Turner Chiropractic

2135 Ridge Road, Suite 102
Rockwall, TX 75087
P 214-771-3990
F 214-771-0664

NON-PREGNANCY AND CONSENT TO X-RAY INTAKE FORM

☐ I am a **male** patient. This does not apply to me, but I do consent to take x-rays, if medically necessary.

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible cause harm to the fetus.

I have been advised that the 10 days following onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

	YES	NO	DON'T KNOW
I am pregnant	____	____	____
I could be pregnant	____	____	____
I am late with my menstrual period	____	____	____
I am taking oral contraceptives	____	____	____
I have an IUD	____	____	____
I have had a tubal ligation	____	____	____
I have had a hysterectomy	____	____	____
I have irregular menstrual periods	____	____	____

My last menstrual period began on _____

With full understanding of the above, and believing that I am not currently at risk, I wish to have an X-ray Examination performed, if medically necessary.

Patient Name: _____ **Date:** _____

Patient Signature: _____

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ **Last Name:** _____

Email address: _____

Preferred method of communication for patient reminders (**Circle one**): Email / Phone / Mail

DOB: __/__/____ Gender (**circle one**): Male / Female **Preferred Language:** _____

Smoking Status (**circle one**): Daily / Occasional / Former / Never

(CMS required providers to report both race and ethnicity)

Race (**circle one**): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / other / I decline to answer

Ethnicity (**circle one**): Hispanic or Latino / Not Hispanic or Latino / I decline to answer

Are you currently taking any medications?(Please include regularly used over the counter medication)

Medication Name	Dosage and Frequency (i.e. 5mg, once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit.** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ **Date:** _____

Height: _____ ***Weight:*** _____ ***Blood Pressure:*** _____ / _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure, or claim to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase of symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment **does not** cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving,and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ **Signature:** _____ **Date:** _____

Parent or Guardian: _____ **Signature:** _____ **Date:** _____

Witness Name: _____ **Signature:** _____ **Date:** _____

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ASSIGNMENT OF BENEFITS AND RIGHT TO COLLECT

In consideration of deferred billing, I hereby authorize and assign any and all insurance carriers, attorneys,agencies, governmental departments, companies, individuals and/or other legal entities ("payers"), which may elect or be obligated to pay, provide or distribute.proceeds to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition"). To assign all payments on my claim exclusively in the name **Turner Chiropractic** ("office") such sums as may be owed said offices for charges incurred by me at the office relating to my condition ("charges"), with such payment to be made exclusively in the name of **Turner Chiropractic.** For the purposes of this document (herein, "assignment"), "proceeds" shall include, but not be limited to, monies/ proceeds from any settlement, judgment, or verdict, as well as any monies/proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes statedherein.

In the event that I retain one or more attorneys to represent me in this matter, I assign my personal insurance company (auto insurance and/or health insurance) to further issue full medical payments to my provider, **Turner Chiropractic**. Additionally, I assign each attorney to issue a **letter of protection** to this office, prior to treatment, and in regards to my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the express written consent of this office.

I authorize this office to release any information regarding my treatment or pertinent to my case(s), to all payers as defined above, to facilitate collection under this assignment. I further authorize and assign all payers to release to office any information regarding any coverage or benefits which *I* may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby assign this office to file a copy of this assignment, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize **Turner Chiropractic** to endorse/sign my name on any and all checks listing me as a payee, which are presented to this office for payment of any account relating to me, my spouse, or any of my dependents.

I understand that I remain personally responsible for the total amounts due Turner Chiropractic for said services. If I discontinue treatment against the medical opinion/advice of my treating doctor, advice of representative, the balance of charges for services rendered will be due and payable immediately. If the office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **Turner Chiropractic** for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

This assignment shall not be modified or revoked without the mutual written consent of Turner Chiropractic and myself. I hereby **revoke** any previously signed authorizations; whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this assignment.

By my signature, be it known that I have read and fully understand the above contract, as well as the co-payment and deductible of my chiropractic treatment would/could be a financial hardship on me.

Patient Signature: _____ **(Print)** _____

Custodian Parent/Legal Guardian: _____ **(Print)** _____

Witness Signature: _____ **(Print)** _____

Date: _____

Patient Authorization and Receipt of Notice of Privacy Practices Per and to HIPAA and Consent for Use of Health Information

I hereby authorize the use and/or disclosure of my protected health information to Turner Chiropractic, LLC. All past, present, and future periods of health care information may be shared for the purpose of my health & safety, to effectively care for my complaint(s), to which will be documented in a timely manner.

I understand that the information used or disclosed under this Authorization Form may be subject to redisclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

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

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken, in reliance on this authorization, cannot be revoked, and my revocation will not affect those actions.

The undersigned does hereby acknowledge that he/she has the right to receive a copy of this office's notice of Privacy Practices Pursuant to HIPAA or a true copy of this office's HIPAA Compliance Manual, of which copy will be made available upon request.

The undersigned does hereby consent to the use of his/her health information in a manner consistent with this office's Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, Social and Federal Law.

Dated this _____day of _____, 2022.

By: _____ (Print) _____ (Sign)

Patient's Name Patient's Signature

If patient is a minor or under a guardianship order, as defined by State Law:

By: _____ (Print) _____ (Sign)

Name of Parent/Guardian (Please circle) Signature of Parent/Guardian

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

I hereby authorize the use and/or disclosure of my protected health information to Turner Chiropractic, LLC. All past, present, and future periods of health care information may be shared for the purpose, of my treating Doctor, to effectively care for my complaint(s), to which will be determined medically necessary.

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

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

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken, in reliance on this authorization, cannot be reversed, and my revocation will not affect those actions.

The undersigned does hereby acknowledge that he/she has the right to receive a copy of this office's Notice of Privacy Practices Pursuant to HIPAA or a full copy of this office's HIPAA Compliance Manual, of which, will be made available upon request.

The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State and Federal Law.

Dated this_____day of _____,2022.

By: _____(Print) _____(Sign)

Patient's Name **Patient's Signature**

If patient is a minor or under a guardianship order, as defined by State Law:

By: _____(Print) _____(Sign)

Name of Parent/Guardian (please circle) **Signature of Parent/Guardian**

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Other _____		
			Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	_____		

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____

_____

_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

X _____
Signature of Patient, Parent, Guardian or Personal Representative

X _____
Please print name of Patient, Parent, Guardian or Personal Representative

X _____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

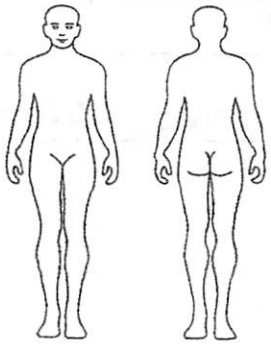
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down