

Spinal Health of North Texas

217 East University Drive Denton Texas 76209

(P)940-591-9097 (F)940-591-8483

www.spinalhealthofnorthtexas.com

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by Steven B. Eustice, D.C., a licensed doctor of chiropractic.

I have had an opportunity to discuss with the doctor or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

Patient's Name (Print)

Date

Patient's Signature

State relationship to patient if signing for patient

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217 East University Drive 940-531-9097 940-591-8483

MOTOR VEHICLE COLLISION QUESTIONNAIRE

Please answer ALL questions as completely as possible:

1. Your name and address:

2. Phone Number[s]: _____

3. Please describe the collision in your own words: _____

4. Where did the collision occur? City/Town: _____ State: _____

5. Date of collision: _____ Time: _____ AM PM

6. Were you the: ☐ driver ☐ passenger ☐ pedestrian

7. If passenger, were you in the ☐ front seat ☐ right rear seat ☐ left rear seat

8. What type of vehicle were you in? _____

9. What type was the other vehicle? _____

10. Did your vehicle strike the other vehicle? ☐ yes ☐ no

11. Was your car struck by the other vehicle? ☐ yes ☐ no

12. What direction was your vehicle going? _____

13. What direction was the other vehicle going? _____

14. Was the impact from: ☐ the front ☐ the rear ☐ the left side ☐ the right side

15. What was the approximate speed at the time of the impact?

Your vehicle _____ mph Other vehicle _____ mph

16. What was the weather at the time of the collision? ☐ dry ☐ wet ☐ icy

17. Was your vehicle in: ☐ park ☐ neutral ☐ in gear ☐ moving ☐ stopped

18. Were your brakes being applied? ☐ yes ☐ no

19. Was your vehicle shoved: ☐ forward ☐ backward ☐ sideways

20. Were you shoved: ☐ forward ☐ whipped backward

21. Did your seat have a head restraint (headrest?) ☐ yes ☐ no

22. If yes, what was the position ☐ low ☐ mid-position ☐ high

23. Did your head ride over the headrest? ☐ yes ☐ no

24. Did your hat/glasses end up in the back seat or rear window? ☐ yes ☐ no

25. Did any other part of your body hit the interior of the vehicle? ☐ yes ☐ no

26. If yes, please specify: ☐ seatbelt restraints ☐ steering wheel ☐ dashboard

☐ windshield ☐ side door ☐ side window ☐ other _____

27. Which part of your body? ☐ chest ☐ head ☐ chin ☐ face ☐ knee [L] or [R]

☐ shoulder [L] or [R] ☐ hand [L] or [R] ☐ other

28. Were you holding on to the steering wheel? ☐ yes ☐ no

29. Did you brace your arms against the dash? ☐ yes ☐ no

30. Did you brace your legs against the floorboard? ☐ yes ☐ no

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31. Was your ankle turned? ☐yes ☐no
32. Did the vehicle go into a spin or roll as a result of the impact? ☐yes ☐no
33. If yes, explain: _____
34. How much damage was there to the outside of the vehicle? ☐none ☐some ☐a lot
35. How much damage was there to the inside of the vehicle? ☐none ☐some ☐a lot
36. At the point of impact, where did you experience pain? Be specific:

37. Immediately after the accident were you: ☐conscious ☐dazed ☐unconscious
38. If you lost consciousness, how long? _____
39. Were you wearing a seat belt? ☐yes ☐no
40. Did the belt have a shoulder harness? ☐yes ☐no
41. If yes, did it contribute to the pain you are experiencing? ☐yes ☐no
42. At the time of impact were you:
☐looking ahead ☐looking to the right ☐looking to the left ☐looking down ☐looking up
43. Did the seat break as a result of the impact? ☐yes ☐no
44. Were you braced for the impact? ☐yes ☐no
45. Were you surprised by the impact? ☐yes ☐no
46. Did you go to the hospital? ☐yes ☐no
47. If yes, when? ☐right after the accident ☐next day ☐other _____
48. If yes, how did you get there? ☐ambulance other: _____
49. If by ambulance, did the ambulance attendants place you in a:
☐neck brace ☐back brace ☐other _____
50. Any medication or medical supplies given? _____
51. Did you have x-rays taken at the hospital? ☐yes ☐no
- If you went to the hospital, please answer the following:
- Name of hospital _____
- Treatment Received _____
52. Have you had any similar problems before? ☐yes ☐no
53. If yes, explain: _____
54. Are you diabetic? ☐yes ☐no
55. Do you have high blood pressure? ☐yes ☐no
56. Do you have low blood pressure? ☐yes ☐no
57. Do you have arthritis or degenerative joint disease? ☐yes ☐no
58. What type of work do you do? _____
59. What are your job requirements? _____
60. Have you lost any days of work from this injury? ☐yes ☐no
61. If yes, give dates: _____

