DATE

Patient Registration Form

West Texas Back Clinic

Patient's Name (Last, First, Middle Initial) Sex: Male/ Female	Referred By
Patient's Address	Employer's Name Telephone ( )
City State Zip	Employer's Address City State Zip
Telephone ( ) Marital Status Date of Birth / /	Employee Status Student Status: If 19 Years or older
Age Social Security Number Drivers License Number	Email address:

PATIENT INFORMATION (Please write information about patient here.)

Primary Insurance Company Name	Secondary Insurance Company Name
Insurance Company's Address	Insurance Company's Address
City State Zip	City State Zip
Insured's ID Number Group Plan Number	Insured's ID Number Group Plan Number

INSUANRCE INFORMATION (Please write information about the patient's insurance here.)

POLICYHOLDER INFORMATION

(Complete the information below if the PATIENT is NOT the POLICYHOLDER)

Is the secondary policyholderthe: Patient, Primary Policy Holder, Other (Complete the information below if you check other)

Primary Policyholder's Name (Last, First, Middle Initial) Date of Birth	Secondary Policyholder's Name (Last, First, Middle Initial) Date of Birth
Primary Policy Holder's Address Sex: Male/ Female	Secondary Policyholder's Address Sex
City State Zip Telephone ( )	City State Zip Telephone ( )
Employer's Name or School Name Telephone ( )	Employer's Name or School Name Telephone ( )
Employer's Address	Employer's Address
City State Zip	City State Zip
Social Security Number Relationship To Patient	Social Security Number Relationship to Patient
Employer Plan Coverage If CHAMPUS: Active Retired Deceased Yes No Branch of Service:_____	Employer Plan Coverage If Champus: Active Retired Deceased Yes No Branch of Service_____

RESPONSIBLE PARTY INFORMATION (Please complete the information below if the person responsible for paying the billis not the PATIENT or POLICYHOLDER)

Responsible Party's Name (Last, First, Middle Initial) Sex	Social Security No. Drivers License No. Legal Representative Yes No
Responsible Party's Address State Zip	Employer's Name Telephone ( )
Telephone ( ) Relationship to Patient	Employer's Address State Zip

HOW DID YOU HEAR ABOUT US? _____

_____

_____

INCASE OF AN EMERGENCY

- WHO SHOULD WE CONTACT -
(Please list someone living at a residence other than those listed on the reverse side)

NAME _____ TELEPHONE: Day – (___)_____

ADDRESS _____ Night – (___)_____

CITY _____ STATE _____ RELATIONSHIP _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companied pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, coinsurance, or any other balance on paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

If this account is assigned to any attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

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

I request that payment of authorized benefits be made on my behalf. I assign that benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named on the other side of this form.

There will be a 1.5% per month service charge on all accounts over 32 days. (Minimum service charge of $1.00)

We reserve the right to charge for appointments cancelled or broken **without** 24 hours advance notice.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I AGREE TO THESE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES SHOWN ON THE BACK OF THIS FORM. YOU SHOULD READ THOSE TERMS CAREFULLY.

X_____ Date: _____

SIGNED (Patient, or parent if under 18 years of age)

West Texas Back Clinic

HISTORY & PHYSICAL FORM - Page 1 of 3

Name (Print): _____ Date: _____
Last First MI

List your **MAIN COMPLAINTS**: _____

Describe your condition (onset, cause, etc.) _____

List the date & type of diagnostic procedures you've had (MRI's, CT, x-rays, etc.) _____

MEDICAL HISTORY & REVIEW OF SYSTEMS

Do you have or had any of the following?

Transmissible Disease(s): ❒ None ❒ Hepatitis A-B-C ❒ HIV ❒ TB

Neurological: ❒ Headaches ❒ Stroke ❒ Epilepsy ❒ Aneurysm ❒ Other _____

Cardiovascular: ❒ Chest Pain ❒ Hypertension ❒ Heart Disease ❒ Other _____

Respiratory: ❒ Lund Disease ❒ Asthma ❒ Shortness of Breath ❒ Other _____

Are you a smoker? ❒ No ❒ Yes # of years_____-# of packs per day_____

Gastrointestinal: ❒ Ulcer ❒ Hernia ❒ Hysterectomy ❒ Other _____

Musculoskeletal: ❒ MSD ❒ Arthritis ❒ Neck or Back Pain ❒ Other _____

Metabolic: ❒ Liver Disease ❒ Thyroid Disease ❒ Bleeding Disorder ❒ Cancer/Type_____
❒ Diabetes___Meds___Insulin ❒ Other_____

Genito-Urinary: ❒ Kidney Disease ❒ Painful Urination ❒ Frequent Urination
❒ Possible Pregnancy ❒ Sexual Dysfunction ❒ Other _____

