TEXAS SPINE & INJURY CENTER

PATIENT INFORMATION FORM (Personal Injury)

General Information

Date:	Name: First Last MI			SS #: ___-___-___
Home phone:	Cell phone:	Sex: ❑ Male ❑ Female	Age: ___	Birth date: ___ / ___ / ___ MM DD YYYY
Address:		City/State:		Zip:
Email:		❑ Married ❑ Separated ❑ Divorced ❑ Single ❑ Widowed ❑ Partnered ❑ Minor		
Occupation:	Patient employer/school:			Employer/School phone:
Spouse or Parent Name: First Last MI			Birth Date: ___/___/___ MM DD YYYY	SS #: ___ - ___ - ___
Spouse or Parent Employer:				

Emergency Information

In case of emergency, contact: First Last		Relationship to patient:
Home phone:	Work phone:	Cell phone:
Primary care physician name:		Primary care physician phone number:

Name: _____ **Date:** _____

Health Insurance

Who is responsible for this account?	Relationship to patient:	SS #: _____ - _____ - _____
Primary insurance company name:	Subscriber Name:	
DOB: _____ / _____ / _____ MM DD YYYY	ID #:	Group #:

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with_____and assign directly to Dr. Aaron Smith all insurance benefits, if any, otherwise payable to me for service 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 deterring insurance benefits or the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Signature of patient, parent/guardian, or personal representative

_____ Printed name of patient, parent/guardian, or personal representative

_____ Date

_____ Relationship to patient

Auto Insurance Information

Do you have Personal Injury Protection (PIP) or MedPay?

❑ yes ❑ no

If yes, please fill out the remaining questions in this section. If no, please proceed to Patient Condition section.

Name of Auto Insurance Company:	Phone number:	Do you have a claim already opened? ❑ yes ❑ no
What are you PIP limits? $ _____		

Accident Information

Is condition due to an accident? ❑ yes ❑ no	Date of accident:	Type of accident: ❑ Auto ❑ Work ❑ Home ❑ Other	To whom have you made a report of your accident? ❑ Auto insurance ❑ Employer ❑ Worker's Comp ❑ Other
Attorney name (if applicable):		Attorney phone (if applicable):	

Name: _____ **Date:** _____

Patient Condition

Reason for your visit?	When did your symptoms begin?
Is this condition getting progressively worse? ❑ yes ❑ no ❑ unknown	Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): 1 2 3 4 5 6 7 8 9 10
Type of pain: ❑ sharp ❑ dull ❑ throbbing ❑ numbness ❑ aching ❑ burning ❑ shooting ❑ cramping ❑ tingling ❑ swelling ❑ stiffness ❑ other	How often do you have this pain?

Is it constant or does it come and go?	Does it interfere with your (check all that apply): ❑ sleep ❑ work ❑ recreation ❑ daily routine	Activities that are painful to perform (check all that apply): ❑ sitting ❑ standing ❑ bending ❑ walking ❑ lying down

Treatment you are receiving or have received for this condition:

❑ Medical Care_____ ❑ Chiropractic Care _____

❑ Physical Therapy_____ ❑ Other _____

Habits

	Yes	No	If yes, please describe:
Smoking	❑	❑	Packs per day: ❑ 0-½ ❑ ½-1 ❑ 2 or more How long? _____
Alcohol consumption	❑	❑	Number of drinks per day_____ # of drinks per week _____
Other drug use (street drugs)	❑	❑	
Exercise	❑	❑	❑ Daily ❑ Weekly ❑ Monthly Type _____

Medications

Please list all medications currently taking and dosage. Include prescription and non-prescription drugs.

_____

_____

Allergies

Please list all known allergies, especially to medications.