Patient Signature _____ Date _____

Print Name _____

REGISTRATION

Date: _____

Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: ☐ F ☐ M Age: _____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____ Email: _____

Insured's Name: _____
Last Name First Name Initial

Patient Agreement:

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to **Spinal Health of North Texas** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date

Present Complaints (Please circle the appropriate ones)

Headache
Mental dullness
Loss of memory
Dizzy
Ears ringing/buzzing
Upper back pain
Lower back pain
Midback pain
Pins and needles in hands
right/left

Feet/Hands Cold
Depression
Rib pain
Nervousness
Eye strain/pain
Shortness of breath
Fear
Confusion
Pins and needles in arms
right/left

Unbalanced
Fainting
Blurred vision
Irritability
Double vision
Loss of smell
Chest pain
Neck pain
Pins and needles in legs
right/left

Medical Implants: _____

Medical alerts: _____

Surgical Implants: _____

Pregnancy: yes ____ no ____

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

**No
Pain**

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

**Excruciating
Pain**

Medications: (please list all medications and supplements that you currently take)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: (please list all medications that cause allergic reaction)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Smoking: ____ Yes ____ No If yes, _____ packs per day for ____ years

Alcohol ____ Yes ____ No If yes, number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____	Date _____
_____	_____
_____	_____
_____	_____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

☐ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> pulmonary embolism | <input type="checkbox"/> respiratory arrest |
| <input type="checkbox"/> COPD | <input type="checkbox"/> pneumonia | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> other: _____ |

Cardiac / Heart and peripheral vascular disease

- | | | |
|--|---|--|
| <input type="checkbox"/> chest pain / angina | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> irregular heartbeat, arrhythmia |
| <input type="checkbox"/> heart attack, myocardial infarction | <input type="checkbox"/> heart murmur, valve disorder | <input type="checkbox"/> peripheral vascular disease |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> deep vein thrombosis |
| <input type="checkbox"/> other: _____ | <input type="checkbox"/> bleeding problems | |

Neurologic Disorders

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> stroke or TIA | <input type="checkbox"/> parkinson's | <input type="checkbox"/> cerebral palsy |
| <input type="checkbox"/> peripheral neuropathy | <input type="checkbox"/> MS | <input type="checkbox"/> polio |
| <input type="checkbox"/> other: _____ | | |

Bone & Joint Disorders

- | | | |
|---|--------------------------------|---|
| <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> gout | <input type="checkbox"/> osteomyelitis |
| <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> lupus | <input type="checkbox"/> ankylosing spondylitis |
| <input type="checkbox"/> other: _____ | | |

Gastrointestinal Disorders

- | | | |
|--|---|---|
| <input type="checkbox"/> peptic ulcer or stomach ulcer | <input type="checkbox"/> diverticulitis | <input type="checkbox"/> hepatitis - Type _____ |
| <input type="checkbox"/> acid reflux, GERD | <input type="checkbox"/> irritable bowel | <input type="checkbox"/> liver disease |
| <input type="checkbox"/> GI bleed | <input type="checkbox"/> inflammatory bowel disease | |
| <input type="checkbox"/> other: _____ | | |

Genitourinary Disorders

- | | | |
|--|--|---|
| <input type="checkbox"/> urinary tract infection | <input type="checkbox"/> kidney problems | <input type="checkbox"/> dialysis, kidney failure |
| <input type="checkbox"/> bladder problems | <input type="checkbox"/> kidney stones | <input type="checkbox"/> other: _____ |

Metabolic & Other Disorders

- | | | |
|---|--|---|
| <input type="checkbox"/> Diabetes x _____ years | <input type="checkbox"/> skin disorder _____ | <input type="checkbox"/> depression |
| <input type="checkbox"/> thyroid problems | <input type="checkbox"/> psoriasis | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> sickle cell disease | <input type="checkbox"/> any skin ulcer | <input type="checkbox"/> alcohol or drug dependency |
| <input type="checkbox"/> high cholesterol or lipids | <input type="checkbox"/> tooth abscess, gingivitis | <input type="checkbox"/> other: _____ |

Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____

Family History:

Please indicate with an "X" any significant family medical history or problems.

