GREENOAKS Spine & Sport

4200 SW Green Oaks Blvd, Ste 100
Arlington, TX 76017

Patient Intake Form

Patient Information

Full Name: ____ Date: ______________________
First MI Last

Address: __________________________ City:__________________ State: ______ Zip: ____________

Age: ____________ Birth Date: ______________ Female:______Male: ______

Social Security Number: ______________________ Email Address: ________________________________

Cell Phone: ___________________ Home Phone: _________________ Work/Other: _________________

I prefer to receive calls at (circle) Cell/Home/Work I am (circle) Under Age18/Single/Married/Divorced/Widowed/Separated

Employer: ____ Occupation: _______________________

Business Address: __________________________ City: __________________ State: ______ Zip: _______

Spouse's Name: ______________________________________ Spouse's Date of Birth: _________________

Emergency Contact: _________________________Emergency Contact Phone Number: ___________________

Payment Information

Person Responsible for Payment: ____

Social Security Number: ________________ Phone: _____________________ Date of Birth: ____________

Insurance Information

Do you have health insurance? _____ Yes _____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release *- By signing below, I authorize Green Oaks Spine & Sport, P.A. to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Green Oaks Spine & Sport, P.A and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signature: ____ Date: ____________________

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Health Questionnaire

Patient Information

Height: ___________Weight: ___________

List all prescription, non-prescription medications and other supplements you take as well as the associated condition:

____

____

____

List **all** surgeries or hospitalizations you have had complete with the month and year for each:

____

____

____

List anything you are allergic to: ____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

____

____

____

Do you exercise? □ Yes □ No Hours per week _____________What activity(s)? ______________________________

____

Are you dieting? □ Yes □ No Since:_________

Do you drink alcoholic beverages? □ Yes □ No How many drinks per (circle) day/week/month? ______________

Do you smoke? □ Yes □ No How many years have you been smoking?_____ How many (circle)cigarettes/packs per day?_______

Do you use other tobacco products? □ Yes □ No

Do you wear? □ Heel lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, How many weeks? ______________________________

Date of last menstrual period: _________________

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Medical History

Describe the reason(s) for your doctor visit today:

____

____

____

____

Are you here because of an accident? ____________________What type? _________________________

When did your symptoms start? ___________________ How did your symptoms begin? _______________

____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (Circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?___________________________

____

____

Have you experienced these symptoms in the past?____

____

____

History of Treatment

Primary care physician: ____________________________ Phone: ___________________________

Date last seen: _____________________________ May we update them on your condition? ___Yes ____ No

Have you seen a chiropractor before? ____Yes ____ No Who referred you to us? ______________________

Have you seen another provider for these symptoms? If yes, indicate name and type of medical provider (Doctor, PT, OT Massage Therapist, etc). Please provide contact information if you have it. ___________________________

____

____

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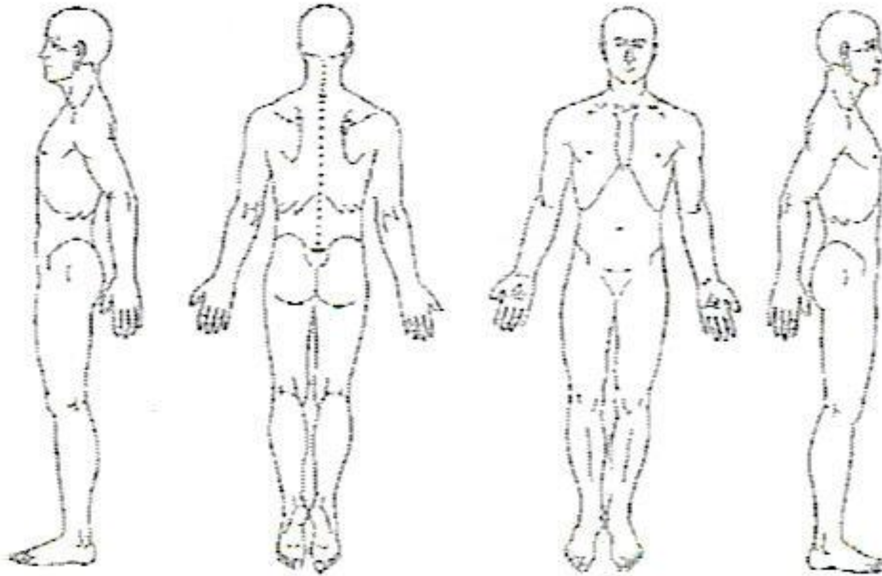
Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