E.E.N.T.: ❒ Blindness ❒ Cataracts ❒ Glaucoma ❒ Vision Difficulty ❒ Deaf
❒ Swallowing Problems ❒ Nose Bleeds

Psychological: ❒ Anxiety ❒ Depression ❒ Fatigue ❒ Nervousness ❒ Other _____

PREVIOUS HOSPITALIZATIONS/SURGERIES (LIST TYPE AND YEAR)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

❒ See Attached

West Texas Back Clinic

HISTORY & PHYSICAL FORM - Page 2 of 3

MEDICATIONS YOU ARE CURRENTLY TAKING

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

☐ See Attached

LIST ALLERGIES

1. _____ 2. _____
3. _____ 4. _____

☐ See Attached

SOCIAL HISTORY

EMPLOYER:_____ Hours worked per week _____

JOB DUTIES:_____

1. USE OF ALCOHOL ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

2. USE OF DRUGS ☐ Yes ☐ No Type_____

3. SLEEP HABITS ☐Good ☐ Intermittent ☐Poor

4. EXERCISE ☐ Never ☐Intermittent ☐ Frequent

5. LEISURE/HOBBIES:_____

6. EDUCATION ☐ High School/G.E.D ☐ College ____# of Years

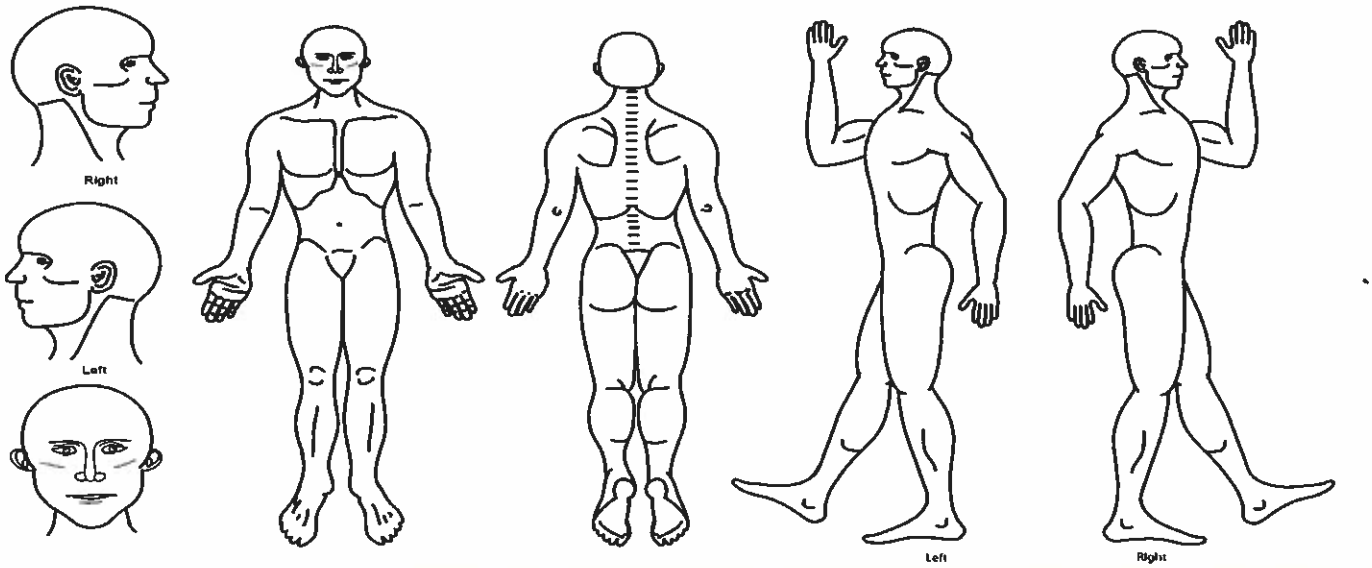
FAMILY MEDICAL HISTORY

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Sibling(s)			
Spouse			
Children			

West Texas Back Clinic

HISTORY & PHYSICAL FORM - Page 3 of 3

Shade your area(s) of pain on the figures below:



Review the information contained in the following table. Circle the number on the left that best describes your pain level today.

0	Pain Free	No medication needed
1	Very minor annoyance – occasional minor twinges	No medication needed
2	Minor annoyance – occasional strong twinges	No medication needed
3	Annoying enough to be distracting	Mild painkillers are effective. (Aspirin, Ibuprofen, Aleve)
4	Can be ignored if you are really involved in your work, but still distracting	Mild painkillers relieve pain for 3-4 hours
5	Can't be ignored for more than 30 minutes	Mild painkillers reduce pain for 3-4 hours
6	Can't be ignored for any length of time, but you can still participate in some activity.	Strong painkillers (Codeine, Vicodin, Hydrocodone) reduce pain for 3-4 hours
7	Makes it difficult to concentrate, interferes with sleep. You can still function with effort.	Stronger painkillers are only partially effective. Strongest painkillers relieve pain (OxyContin, Morphine)
8	Physical activity is severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.	Stronger painkillers are minimally effective. Strongest painkillers reduce pain for 3-4 hours.
9	Unable to speak. Crying out or moaning uncontrollably – Near delirium.	Strongest painkillers are only partially effective.
10	Unconscious. Pain makes you pass out	Strongest painkillers are only partially effective.

