	Secondary Ins Group#

INSURED INFORMATION

Are the insured and patient the same person? ☐ Yes ☐ No **IF YES, SKIP**

Last Name	First Name	M.I.
Street	City	State Zip
Age Date of Birth	Social Security #	Sex: ☐ M ☐ F
Insured relationship to Patient	☐ Spouse ☐ Parent/Guardian	☐ Other

At Cowboy Spine & Performance we are here to service our patients the best way we know how. We understand the value of health insurance, however because many health insurance plans are intended to supplement out pocket expenses for care, it may not cover the entirety of the care you need. While it is ultimately your responsibility to understand your given plan, we will work with you to help understand your plan as it relates to care at this facility.

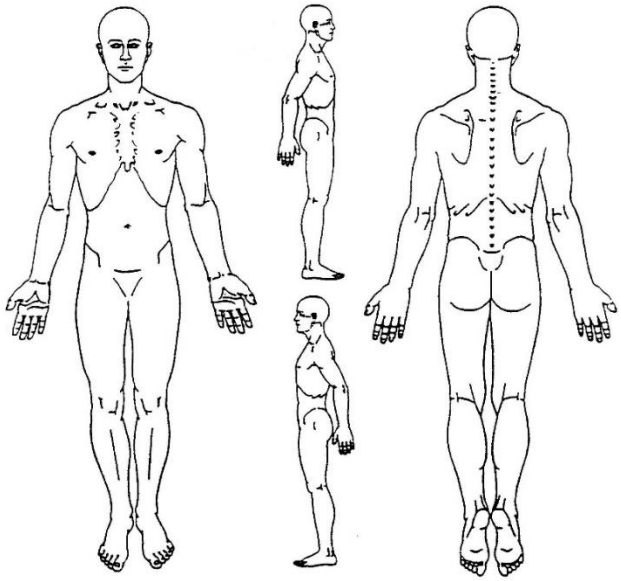
Our relationships are with each patient individually, not the insurance companies. If we believe that we may be able to help you and we accept your case, our recommendation will be based on what we believe is the best course of care for you, supported by evidence and our experience. We take great care in making our services affordable regardless of health insurance Coverage.

SYMPTOM DIAGRAM

Please indicate on the body diagram any symptoms you are experiencing.

Mark the diagram with the following letters to indicate your symptoms:

R = Radiating
B = Burning
D = Dull
A = Aching
N = Numbness
S = Sharp/stabbing
T = Tingling



CURRENT SYMPTOMS

Date of Injury: _____

Please describe how the injury, pain, or discomfort began:

_____

_____

Select the frequency you experience pain from this condition:

☐ Always ☐ Hourly ☐ Daily ☐ Occasionally (describe) _____

If constant/always or chronic issue – when is the last time you went 2 weeks without symptoms?

_____

Does this condition interfere with any of your daily activities or routines?

☐ No ☐ Yes, Explain: _____

Have you missed any work due to this injury/condition?

☐ No ☐ Yes

List anything that aggravates your condition:

_____

_____

List anything that relieves or improves your condition or symptoms :

_____

_____

Have you received any professional treatment for this condition?

☐ No ☐ Yes, Explain: _____

Pain level Rating – Scale 0 to 10 (Where 0 is no pain and 10 is the worst pain you can imagine):

Circle one: 0 1 2 3 4 5 6 7 8 9 10

Have you ever had this same condition?

☐ No ☐ Yes, When? _____

PERSONAL HEALTH

Have you had any surgeries?
☐ No ☐ Yes, Explain _____
_____
_____

Do you currently or have you had any serious illness/diseases?
☐ No ☐ Yes, Explain _____
_____
_____

(For women only) Are you or is there any chance you might be pregnant?
☐ No ☐ Yes

ALLERGIES

Do you have any allergies?
☐ No ☐ Yes, Explain _____
_____

Do you have any reactions to topical creams/gels/perfumes?
☐ No ☐ Yes, Explain _____
_____

FAMILY HEALTH HISTORY

Please list diagnosed health condition and untimely deaths (condition, relationship to you)
Please list family members each on a separate line.
(Example: arthritis, cancer, diabetes, heart disease, kidney disease, high cholesterol, etc.)

_____
_____
_____

CHIROPRACTIC EXPERIENCE

Have you ever been to a chiropractor before?
☐ No ☐ Yes – What was the reason for those visits? _____
_____

Doctor's Name: _____ Approx. Date of Last Visit: _____

REVIEW OF SYSTEMS

Please check any of the following you are currently experiencing or have experienced within the past 2 years.

