PATIENT CASE INFORMATION

Date: _____ **Patient No:** _____

Patient Information

Name :*(First MI Last)* _____ **Preferred Name:** _____

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

Cell Phone: _____ **Cell Carrier:** _____ **Home Phone:** _____

Email Address: _____ **Gender:** M / F **Marital Status:** Single / Married / Other

Social Security #: _____ **Date of Birth:** _____

Student Status: Full Student / Part Student / Non-Student **Employed:** Y / N **Where:** _____

Ethnicity: Hispanic or Latina / Not Hispanic or Latino / Decline **Preferred Language:** English / Decline / Other: _____

Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline

Smoker: Everyday / Some Days / Former / Never

** **Referred By:** _____ Family / Friend / Co-Worker / Doctor/ Other Source

Emergency Contact Information

Name: (First MI Last) _____ **Primary Care Physician:** _____

Phone: _____ **Doctor's Phone:** _____

Relationship: Child / Parent / Spouse / Other: _____

Insurance / Financial Information

Who is responsible for payment? Self / Other - Name: _____ **Relationship:** _____

☐Insurance☐ Worker's Comp ☐ Self-Pay (Cash) ☐ Personal Injury / Auto ☐ Other (please explain): _____

Primary Insurance Name: _____ **Secondary Insurance Name:** _____

** ***(Please supply insurance cards to office staff so that they can be copied)***

Consent to Treat, Authorization to Release & HIPPA

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation, examination, chiropractic care, diagnostic testing, and/or therapeutic services on the above, in accordance with this state's statutes. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.
ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

Signature of Patient: _____ ***Signature of Parent or Guardian:*** _____ ***Date:*** _____

(It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged)

ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI)_____ **Today's Date:** _____

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- **Was anyone else in the vehicle with you?** ☐ No ☐ Yes - *(Number of people)* _____
- **You were?** ☐ Front seat – *Driver / Passenger* ☐ Rear Seat– Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row
- **Name of Driver**, *if not self*: _____ **Name of Driver of other vehicle:** _____
- **Did airbags deploy?** ☐ No ☐ Yes **Did Police arrive?** ☐ No ☐ Yes **Using Seatbelt?** ☐ No ☐ Yes
- **Did you strike the windshield or object in car?** ☐ No ☐ Yes - *(Describe)* _____
- **Were you knocked unconscious?** ☐ No ☐ Yes *(How long?)* _____
- **Where was your vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Where was the other vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Your Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:** _____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____
- **Other's Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:** _____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: _____ **Occupation:** _____ **Claim #:** _____

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

Contact Person: _____ **Phone:** _____ **Email:** _____

GENERAL ACCIDENT/INJURY INFORMATION – *(PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)*

Date of Accident: ___/___/_____ **Time:** ___:_____ AM / PM

Please describe the accident in as much detail as possible? _____

_____

_____

_____

Before the accident/injury:

- **Have you ever had any complaints in the involved area before?** ☐ No ☐ Yes
  - *If yes* - **Were they present at the time of the accident/injury?** ☐ No ☐ Yes
    - *If yes* - **Summarize these complaints prior to the accident:** _____
- **Were you capable of performing all of your work activities without restriction?** ☐ No ☐ Yes

At the time of the accident/injury:

- **Did you feel pain immediately after the accident?** ☐ No ☐ Yes ☐ Later that day ☐ Next day ☐ When? _____
- **Were you taken anywhere after the accident?** ☐ No ☐ Yes ☐ Later that day ☐ Next day ☐ When? _____
  - *If yes*, **How?**_____ **Where?**_____
  - *If yes*, **Did you receive treatment?** ☐ No ☐ Yes - *(Describe)* _____

Since the accident/injury:

- **Are your symptoms:** ☐ Improving? ☐ Getting Worse? ☐ The Same?
- **Are your work activities restricted as a result of this accident/injury?** ☐ No ☐ Yes - *(How?)* _____
- **Have you missed any work since this accident?** ☐ No ☐ Yes - *(Dates?)* _____
- **Have you retained an Attorney?** ☐ No ☐ Yes - **Name:**_____ **Phone:** _____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

Patient No: _____

COMPLAINT INFORMATION

Date: _____ **Patient No:** _____

History of Current Condition

Major Complaint: _____

Secondary Complaint: _____

When and How this began? _____

_____

_____

Intensity of Pain/Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore

How frequent is the complaint? Off & On / Constant

Does the complaint radiate? No / Yes (Describe) _____

Head - Base of Skull / Forehead / Temple L / R / Both Leg - Hip / Thigh-Knee / Calf / Toes L / R / B