Check the box which most accurately describes the frequency of your pain (Percentage of Time in Pain):

☐ Intermittently (25%) ☐ Occasionally (26-50%) ☐ Frequently (51-75%) ☐ Constantly (100%)

Signature _____ Date: _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

- **The nature of the chiropractic manipulation**

Your manipulations are performed by hand or a mechanical instrument upon your body in such a way to move your joints. The manipulation can produce an audible "click" or "pop" much like when you have "cracked" your knuckles. You should realize that your bones are not "cracking", but rather gases are being released from the joint and producing sound.

- **The material risks inherent in chiropractic manipulation**

As with any health care procedure, there are certain complications which can arise during a chiropractic manipulation. Those complications include: fracture, dislocations, muscle strain, costovertebral (rib) strains and separations, and cervical myelopathy. Some types of manipulations 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. Stiffness and soreness can be experienced following manipulation.

- **Other treatments**

In addition to chiropractic manipulation, the following physiotherapy may be used to enhance your recovery and healing. These include: hot/cold packs, interferential/electric muscle stimulation, ultrasound, and intersegmental traction. These treatments involve the following risks: spreading of unknown infection, burns, and electrical shock.

- **Availability of other treatments**

Other treatment options for you condition include: over-the-counter medication and bed rest, prescription medication for pain, inflammation and muscle spasm, hospitalization, and surgery.

- **The material risks and probability of risks occurring in other treatments**

Professional literature describes highly undesirable effects from long-term use of over-the-counter medications. The probability of such complications arising is dependent upon the patient's general health, type of medication prescribed, and the amount and length of time taken.

- **The risks of remaining untreated**

Remaining untreated can lead to disc problems, arthritis, and neurological complications.

Remaining untreated after an injury allows for the formation of adhesions from scar tissue resulting in decreased joint mobility. Decreased joint mobility can lead to neurological complications, pain, stiffness, and diminished blood flow most commonly resulting in arthritis.

By signing below, I acknowledge I have read the above explanations of chiropractic manipulation, treatment, and risks. I have weighed the risk involved in treatment and give my consent to the doctor listed below to perform the treatment. I also acknowledge no guarantee or assurance as to the results that can be obtained from the recommended treatment.

Printed name _____

Signature _____

Date _____

WEST TEXAS BACK CLINIC
1750 South Clack St.
Abilene, Texas 79605-4611
325-695-2225

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, **WEST TEXAS BACK CLINIC**, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits that to 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 adjuster 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 for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court cost, 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 to me/us for treatment rendered by the physician/facility named above 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. 542.057** of the Texas Insurance Code, and **Article 21.55** 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 **WEST TEXAS BACK CLINIC,** and to send all checks to **1750 South Clack St. Abilene, Texas 79605-4611.**

THIRD PARTY LIABILITY: If my injuries are result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to **WEST TEXAS BACK CLINIC,** and to send any and all checks to **1750 South Clack St. Abilene, Texas 79605-4611.**

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

LIMITED POWER OF ATTORNEY: I hereby grant to 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 and 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 in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above 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, 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 jeopardized my case.

Signature of Patient and/or Responsible Parties:

_____ Date: _____

West Texas Back Clinic
1750 S. Clack St
Abilene, TX 79605
(325)695-2225

Consent to Use and Disclosure of Protected Health Information

☆ **Use and Disclosure of your Protected Health Information**
Your Procted Health information will be used by West Texas Back Clinic or disclosed to others for the purposes of treatment, obtaining payment, or supporting day-to-day heatlh 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.

☆ **Requesting a Restriction on the Use of Disclosure of Your Information**
You may request a restriction on the use or disclosure of your Protected Information. This office may or may agree to restrict the use or disclosure or your Proctected Information. If we agree to our request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction willbe a violation of the federal privacy standards.

☆ **Revocation of Consent**
You may revoke this consent to the use and disclosure of your Proctected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which our 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 this notice.