General:
☐ Abnormal weight gain
☐ Abnormal weight loss
☐ Fatigue/weakness
☐ Frequent/current fevers

Musculoskeletal:
☐ Painful joints
☐ Frequent muscle aches
☐ Swollen joints
☐ Joint redness
☐ Osteoporosis
☐ Osteopenia
☐ Trauma
☐ Loss of muscle size
☐ Arthritis
☐ Artificial joints

Head
☐ Headaches
☐ Head injury

Neck
☐ Pain
☐ Stiffness
☐ Swollen glands
☐ Goiter
☐ Whiplash

Low Back
☐ Pain
☐ Stiffness
☐ Sciatica
☐ Locking or catching

Shoulder
☐ Weakness
☐ Stiffness
☐ Loss of motion
☐ Clicking or popping
☐ Dislocation

Hip
☐ Weakness
☐ Stiffness
☐ Loss of motion
☐ Limp
☐ Catching/locking

Knee
☐ Weakness
☐ Stiffness
☐ Catching/locking
☐ Instability/giving way

Neurologic
☐ Dizziness
☐ Fainting
☐ Seizures
☐ Weakness
☐ Tingling/numbness
☐ Tremor (shaky hands)
☐ Ticks
☐ Balance difficulty
☐ Gait abnormalities
☐ Headaches/Migraines
☐ Loss of strength

Eyes
☐ Glasses or contacts
☐ Change in vision
☐ Eye pain

Ears
☐ Change in hearing
☐ Ringing

Breast
☐ Lumps
☐ Pain

Allergies
☐ Hives
☐ Rash
☐ Asthma
☐ Eczema/Sensitive Skin

Mouth/Throat
☐ Loss of taste
☐ Hoarseness
☐ Sore throat

Respiratory/Cardiac
☐ Shortness of breath
☐ Cough
☐ Pain with deep breath
☐ Wheezing
☐ Chest pain
☐ Fever
☐ Night sweats
☐ Blue fingers/toes
☐ Skipping heart beat
☐ Pacemaker
☐ Emphysema/COPD
☐ Heart Attack

Peripheral Vascular
☐ Leg cramps
☐ Varicose veins
☐ Clots in veins

Psychiatric
☐ Anxiety
☐ Depression
☐ Suicidal ideation
☐ Memory problems
☐ Sleep problem

Systemic
☐ HIV/Aids
☐ Alcohol/Drug Abuse
☐ Cancer
☐ Diabetes
☐ Hepatitis
☐ Anem

AUTO INSURANCE INFORMATION

Your Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Responsible Party Name: _____

Responsible Party Ins. Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy Holder's Name: _____ Policy #: _____

Agent's Name: _____ Phone: _____ Ext: _____

Claim number: _____

ATTORNEY INFORMATION

Name: _____Phone: _____ Ext: _____

Firm: _____

Address: _____

City: _____ State: _____ Zip Code: _____

ABOUT YOUR COLLISION

Date of Collision _____/_____/_____ Time of Collision _____ ☐ AM ☐ PM

Where were you located?

☐ Driver ☐ Front Passenger ☐ Left Rear Passenger ☐ Right Rear Passenger
☐ Pedestrian ☐ Other:_____

What did your vehicle make contact with?

☐ Another vehicle ☐ Stationary object ☐ Second Impact
☐ Other:_____

Where did your vehicle get struck from or strike the object?

☐ Behind ☐ Right side ☐ Left side ☐ Front ☐ Parked ☐ Moving
☐ 2nd Impact ☐ Other:_____

Make and Model of your vehicle:

_____

Approximately how fast were you moving at moment of impact?

_____

What direction were you heading at moment of impact?

☐ North ☐ South ☐ East ☐ West ☐ Unknown

Make and Model of any other vehicles involved in the collision:

_____

Approximately how fast was the other vehicle(s) moving at moment of impact?

_____

What direction was the other vehicle heading at moment of impact?

☐ North ☐ South ☐ East ☐ West ☐ Unknown

Name of street/intersection of the collision:

_____

Where were you looking at time of impact?

☐ Straight ahead ☐ Behind ☐ Right ☐ Left ☐ Down
☐ Other: _____

Did you hit any part of your body inside the vehicle?