_____

Name: _____ **Date:** _____

Review of Systems

Constitutional	No	Yes
Excessive thirst	❑	❑
Chills	❑	❑
Convulsions	❑	❑
Dizziness	❑	❑
Fainting	❑	❑
Fatigue	❑	❑
Fever	❑	❑
Weight loss	❑	❑
Loss of sleep	❑	❑
Night sweats	❑	❑
Psychiatric		
Nervousness	❑	❑
Depression	❑	❑
Mood swings	❑	❑
Musculoskeletal		
Arthritis	❑	❑
Bursitis	❑	❑
Foot trouble	❑	❑
Hernia	❑	❑
Neck pain	❑	❑
Mid back pain	❑	❑
Low back pain	❑	❑
Fractures	❑	❑
Cardiovascular		
Hardening of arteries	❑	❑
High blood pressure	❑	❑
Low blood pressure	❑	❑
Chest pain	❑	❑
Poor circulation	❑	❑
Rapid heartbeat	❑	❑
Slow heartbeat	❑	❑
Swelling of ankles	❑	❑

Respiratory	No	Yes
Chest pain	❑	❑
Chronic cough	❑	❑
Difficulty breathing	❑	❑
Spitting up blood	❑	❑
Spitting up phlegm	❑	❑
Wheezing	❑	❑
Asthma	❑	❑
Gastrointestinal		
Excessive belching	❑	❑
Excessive gas	❑	❑
Colitis	❑	❑
Colon trouble	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Difficult digestion	❑	❑
Bloated abdomen	❑	❑
Excessive hunger	❑	❑
Gallbladder trouble	❑	❑
Hemorrhoids	❑	❑
Intestinal worms	❑	❑
Jaundice	❑	❑
Liver trouble	❑	❑
Nausea	❑	❑
Stomach pain	❑	❑
Poor appetite	❑	❑
Vomiting	❑	❑
Vomiting of blood	❑	❑
Skin		
Bruise easily	❑	❑
Dryness	❑	❑
Hives/allergy	❑	❑
Itching	❑	❑
Varicose veins	❑	❑

Eye	No	Yes
Eye pain	❑	❑
Failing vision	❑	❑
Far sighted	❑	❑
Near sighted	❑	❑
Glaucoma	❑	❑
Blurred vision	❑	❑
Ears, Nose, and Throat		
Ringing in ears	❑	❑
Colds	❑	❑
Deafness	❑	❑
Earaches	❑	❑
Ear discharge	❑	❑
Ear noise	❑	❑
Enlarged glands	❑	❑
Enlarged thyroid	❑	❑
Gum trouble	❑	❑
Hay fever	❑	❑
Hoarseness	❑	❑
Nasal obstruction	❑	❑
Nose bleeds	❑	❑
Sinus infections	❑	❑
Sore throat	❑	❑
Genitourinary		
Blood in urine	❑	❑
Frequent urination	❑	❑
Kidney infection	❑	❑
Painful urination	❑	❑
Prostate trouble	❑	❑
Seizures	❑	❑
Are you pregnant?	❑	❑
Neurological		
Tremors	❑	❑
Fainting spells	❑	❑
Coordination difficulty	❑	❑

Family History

Please mark relative's current age or age at time of death. Place an X in the boxes that apply to them. Describe "Other" and list cause of death.

	Age	Allergy-Asthma	Alcohol abuse	Arthritis - Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or back disorder	Stroke	Tuberculosis	Other (describe)	
Father																			
Mother																			
Siblings																			

Name: _____ **Date:** _____

Surgeries

YEAR	BODY REGION	PROCEDURE

Prior Auto Accidents/Work Injuries

YEAR	AUTO/WORK COMP	BODY REGION(S)	LENGTH OF TREATMENT

Medical Illnesses

List current and past illnesses not mentioned above.