Arm - Across Shoulder / Elbow / Hand-Fingers L / R / Both Other Area: _____

What makes it Better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

What makes it Worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected? (*Describe*) _____

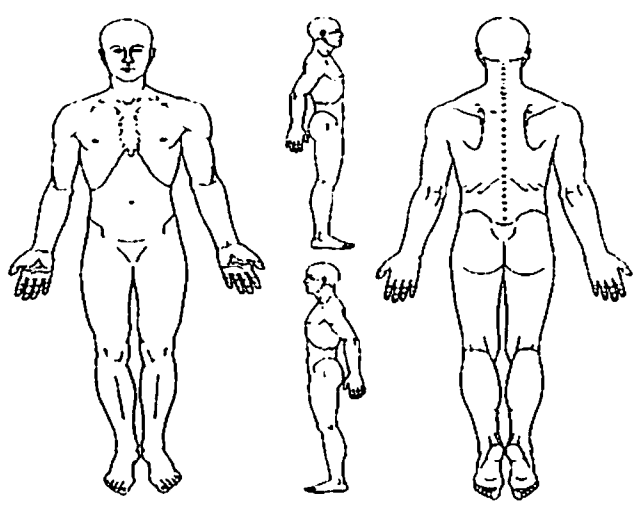
For this condition, have you:

Other Treatment? None / DC / MD / PT / Massage / Other: _____ Where: _____

Other Diagnostic Testing? X-rays / MRI / CT / Other: _____ Where: _____

Pain Complaint Diagram

SYMPTOM DIAGRAM



T ___ Tender

P ___ Pain

N ___ Numb

H ___ Hypoesthesia

S ___ Spasm

Patient Signature: _____ ***Physician's Initials:*** _____

REVIEW OF SYSTEMS

Patient Name: (First MI Last) _____ **Patient No:** _____

Review of Systems

Zone 1 Glandular System:
- ☐ Memory Loss
- ☐ Sleep Problems
- ☐ Skin Problems
- ☐ Hair Loss/Condition
- ☐ Menstrual
- ☐ Thyroid/Energy
- ☐ Adrenals
- ☐ Depression
- ☐ ED/Fertility
- ☐ Anger Easily
- ☐ Unable to Concentrate
- ☐ Low Immunity

Zone 2 Eliminative System:
- ☐ Sinuses
- ☐ Throat Pain
- ☐ Kidney Condition
- ☐ Bladder Problems
- ☐ Constipation/Diarrhea
- ☐ Nasal Passages
- ☐ Lungs Problems
- ☐ Cough
- ☐ Lymphedema
- ☐ Bloating

Zone 3 Nervous System:
- ☐ Eyes Poor Eyesight
- ☐ Balance/Dizziness
- ☐ Poor Sleep
- ☐ Low Energy
- ☐ Unable to Relax
- ☐ Nervousness
- ☐ Ears Hearing Loss
- ☐ Tingling in Extremities
- ☐ Allergies/Food Issues
- ☐ Indigestion
- ☐ Mood Swings
- ☐ Hormone Imbalances

Zone 4 Digestive System:
- ☐ Appetite Excessive
- ☐ Acid Reflux
- ☐ Liver
- ☐ Stomach Issues
- ☐ Intestinal Issues
- ☐ Indigestion
- ☐ Taste
- ☐ Heartburn
- ☐ Gallbladder
- ☐ Pancreas/Diabetes
- ☐ Weight Gain
- ☐ Bowels

Zone 5 Muscular System:
- ☐ Neck Pain
- ☐ Arms/Hands Pain
- ☐ Middle Back Pain
- ☐ Legs/Feet Pain
- ☐ Abdomen Pain
- ☐ Disc Problems
- ☐ Shoulder Pain
- ☐ Upper Back Pain
- ☐ Lower Back Pain
- ☐ Chest Pain
- ☐ Muscle Weakness
- ☐ Muscle/Joint Pain

Zone 6 Circulatory/Lymphatic System:
- ☐ Thyroid
- ☐ Blood Pressure
- ☐ Heart Problems
- ☐ Headaches/Migraines
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Poor Circulation

Health History

Medications and Supplements:

Allergies to Medications: ☐NONE

Name	Reaction

Current Medications & Supplements: ☐NONE

Name	Dosage

Past Health History:

Surgeries: ☐NONE

Date	Describe

Major Injuries / Traumas / Hospitalizations: ☐NONE

Date	Describe

Family Health History: ☐NONE

List major health problems of 1st degree relatives:

Problem	Relation (Parent, Sibling, Child)

Social and Occupational History:

Smoking: ☐Every Day ☐Some Days ☐ Former ☐Never

Habit	Type / Amount / Year Started
Smoking	
Tobacco	
Alcohol	
Caffeine	
Rec. Drugs	

PERFORMANCE
Chiropractic Clinic

Patient Name:
Patient Number:

Informed Consent for Chiropractic Acupuncture Services

I have been informed of the following:

1. The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (ribs, legs, arms etc.), often, but not necessarily resulting, in an audible pop or clicking sound;
2. I have been informed that Acupuncture, and the related practices of Acupressure and meridian therapy may be performed by various means, including manipulation, heat, cold, pressure, vibrations, laser, ultrasound, light electro-current or the insertion of needles for the purpose of obtaining a bio positive reflex by nerve stimulation.
3. I have been informed that in addition to the Chiropractic Adjustment, one or more "Supportive Therapies" may be applied by the chiropractor or by staff under their direction and supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, heat, cold, and/or nutritional/lifestyle recommendations;
4. I have been informed that coinciding with the process of a Chiropractic Adjustment and/or Supportive Therapies there may be, at times, some temporary soreness and/or stiffness; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely tissue bruising and/or swelling, more rare joint/bone separation/fracture; and extremely rare, disc, nerve or vascular injury. The possible consequences and possible complications have been explained to me by the chiropractor;
5. I have been informed that at times treatment techniques may include skin to skin contact, tissue mobilization and/or stretching of involved or related areas and digital pressure/light touch/brushing over regions both on and/or away from your primary complaint location;
6. I have been informed that certain techniques may require close proximity between clinician and patient;
7. I acknowledge that the chiropractor has made no guarantee of a positive outcome from treatment;
8. I have been afforded ample opportunity for questions and answers; and
9. I have been informed of my condition, possible benefits, risks of treatment if any, options, and financial obligations.
10. By signing below you authorized office/provider to complete a consultation and exam, as well as declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

Therefore, by signing below:

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature:_____ Date:_____

Guardian Name (if applicable):_____

Guardian Signature (if applicable):_____ Date:_____

Witness Signature:_____ Date:_____

PERFORMANCE
Chiropractic Clinic

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

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Performance Chiropractic Clinic, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all 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 adjustor 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 forsuchservices,akedmenadinmynameforpyament,andprosecuteandreceive 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 tome/us for treatment rendered by the physician/facility named above and below within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.05 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 Performance Chiropractic Clinic, and send to 1135 Keller Parkway, Suite 200, Keller, TX 76248.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issues a separate draft to pay in full all services rendered, payable directly to Performance Chiropractic Clinic, and to send any and all checks to 1135 Keller Parkway, Suite 200, Keller, TX 76248.

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 and below, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment of 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 inwriting to the physician/facility name above and below.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above and below to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above and below, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

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

Printed Name: _____

Signature of Patient/Responsible Parties: _____ **Date:** _____

Dr. Dennis James
1135 Keller Parkway Suite 200 | Keller Texas 76248 | P: 817-337-3636 | F: 817-337-3635
www.PerformanceChiropractic.clinic | staff@performancechiropractic.clinic

PERFORMANCE
Chiropractic Clinic

PERSONAL INJURY POLICIES

This office will accept you as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of your injuries. Your responsibility to this office will be to follow the Doctor's recommendations and to provide the appropriate financial information so that payment for services can be received.

- PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING YOUR CASE:
  - Third Party
  - Personal Injury Protection (P.I.P.); required if no attorney used
  - Attorney (If applicable)

You are asked to give 24 hour notice if you need to reschedule an appointment. All appointments that have been missed without notice may be billed to your account.

If at any point during treatment you acquire a new adjustor/attorney you will notify this office with the appropriate financial information so that payment for service scan be rendered.

Following the completion of your treatment in this office, your bill will be forwarded to the responsible party. Please note that this account is still your responsibility and will be subject to monthly interest charges of 1.5% effective 90 days following your completed care. If payment has been made to you directly, you must pay our office within72 hours.

Patient Signature: _____ Date: _____

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