☐ No ☐ Yes, explain: _____

_____

Did you hit your head or lose consciousness?

☐ No ☐ Yes, How long: _____

What were the road conditions at the time of your collision?

☐ Dry ☐ Wet ☐ Icy ☐ Other: _____

Please answer the following questions about your accident:

Did police arrive at the scene of the collision?	☐ Yes ☐ No ☐ Unknown
Was a police report filed?	☐ Yes ☐ No ☐ Unknown
Did EMTs arrive at the scene of the collision?	☐ Yes ☐ No ☐ Unknown
Were there other passengers in your vehicle?	☐ Yes ☐ No ☐ Unknown
Were you wearing your seatbelt?	☐ Yes ☐ No ☐ Unknown
Did your head hit the headrest?	☐ Yes ☐ No ☐ Unknown
Did the airbags deploy?	☐ Yes ☐ No ☐ Unknown
Did your seat break?	☐ Yes ☐ No ☐ Unknown
Did you see the crash coming?	☐ Yes ☐ No ☐ Unknown
Were you braced for the impact?	☐ Yes ☐ No ☐ Unknown
Were any objects thrown around the inside of your vehicle?	☐ Yes ☐ No ☐ Unknown

Please briefly describe your collision:

_____

_____

_____

_____

AFTER YOUR COLLISION

Please describe how you felt immediately after the accident:

☐ Disoriented ☐ Discomfort ☐ Immediate Pain ☐ Tightness/Stiffness

☐ Anxiety ☐ Frightened/Scared ☐ Stunned ☐ Went straight to hospital

☐ Other, please explain: _____

Have you gone to the Hospital or Emergency Room?

☐ No ☐ Yes, When: _____

How did you get there? ☐ Ambulance ☐ Drove yourself ☐ Other private transport

Have you seen any other doctors for this collision?

☐ No ☐ Yes, Who: _____

What kind of treatment did you receive?

☐ Prescription Medication ☐ Over the counter pain meds ☐ Chiropractic/PT

☐ Other: _____

Have you had x-rays taken for this injury?

☐ No ☐ Yes, Where: _____

Have you had an MRI or CT taken for this injury?

☐ No ☐ Yes, Where: _____

Have you missed any work due to this injury?

☐ No ☐ Yes

If yes:

What was the date you were last able to work: _____

When do you have to or expect to return to work: _____

Have you limited or reduced your work hours or activities due to this injury?

☐ No ☐ Yes, Explain: _____

Please select any of the following symptoms you have experienced because of this accident.

☐ Dizziness	☐ Difficulty sleeping	☐ Jaw/TMJ Problems	☐ Nausea
☐ Memory Loss	☐ Irritability	☐ Arm/Shoulder pain	☐ Back pain
☐ Headache(s)	☐ Neck stiffness	☐ Numb hands/fingers	☐ Fatigue
☐ Blurred vision	☐ Low back pain	☐ Back stiffness	☐ Chest pain
☐ Buzzing in the ear	☐ Tension	☐ Short of breath	☐ Leg pain
☐ Ringing in the ear	☐ Neck pain	☐ Stomach upset	☐ Numb feet
☐ Depression	☐ Anxiety	☐ Other: _____	

CHIROPRACTIC INFORMED CONSENT

Patient Name (please print): _____

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

The nature of the chiropractic adjustment

The primary treatment that is used by Doctors of Chiropractic is spinal and extremity manipulative therapy. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following: Spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, therapeutic ultrasound, hot/cold therapy, EMS / "e-stim," and any other procedures the doctor deems necessary for adequate assessment of your current complaint.

The risks inherent in the chiropractic adjustment

As with any heathcare procedure, there are certain risks and complications that may arise during chiropractic manipulation and therapy. These complications, while rare, may include but are not limited to: fractures, disc injury, dislocation, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to arteries in the neck leading to or contributing to serious complications including stroke (current evidence may be obtained upon request). Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform your doctor.