_____

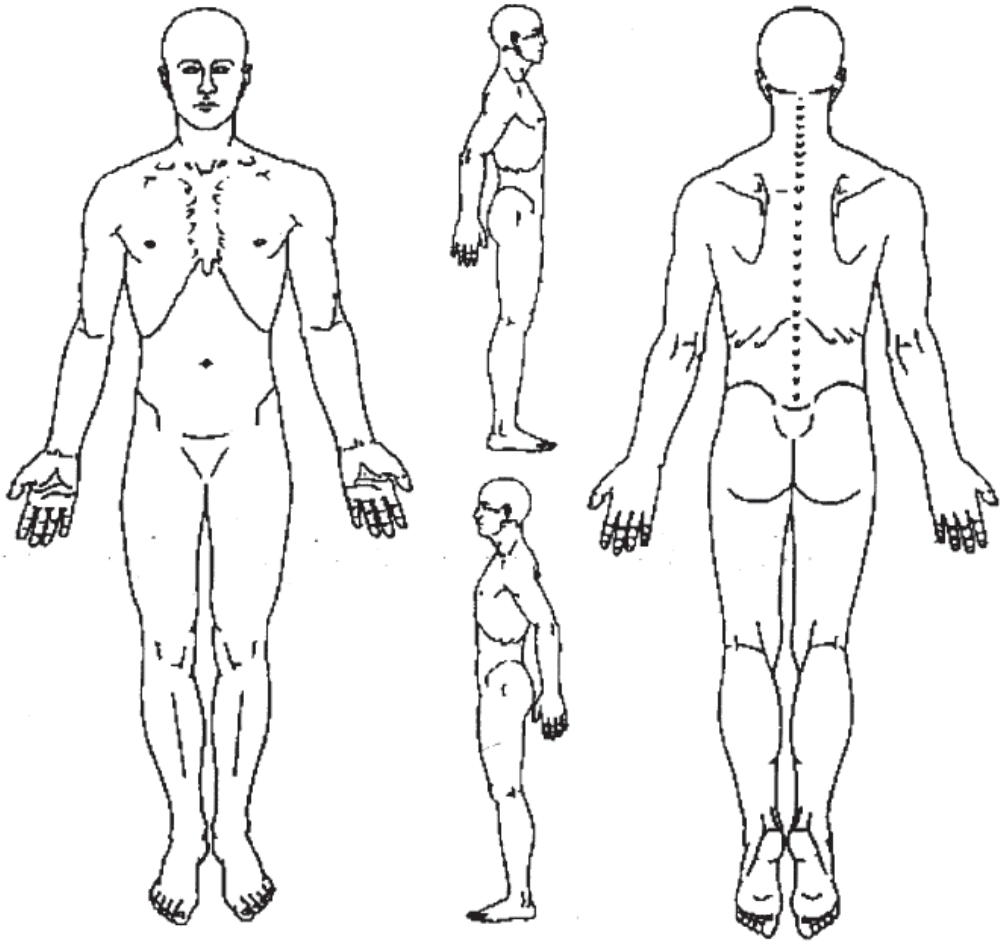
_____

I understand that if any changes are made to my personal or insurance information while being treated, it is my responsibility to inform the facility of said changes in a timely manner.

X _____ Date: _____

Patient/Responsible Party Signature

TEXAS
SPINE & INJURY
CENTER



On the above diagram, please indicate where you are experiencing pain and/or other symptoms.

A = Ache	S = Stabbing
P = Pins & Needles	N = Numbness
B = Burning	O = Other

Patient Name: _____ Date: _____

Patient Name: _____ Date: _____

Motor Vehicle Collision Questionnaire

Date of Accident: _____ Location of Accident: _____

Questions about the accident circumstances:

Year and Make of vehicle you were riding in:

_____

Year and Make of other vehicle(s):

Vehicle 2: _____

Vehicle 3: _____

Monetary damage to your vehicle: $_____

Was there damage to other vehicles?

_____

Your head rest was adjusted to:

- ○ Top of Shoulder
- ○ Top of Ear
- ○ Top of Head

Were you the

- ○ Driver
- ○ Passenger

If passenger, where were you seated?

- ○ Passenger's seat
- ○ Rear seat, driver's side
- ○ Rear seat, passenger's side

Were you wearing a seat belt at the time?

○ Yes ○ No

Was your vehicle moving or stopped?

○ Moving ○ Stopped

Did your vehicle strike another vehicle?

○ Yes ○ No

Where was your vehicle hit?

- ○ In the front
- ○ In the rear
- ○ On the driver's side
- ○ On the passenger' side

Describe the collision: _____

_____

_____

If your vehicle had airbags, did they deploy?

○ Yes ○ No

What were the road conditions (circle)?

Dry Wet Icy Snow-packed

Other, *describe* _____

How far did your car move after impact?