Left Back Front Right

On a scale of one to ten how intense are your symptoms? Not intense ⓪①②③④⑤⑥⑦⑧⑨⑩ Unbearable

Pain Scale Described As:

0 No Pain

1-3 Has pain on and off but can do all activity and pain is mild. 3 would be mild to moderate pain but can continue to do all activity and may be on and off or constant.

4-6 Pain that is moderate and will disrupt some activities such as not being able to lift, work out, run, etc. 6 would be moderate to severe pain that disrupts most activity and may be constant.

7-9 Severe pain, is unable to do nearly any activity. Needs intervention before can do nearly any daily function.

10 Shoot Me.

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For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
○	○	Abdominal Pain	○	○	Elbow/upper arm pain	○	○	Liver/Gall Bladder Disorder
○	○	Abnormal Weight gain/loss	○	○	Epilepsy	○	○	Loss of Bladder Control
○	○	Allergies	○	○	Excessive thirst	○	○	Low back pain
○	○	Angina	○	○	Frequent Urination	○	○	Mid back pain
○	○	Ankle/foot pain	○	○	General Fatigue	○	○	Neck pain
○	○	Arthritis	○	○	Hand pain	○	○	Painful Urination
○	○	Asthma	○	○	Heart attack	○	○	Prostate Problems
○	○	Bladder Infection	○	○	Hepatitis	○	○	Shoulder pain
○	○	Birth Control Pills	○	○	High blood pressure	○	○	Smoking/tobacco Use
○	○	Cancer	○	○	Hip/upper leg pain	○	○	Stroke
○	○	Chest Pains	○	○	HIV/AIDS	○	○	Systematic Lupus
○	○	Chronic Sinusitis	○	○	Hormone Therapy	○	○	Thoracic Outlet Syndrome
○	○	Depression	○	○	Jaw pain	○	○	Tumor
○	○	Dermatitis/Eczema	○	○	Joint swelling/stiffness	○	○	Ulcer
○	○	Dizziness	○	○	Kidney Stones	○	○	Upper back pain
○	○	Drug/Alcohol Use	○	○	Knee/lower leg pain	○	○	Wrist pain
						○	○	Headaches

Additional comments you would like the doctor to know: ____

____

____

Patient's signature: ______________________________ **Doctor's signature:** ______________________________

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Informed Consent

PATIENT NAME: ________________________________

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document.

The nature of the chiropractic adjustment.

The primary treatment used by the doctors of chiropractic is spinal manipulative therapy. The spinal manipulative therapy is performed by using the hands or a mechanical device upon your body in such a way as to improve mobility in your joints. That may cause an audible "POP" or "CLICK" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination and treatment, you are consenting to the following procedures:

- spinal manipulative therapy
- palpation
- vital signs
- range of motion testing
- orthopedic testing
- basic neurological testing
- radiographic studies (x-ray)
- rehabilitative therapies
- electrical muscle stimulation
- ultrasound
- cold laser
- decompression therapy
- Active Release Technique
- hot/cold therapy
- nutritional support

The material risks inherent in chiropractic adjustment.

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. 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. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care, however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as "rare."

Ancillary Treatments

In addition to spinal manipulation, you will receive supportive treatments which will further assist in the management of your condition. While the risk of complication is low there is the possibility of side effects such as burns, soreness, skin irritation, etc. Some of the additional treatments which may be provided include ART, hot moist heat, cold laser, decompression, ultrasound, TENS, electrical muscle stimulation, interferential therapy as well as multiple other modalities.

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The availability and nature of other treatment options.

Other treatment options for your condition include:

- -Self-administered, over-the-counter analgesics and rest.
- -Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-medications.
- -Injections
- -Hospitalization
- -Surgery

If you choose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighted the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give consent to that treatment.

