



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

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.

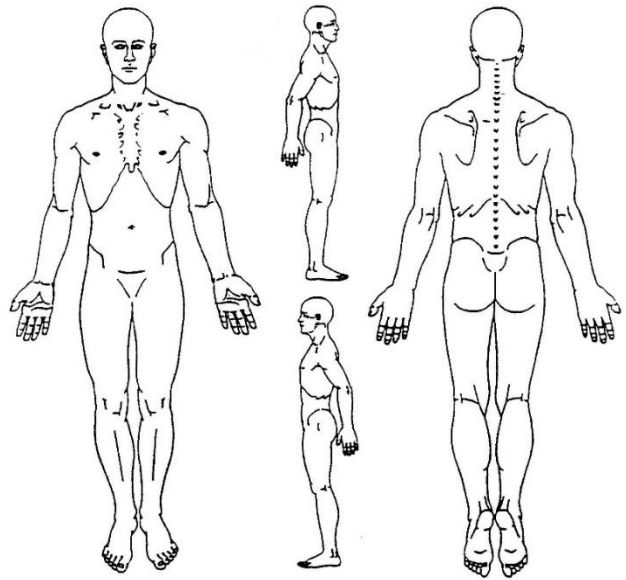
Our relationships are with each patient individually, not the insurance companies. If we believe that we may be able to help you and we accept your case, our recommendation will be based on what we believe is the best course of care for you, supported by evidence and our experience. We take great care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

Who referred you to our office?

Where did you first hear about us?
 Sign Community Event Friend/Family Other: _____

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
- Anemia

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 healthcare 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

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:

PLEASE INCLUDE NAMES

- Spouse _____
- Child(ren) _____
- Family doctor _____
- Coach _____
- 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: ____/____/____

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by COWBOY SPINE & PERFORMANCE CENTER, PC or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

I am aware this office DOES DOES NOT have open therapy areas.

Name of Patient (print)

Signature of Patient

Date

Signature of Patient Representative

Date

Relationship of Patient Representative to Patient

Office Representative

Date

Others we may release your PHI to