The probability of those risks occurring

Fractures are rare occurrences and generally result from an underlying weakness of the bone which we check for during history taking and during physical examination. We may refer for X-Ray or advanced imaging if suspicion of these conditions is high. Stroke and/or arterial dissection cause by chiropractic manipulation 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. A causal relationship is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment(s). I have discussed it with one of the doctors at *Cowboy Spine & Performance Center* 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 my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

AUTHORIZATION

I certify that I'm the patient or legal guardian listed above. I have read/understood the included information and certify the information to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information within this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors deem necessary. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree to pay any charges for missed or late appointments which will be provided by request. I understand and agree that health/accident insurance policies are an arrangement between the insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Name of Responsible Party: _____

Relationship to Patient: _____

Signature: _____ Date: _____

CANCELLATION/NO SHOW POLICIES:

Appointments

Please arrive on time for your appointments. The doctors try their best to stay on schedule and this needs your cooperation. If you happen to arrive late for an appointment, your visit may be shortened and end at the originally scheduled time in order to accommodate patients whose appointments follow yours.

Depending on the degree of your tardiness, your doctor will determine if there is enough time remaining to start your treatment.

Regardless of the length of time the treatment is provided, you will be responsible for the full amount of your scheduled appointment.

Tardiness in excess of 15 minutes will be considered a "No-Show" appointment and you may be asked to reschedule your current appointment.

Out of respect and consideration for your doctor and other patients, please plan accordingly and arrive on time for your appointments.

No-Show Policy

This policy is to ensure that patients have access to care when needed and to avoid the great expense to our office due to late cancellations and no shows. This policy is designed to help keep our costs down and keep appropriate care for all our patients. We take your time very seriously and are committed to serving you with the highest level of care. We ask that in return you respect our time as well.

Anyone who either forgets or consciously chooses to forgo a scheduled Chiropractic appointment will be considered a "No-Show." We reserve the right to charge you a **fee of $65** for your missed appointment. For anyone who forgets or consciously chooses to forgo a scheduled Massage appointment, we reserve the right to charge you up to the **FULL AMOUNT** of the scheduled Massage. The fee must be paid prior to scheduling your next appointment.

Cancellations

24 hour advanced notice is required when cancelling any appointment. This allows the opportunity for other patients to schedule an appointment. If you are unable to give us 24 hours advanced notice, we reserve the right to charge you a **fee of $65** for missed Chiropractic appointment, and the **FULL AMOUNT** for missed Massage appointment. This amount must be paid prior to your next scheduled appointment

I, _____, authorize Cowboy Spine & Performance Center to process payment on my Visa, MasterCard, Discover Card, or HSA card for the purposes of:

1.) My payment responsibilities as designated by our agreement by the end of the day on the date of service provided.
2.) Any outstanding balance that has not been received after 90 days of the service that was provided to me by a CSPC provider (i.e. chiropractic, massage, etc.).

I understand and agree that if an appointment is missed and I do not follow the cancellation policy as specified in the section Cancellation and Missed Appointment Policy, Cowboy Spine & Performance Center is authorized to charge my credit card up to the full cost of the missed appointment.

I understand and agree that if my card is declined, Cowboy Spine & Performance Center may put my credit card payment through on another day when funds become available.

I understand and agree that I have given Cowboy Spine & Performance Center my credit card information. I further understand that if I miss a scheduled appointment or fail to provide 24 hours notice, my credit card may be charged up to the full amount of the session.

I have read and understand this form. I attest that the information below is true and accurate.

_____

Signature of card holder

My credit card information is as follows:

_____	_____	_____
Cardholder's name	**Patient's name**	**Date**
_____	_____	_____
Credit Card Number	**Expiration Date**	**Security Code**
_____	_____	_____
Address Credit Card Account is under	**Zip Code CC Account is under**	**Email Address**

Notice of Doctor's Lien and Irrevocable Assignment of Director of Proceeds

I hereby authorize my healthcare provider, Cowboy Spine & Performance Center hereinafter "Provider", to furnish to my attorney, insurance company or other person or entity involved in my claim with a full report of my case history, examination, diagnosis, treatment, prognosis, or other medical/billing resulting in my treatment by Provider. I also authorize Cowboy Spine & Performance Center to disclose such information to its attorney and any billing or collection entity that it may retain.

I further, for good and valuable consideration of which is hereby acknowledged, assign and transfer, irrevocable, to Provider all rights, title and interest that I may now have in the future to any and all benefits, proceeds and/or monies that may be due to me from any third-party and/or payer, including but not limited to third party liability payers, personal injury protection (PIP) coverage, underinsured/uninsured coverage, third partied group health plans as a result of the accident or injury event for which Provider has rendered and/or will render medical goods and services on my behalf.

