BackBone
WELLNESS CENTER

12101 W. Parmer Lane Ste. 200
Cedar Park, Texas 78613
Phone: 512.363.5178
Fax: 512.339.2664

Welcome!!! Please allow our staff to photocopy your driver's license and insurance or Medicare card (if applicable).

NEW PATIENT INFORMATION

First Appointment date: _____

Name Mr. / Mrs. / Ms. / Dr. _____

Address _____
Street City State Zip Code

Social Security # _____ Sex: Male / Female

Birth date _____ Age _____ Marital Status: Married / Single

Home # ( ) _____ Work # ( ) _____ Cell # ( ) _____

E-Mail Address _____@_____

Preferred Method of Contact: □ E-Mail □ Postal Mail □ Home Phone □ Work Phone □ Cell Phone

Employer _____ Occupation _____

Job Functions/Work Environment _____

How did you hear about our clinic? Whom may we thank for referring you? _____

PRIMARY INSURANCE CARD HOLDER / SPOUSE'S INFORMATION

Insurance Company _____ Phone # ( ) _____

Name _____ Birth date _____

Occupation _____ Employer _____

Social Security # _____ Work # ( ) _____

INSURANCE IS NOT A GUARANTEE OF PAYMENT;
YOUR ESTIMATED PORTION MAY CHANGE IN RECEIPT OF THE INSURANCE EXPLANATION OF BENEFITS.
PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

Have you been injured in a car accident? Yes/No Date of accident: _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY:

Name _____ Phone # ( ) _____ Relationship _____

Address _____City_____ Zip _____

Patient Informed Consent

I, _____, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving the interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature _____

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HEALTH CONCERNS: Please list your top health concerns in order of priority.

1.) _____

2.) _____

3.) _____

TREATMENT GOALS: (Please circle) Minimal-Patch up Resolve Symptoms-Fix Cause Optimal Health & Wellness

Are you interested in receiving more information regarding: (Please circle)

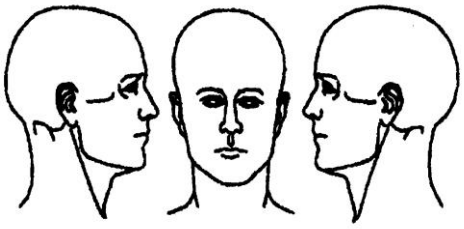
a. Stretching/rehabilitation	b. Nutrition	c. Acupuncture	d. Massage Therapy
e. Ergonomics	f. Detoxification	g. Herbs	h. Pediatric Chiropractic
i. Changing Body Composition	j. Lowering Cholesterol/BP/Triglcerides		k. Metabolic Syndrome

1. Have you been treated by a Chiropractor in the past? Yes/No Acupuncturist? Yes/No
2. Did you have a good experience? Yes/No Please explain to us what you liked/did not like: _____
3. Do you exercise regularly? Yes/No How many times a week? _____
4. Are you healthier today than you were 5 years ago? Yes/No Why? _____
6. Does your current health situation prevent you from doing anything that you would normally enjoy doing? What?

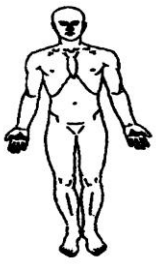
   _____
7. In relation to your primary concern: Has another doctor treated you for this condition? Yes/No

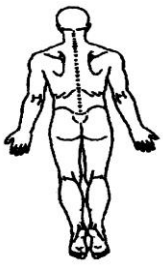
   If yes, whom? _____ Treatment? _____ X-ray/MRI? _____
8. If this is a recurrence, when was the first time you noticed? _____ # of episodes?_____
9. How did it originally occur? _____ Date:_____
11. Has it become worse recently? Yes/No/Same/Better/Gradually worse
12. How frequent is the condition? Constant Daily Intermittent Nightly only
13. Is this condition interfering with your: work/sleep/Daily routine, other: _____
14. Is there anything that can relieve the problem? Yes/No, Please describe:_____

Please shade/mark in your areas of discomfort on the models below. .