- | | | |
|--|---|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> COPD or Emphysema | <input type="checkbox"/> other lung : _____ | |
| <input type="checkbox"/> heart attack, myocardial infarction | <input type="checkbox"/> congestive heart failure | |
| <input type="checkbox"/> irregular heartbeat, arrhythmia | <input type="checkbox"/> bleeding problems | |
| <input type="checkbox"/> other heart : _____ | | |
| <input type="checkbox"/> Peripheral neuropathy | <input type="checkbox"/> MS or Parkinson's | <input type="checkbox"/> other neuro : _____ |
| <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> Lupus | <input type="checkbox"/> gout |
| <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> Other bone & joint: _____ | |
| <input type="checkbox"/> acid reflux, GERD | <input type="checkbox"/> inflammatory bowel disease | |
| <input type="checkbox"/> hepatitis - Type _____ | | |
| <input type="checkbox"/> liver disease | <input type="checkbox"/> other GI : _____ | |
| <input type="checkbox"/> kidney problems | <input type="checkbox"/> dialysis, kidney failure | |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> psoriasis | <input type="checkbox"/> high cholesterol or lipids |
| <input type="checkbox"/> thyroid problems | <input type="checkbox"/> sickle cell disease | <input type="checkbox"/> any skin ulcer |

☐ Malignant hyperthermia
Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Blue Shield | <input type="checkbox"/> Auto Accident |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Major Medical | <input type="checkbox"/> Union Plan |
| <input type="checkbox"/> Blue Cross | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Other |

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

Major Medical or Auto Insurance:

Date of Accident: _____

Insurance Company Name: _____

Adjuster: _____

Address/Phone: _____

Claim #: _____ Policy #: _____ Effective Date: _____

Primary Care Physician:

Name & Address: _____

Phone #: _____

LEGAL INFORMATION:

Attorney Name & Address: _____

Attorney Phone #: _____

*Person to contact in an emergency (Name and Phone #):

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Privacy Policy

We may use and disclose your PHI (private health information) in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

We may use or disclose your PHI for workers compensation and similar programs.

We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree with your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have:

You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information. (A fee for the costs of copying, mailing, labor and supplies associated with your request will be charged.)

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised policy as stated in this notice.

Signature of Patient or Legal Guardian: _____

Date: _____

Print Name of Patient or Legal Guardian: _____

Date: _____

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LIEN ASSIGNMENT

I _____ (patient name) residing at _____ (address)

hereby enter into the following agreement with **Spinal Health of North Texas** (medical provider), hereinafter known as "the provider" in order to guarantee payment for services rendered by "the provider" to me. I understand that I am directly and fully responsible to "the provider" for all medical bills for services rendered to me. I understand that I am directly and fully responsible to "the provider" for any remaining balance on all medical bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier. This document further serves to acknowledge my responsibility to repay all remaining balances subsequent to all applicable insurance payments. I agree to make myself available to appear or correspond with "the provider" as often as may be necessary for any collections effort that is undertaken.

I agree to comply with all Insurance Company regulations including, but not limited to examinations under oath and independent medical examinations. I understand that any failure on my part to comply with any condition precedent to insurance coverage, may, at the election of the medical provider, serve to revoke any assignment of benefits.

The Provider agrees to seek compensation from the appropriate insurance carrier prior to invoking the terms of this lien based on the accuracy of the information the patient has provided. The patient shall provide all necessary insurance information, police reports, and any additional documentation or information deemed necessary by the provider for the submission of the aforementioned insurance claim as applicable. Failure to provide accurate insurance information leading to a viable source of coverage may serve to invalidate any executed assignment of benefits.

I hereby give and grant this lien on my case to "the provider" against any and all proceeds of any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf that may be paid to me OR MY ATTORNEY as a result of the injuries for which I have been treated. I grant "the provider" the aforesaid lien against such sums of the aforesaid settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me and towards all outstanding balances. I hereby agree to provide accurate contact information for the attorney pursuing any litigation on my behalf.

I hereby **direct** and **authorize** direct payment to "the provider", such sums as may be due and owing for medical services rendered to me. I further direct my ATTORNEY to honor the aforesaid lien and to withhold such sums from any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me towards all outstanding balances.

I understand that this document may not be rescinded and that my ATTORNEY shall not honor any such rescission. I hereby instruct that in the event another ATTORNEY is substituted in my case, the new ATTORNEY honor this lien as inherent to the settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct my attorney, on demand, to provide the status of such litigation to "the provider" or his attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact "the provider" prior to disbursement of any funds to ascertain any outstanding balances due and owing to **Spinal Health of North Texas** (medical provider).

Patient: _____ Signature: _____ Date: _____

Attorney: _____ Signature: _____ Date: _____

Provider: Spinal Health of North Texas Signature: _____ Date: _____