I further irrevocably assign entitlement to benefits, proceeds and/or monies to Provider and irrevocably grant a lien to the extent of my indebtedness to Provider and irrevocably direct and third-partied and/or payers, including but not limited to third-party liability payers, personal injury protection (PIP) coverage, Medpay, underinsured/uninsured coverage, homeowners coverage, third parties and group health plans to make benefits, proceeds and/or monies payable to include Provider. I additionally issue this directive that no money, check, draft, electronic fund transfer, or any other payment is to be made to myself, my attorneys, my heirs or assigns from the above listed third-parties and payer without including Cowboy Spine & Performance Center as a payee on such disbursements.

I further irrevocably direct my attorney representing me as a result of the accident, occurrence, or injury-causing event to protect Provider's total charges out of any recovery that is obtained on my behalf by directing and forwarding payment of said recovery to Provider to the extent of m total indebtedness to Provider. I fully understand that my attorney shall abide by this irrevocable assignment, directive, and notice without further consultation with me and shall disclose to Provider and/or its representatives, agents, independent contractors and attorneys and all information related to my claim(s) and settlement, judgement, verdict or recovery.

I further agree to fully inform Provider to any and all potential third-parties and/or payers, personal injury protection (PIP) coverage, underinsured/uninsured coverage, third parties or group health plans that may be liable for my injuries and to provide the names and addresses of any attorney(s) that may represents me now or in the future concerning this accident, occurrence or injury event. I fully understand that this irrevocable assignment, directive and notice or lien shall remain with respect to any future attorney that I retain.

Patient initials: _____

I further agree to defend, indemnify and to hold harmless Provider against any payer(s) and its agents, representatives, employees, officers, directors, partners, shareholders, affiliates, attorneys, subcontractors, independent contractors, heirs, assigns and all other persons, firms, corporations, associations, or partnerships or other entities from any and all claims, actions, causes of actions, damages, costs, expenses, compensation, or otherwise on account of or in any way growing out of the direct payment to Provider. I fully understand that it is my sole responsibility to maintain any and all claims, causes of action, appeals, and conditions to recover against any and all potential third-parties and/or payers, including but not limited to third-parties and group health plans.

I further fully understand and agree that regardless of my execution of this agreement, that I am directly and fully responsible to Provider for medical goods and services provided and/or that will be provided to me and that this agreement is made solely for additional protection to Provider and in consideration of Provider awaiting payment. It is hereby understood and agreed that my responsibility for payment is not contingent upon any settlement, claim, judgement, verdict, recovery or otherwise that I may obtain. I also understand that any payments made on my behalf, whether by insurance companies, attorneys, or myself, if less than the full amount of my outstanding balance, is only partial payment toward my account. Any such partial payment is not and will not be considered and offer in compromise: or release me from my remaining balance owed to Cowboy Spine & Performance Center.

It is further understood and agreed that I shall fully inform and notify any third parties and payers, including but not limited to third-party liability payers personal injury protection (PIP) coverage, underinsured/uninsured coverage, third parties and group health plans and/or attorneys, or irrevocable Assignment, Directive and Notice.

I further agree to waive for two years after any settlement is reached the statue of limitations applicable to Provider's claim causes of action, rights and/or remedies in collecting its total charges pursuant to this irrevocable Assignment Directive and Notice or pursuant to any remedy available to Provider in collecting its total charges, damages, interest, court costs of collection and any other relief to which Provider may be entitled. In addition to any cause of action available under Texas law or any other applicable state's laws, I understand and agree that Provider may seek a recovery from me and my attorney, agents, heirs or assigns for breach of contract if I do not comply with this agreement.

This Irrevocable Assignment, Directive, and Notice of Lien shall be irrevocable upon execution by me.

_____ _____

Patient/Responsible Party/Guardian Signature Date

_____ _____

Print Name Date of Injury

_____

Print Address and Phone Number

Medical Release of Information

☐ *I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:*

- ☐ Spouse _____
- ☐ Child(ren) _____
- ☐ Family doctor _____
- ☐ Other _____

☐ Information is **not** to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me or an authorized agent in writing.

Messages

Please call my ☐ cell, ☐ home, ☐ work number _____

If unable to reach me, *I authorize Cowboy Spine & Performance Center, PC or its employees to:*

- ☐ Leave a detailed message
- ☐ Leave a message asking for me to return your call
- ☐ _____

I understand and acknowledge that by my signing of this ***Release of Information*** *I will not hold Cowboy Spine & Performance Center, PC or its employees liable for any disclosure of my protected health information to the above entities or via message as described above.*

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____