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) herby 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**

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	Feet/Hands Cold	Unbalanced
Mental dullness	Depression	Fainting
Loss of memory	Rib pain	Blurred vision
Dizzy	Nervousness	Irritability
Ears ringing/buzzing	Eye strain/pain	Double vision
Upper back pain	Shortness of breath	Loss of smell
Lower back pain	Fear	Chest pain
Midback pain	Confusion	Neck pain
Pins and needles in hands right/left	Pins and needles in arms right/left	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

□ asthma □ pulmonary embolism □ respiratory arrest
□ COPD □ pneumonia □ sleep apnea
□ emphysema □ tuberculosis □ other: _____

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina □ high blood pressure □ irregular heartbeat, arrhythmia
□ heart attack, myocardial infarction □ heart murmur, valve disorder □ peripheral vascular disease
□ congestive heart failure □ mitral valve prolapse □ deep vein thrombosis
□ other: _____ □ bleeding problems

Neurologic Disorders

□ stroke or TIA □ parkinson's □ cerebral palsy
□ peripheral neuropathy □ MS □ polio
□ other: _____

Bone & Joint Disorders

□ osteoarthritis □ gout □ osteomyelitis
□ rheumatoid arthritis □ lupus □ ankylosing spondylitis
□ other: _____

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer □ diverticulitis □ hepatitis - Type _____
□ acid reflux, GERD □ irritable bowel □ liver disease
□ GI bleed □ inflammatory bowel disease
□ other: _____

Genitourinary Disorders

□ urinary tract infection □ kidney problems □ dialysis, kidney failure
□ bladder problems □ kidney stones □ other: _____

Metabolic & Other Disorders

□ Diabetes x _____ years □ skin disorder _____ □ depression
□ thyroid problems □ psoriasis □ anxiety
□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency
□ high cholesterol or lipids □ tooth abscess, gingivitis □ 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.

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

☐ Medicare ☐ Blue Shield ☐ Auto Accident
☐ Medicaid ☐ Major Medical ☐ Union Plan
☐ Blue Cross ☐ Worker's Compensation ☐ 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: _____