Stabbing/Cutting- lll Tingling -:::
Burning- XXX Cramping - <<
Numbness - === Dull - ###





MEDICAL HISTORY

P = Present • **N** = Not Present • **PN** = if it has ever been present in the past

P	N	CONDITION	PN
		Weakness	
		Fatigue	
		Fever	
		Chills	
		Night Sweats	
		Fainting	
		Nervousness	
		Concentration Loss	
		Dizzy Spells	
		Irritability	
		Depression	
		Memory Loss	
		Loss of Sleep	
		Headache	

P	N	CONDITION	PN
		Muscle Pain	
		Muscle Weakness	
		Muscle Cramps	
		Joint Stiffness	
		Joint Tenderness	
		Spinal Curvature	
		Back Pain	
		Hot Joints	
		Joint Swelling	
		Stiff Neck	
		Soreness	
		Lumps	
		Masses	
		Apprehension	

P	N	CONDITION	PN
		Seizures	
		Vertigo	
		Dizziness	
		Tremors	
		Loss of Sensation	
		Loss of Coordination	
		Weak Grip	
		Paralysis	
		Difficulty of Speech	
		Tingling	
		Numbness	
		Pregnant	
		Pacemaker	

P	N	ALLERGIES	PN
		Animal Dander	
		Latex	
		Food Allergies	
		Penicillin	
		Pollen	
		Second-Hand Smoke	
		Grasses	
		Sulfa Drugs	
		Dairy Products	
		Perfumes	
		Hay	

P	N	DIAGNOSIS	DATE AND EXPLANATION OF CONDITION
		Cancer	
		Balance Problems	
		Stroke	
		Thyroid Problems	
		Asthma	
		Heart Attack	
		HIV	
		Angina/Chest Pain	
		Diabetes	
		Gout	
		Broken Bones	
		Arthritis	
		Serious Depression	
		Other	

SURGERY	YES	NO	YEAR	SURGERY	YES	NO	YEAR
Tonsils				**WOMEN**			
Colon				Breast			
Hernia				Uterus			
Appendix				Ovaries			
Gall Bladder				**MEN**			
Stomach				Prostate			
Heart				Other			
Kidney							
Other							

What other major injuries have you had? (Include Dates)
What medications / vitamins are you currently taking?
Hospitalizations:
Family History of Illnesses:

Marital Status _____Married _____Divorced _____Single _____Separated _____Widowed

Number of Children: _____

Frequency of Exercise _____Never _____Rarely _____Occasionally _____Moderately _____Regularly

Intensity of Exercise _____Low Level _____Medium Level _____High Level _____Competition Level

Sufficient Rest _____Never _____Rarely _____Occasionally _____Moderately

Hours of Sleep _____ _____10 or more hours

Well balanced diet _____Never _____Rarely _____Occasionally _____Moderately

Do you smoke?

_____No _____Occasionally _____1 to 2 _____2 to 3 _____4 to 5 _____More than 5 packs/day

Do you drink caffeinated beverages?

_____No _____Occasionally _____1 to 2 _____2 to 3 _____4 to 5 _____More than 5 drinks/day

Do you drink alcoholic beverages?

_____No _____Occasionally _____1 to 2 _____2 to 3 _____4 to 5 _____More than 5 5 drinks/day

Hobbies: _____

_____

_____

HIPAA PATIENT CONSENT FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Consent and you are advised to do so. This authorization for release of information covers the period of healthcare from _____, 20___ to _____, 20___.

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The patient understands and agrees that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this consent. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

Protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes.

The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures that require the patient's prior written consent will then cease.

The Clinic may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: _____
Printed Name – Patient or Representative

_____
Signature Date

Relationship to Patient
(if other than patient) _____

Witness: _____
Printed Name – Clinic Representative

_____
Signature Date

For Internal Use:

☐ Patient Refused to Sign ☐ Patient unable to sign for the following reason: _____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

TO THE PATIENT*: You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible). The treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future are employed by, working for or associated with, or serving as back-up for the Doctor of Chiropractic named below.

I have had an opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including to treatment at all.

I understand that there are some risks to chiropractic treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns/frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ Increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other: _____

In rare cases, some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke and death. I do not expect the Doctor to anticipate all risks and complications and I wish to rely on the Doctor to exercise judgment during the course of the procedure(s) which the Doctor feels at the time, based upon the facts then known, are in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of my treatment for my current and future conditions.

To be completed by patient:

_____
PRINTED NAME

_____
SIGNATURE OF PATIENT

_____
DATE SIGNED

_____
PRINTED NAME OF DOCTOR OF CHIROPRACTIC

To be completed by the patent's representative:

_____
PRINT NAME OF PATIENT

_____
PRINT NAME OF PATIENT'S REPRESENTATIVE

_____
SIGNATURE OF PATIENT'S REPRESENTATIVE

AS: _____
RELATIONSHIP/AUTHORITY OF REPRESENTATIVE

_____
DATE SIGNED

To be completed by Doctor or staff:

_____
WITNESS TO PATIENT'S SIGNATURE

_____
DATE SIGNED

_____
Translated by

_____
DATE SIGNED

FINANCIAL AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, BackBone shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____ _____

PATIENT SIGNATURE INSURED'S SIGNATURE

_____

DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to BackBone all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

SIGNATURE OF INSURED/GUARDIAN DATE