Dated: ________________ Dated: _________________

______________________________ ______________________________
Patient’s Name Doctor’s Name

______________________________ ______________________________
Patient’s Signature Doctor’s Signature

____
Signature of Parent or Guardian
(if a minor)

____
Signature of Interpreter

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Financial Policy

Insurance Coverage

Welcome to Green Oaks Spine & Sport, P.A. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deductible of $100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your $100 at the beginning of the year. Our clinic will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations.

Payments

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (please initial)

A___ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B___ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (please initial)

C___I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

Missed Appointments

It is the policy of Green Oaks Spine & Sport, P.A. to assess a **$75** missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others. **Repeated missed appointments may result in being released from care and termination of the doctor patient relationship.**

____ My initials here indicate that I understand the above missed visit policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

______________________________ ____________________

Signature Date

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Assignment of Benefits / ERISA Authorized Representative

Financial Responsibility
I have requested professional services from Green Oaks Spine & Sport, P.A. ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits
I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information
I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization
I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

______________________________ ______________
Patient Signature Date

______________________________ ______________
Policyholder/Insured/Authorized Agent Date

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used by Green Oaks Spine & Sport, PA, hereinto referred to as "this office", and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8. I ___ object / ___ agree to any and all disclosure regarding my PHI to any other entity than listed above. If agree, list person(s) to whom PHI may be disclosed:

   ____

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. This authorization is effective as of the date below and remains in effect until revoked in writing to the office.

______________________________ ____________________

Name of Patient Date

____

Patient Signature

GREENOAKS Spine & Sport

4200 SW Green Oaks Blvd, Ste 100
Arlington, TX 76017

Authorization for the Release of Medical Records

Patient Name:_____________________________________Date of Birth:___________

I hereby request and authorize:

____

To Disclose information to:

Green Oaks Spine & Sport, P.A.
4200 SW Green Oaks Blvd, Suite 100
Arlington, TX 76017
Phone: (817) 478-5800
Fax: (817) 478-5803

Information to be disclosed includes copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam forms
_____Daily chart notes
_____X-ray Reports
_____X-ray Films
_____MRI Reports:
_____Other, specify:______________________________

Purpose for disclosure:

_____ Treatment, Payment OR _____ Other (Specify)__________________

This authorization will be effective for six months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

____Date:______________
Signature of Patient

OR

____Date:______________
Signature of Legal Representative/Relationship

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

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Accident/Injury Form

(Complete only if involved in an Accident)

Patient Name:_______________________________________ Date of Accident: __________

Time of the accident: __________ ( ) am ( ) pm Location of Accident:________________________________

AUTO INJURY

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No

* *

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

( ) Headache	( ) Sleeping Problems	( ) Lights Bother Eyes	( ) Diarrhea
( ) Neck Pain	( ) Head Too Heavy	( ) Loss of Memory	( ) Feet Cold
( ) Neck Stiff	( ) Pins & Needles in Arms	( ) Ears Ringing	( ) Hands Cold
( ) Dizziness	( ) Pins & Needles in Legs	( ) Face Flushed	( ) Stomach Upset
( ) Back Pain	( ) Numbness in Fingers	( ) Buzzing in Ears	

Did you require post-accident hospitalization? ( ) Yes ( ) No

What Hospital did you go to? ____

Were X-rays, CT or MRI's performed? __________ What body part? _____________________________________

Were you given prescriptions? ______ What were they? ____

Have your symptoms: improved ( ) or worsened ( )

Have you lost any days of work? ( ) Yes ( ) No If Yes, list the dates: ______________________________

INSURANCE INFORMATION

Your Insurance Company: _________________________ Your Claim #: _________________________________

Your adjustors name:______________________________Your Adjustors Phone #:_________________________

Other Party's Name___________________________ Other Party's Ins. Co.________________________________

Do you have Personal Injury Protection (PIP) or MedPay on your car insurance? ( ) Yes ( ) No

If yes, what is the amount? _________How much is remaining? ____________

Do you have an attorney that has advised you in this case: ( ) Yes ( ) No

If yes, attorney's contact information:____

Signature______________________________