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

_____
Name of Patient (print)

_____
Signature

_____
Signature of Patient Representative

_____
Relationship to Patient

_____
Date

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

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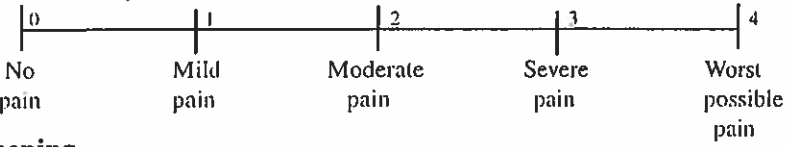
Date

Functional Rating Index

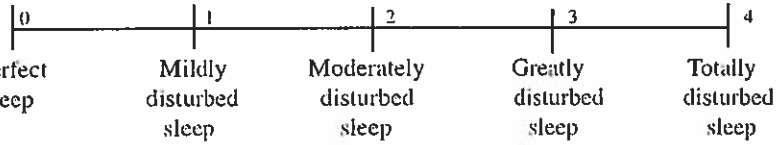
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

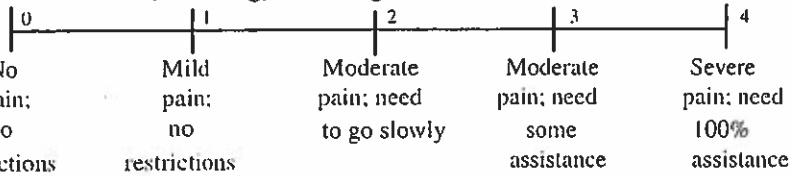
1. Pain Intensity



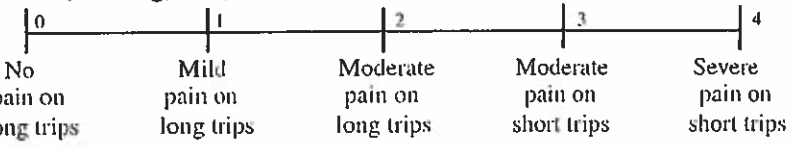
2. Sleeping



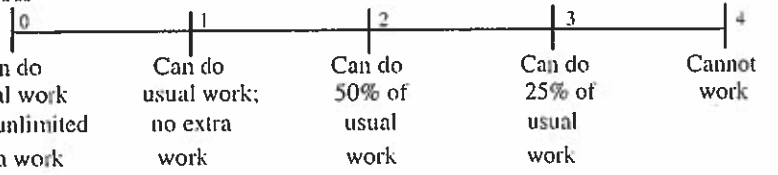
3. Personal Care (washing, dressing, etc.)



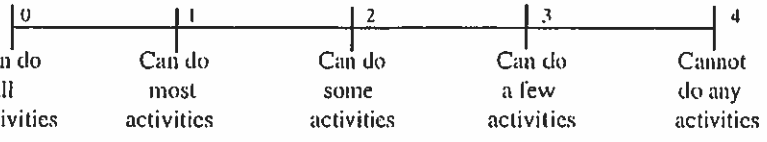
4. Travel (driving, etc.)



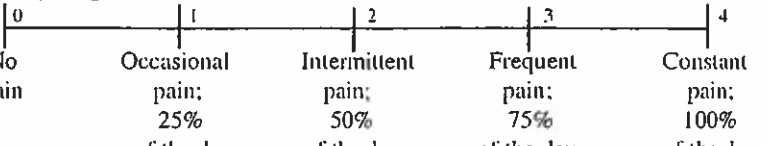
5. Work



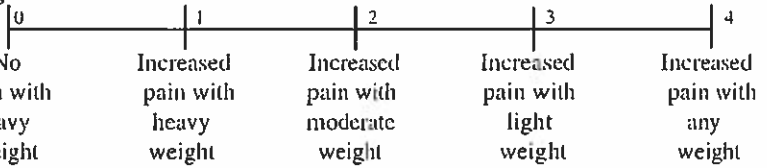
6. Recreation



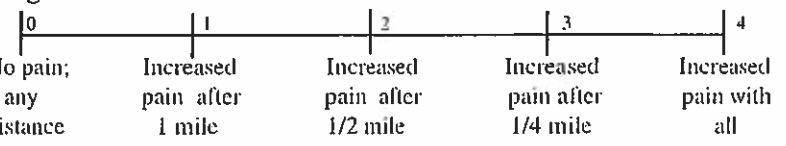
7. Frequency of pain



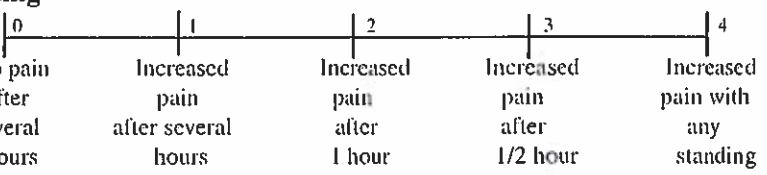
8. Lifting



9. Walking



10. Standing



Total Score _____

Name _____
PRINTED

_____
Signature

_____
Date