Car lengths: _____

Feet: _____

Who was at fault for the accident? _____

Did the police write any tickets?

○ Yes ○ No

To Whom? _____

Questions about your circumstances at impact:

Were you aware of the impending impact?

○ Yes ○ No

If yes, did you brace yourself before the impact?

○ Yes ○ No

Were you looking in a mirror?

○ Yes ○ No

If yes, please describe:

_____

What was your body position at time of impact?

(Circle one)

○ Neutral ○ Forward ○ Rotated: Left / Right (circle one)

Did you strike another object?

○ Steering wheel ○ Dash ○ Window

Other: _____

Did you experience any of the following at the time of impact? (circle all the apply)

Cuts Bruises Bumps Nausea Dislocations

Immediate head pain Vision problems

Altered consciousness Immediate dizziness

Loss of consciousness*, how long*? _____

Immediate pain, *Where*? _____

Abrasions, *where*? _____

Questions about your circumstances after the accident:

Were you able to get out of the vehicle and walk on your own?

○ Yes ○ No

Was your car drivable from scene of accident?

○ Yes ○ No

Where did you go after the accident?

○ Home ○ Work ○ Hospital

If taken to a hospital answer the following questions:

Were you taken by ambulance?

○ Yes ○ No

Where? _____

Did you stay overnight? ○ Yes ○ No

If you went to a hospital, were any x-rays taken?

○ Yes ○ No

What areas of your body were x-rayed?

_____

How did you feel that night? (circle all that apply)

Restless In pain Stiff Sore Fine

How did you feel the next day?

○ Better ○ Same ○ Worse

Have you missed any time from work?

○ Yes ○ no

How much? _____

IRREVOCABLE ASSIGNMENT OF BENEFITS AND PAYMENT AGREEMENT

Patient:_____ Provider: Texas Chiropractic and Rehab, PC
DBA: Texas Spine and Injury Center
Address:_____ Address: 1603 Medical Parkway Ste. 310
City, State, Zip:_____ City, State, Zip: Cedar Park, TX 78613

THIS AGREEMENT is made and entered into by and between the above name PATIENT and PROVIDER. WHEREAS PATIENT desires to receive services from this health care PROVIDER and therefore desires to assign certain rights and benefits to PROVIDER it is hereby agreed:

1. PATIENT assigns to PROVIDER any and all benefits payable by PATIENTS insurance (Automobile, Workers Comp, Major Medical, and/or Health Insurance) plans as a result of charges incurred by PATIENT for services rendered by this PROVIDER. PATIENT also assigns to PROVIDER any and all contractual rights PATIENT has against any insurance company, health care benefit plan, or any other party contractually liable to PATIENT for payment of health care costs incurred by PATIENT as a result of services rendered by this PROVIDER. This assignment of benefits and contractual rights relating to those benefits includes but is not limited to the following described policies or plans. This agreement nullifies any agreement now or in the future for any third party (Attorneys) other than provides to receive any payments for any insurance benefits including Person Injury Protection or Med Pay of medical services provided and billed from this clinic. This is the financial agreement of this PATIENT and TEXAS CHIROPRACTIC AND REHAB, PC to have directly sent to PROVIDER as addressed above.

2. PATIENT hereby directs all insurers and other persons responsible for PATIENT'S health care costs to make all payment for health care services rendered by this PROVIDER directly to PROVIDER.

3. Patient understands that patient is financially responsible for all charges and services rendered by provider. Any legal or collection expenses incurred by this clinic to collect balance owed by the patient will be the financial responsibility of the patient.

_____ _____
Patient Signature Date

_____
Patient Printed Name

_____ _____
Witness Date

_____
Witness Printed Name

DOCTOR'S LIEN

Attorney's Name:_____
Address:_____
City, State, Zip:_____
Phone:_____

Patient's Name_____
Address:_____
City, State, Zip:_____

Provider: Texas Chiropractic and Rehab
DBA: Texas Spine and Injury Center
1603 Medical Parkway Suite 310
Cedar Park, TX 78613
Phone: (512) 918-2225 Fax: (512) 918-2229

I hereby authorized Texas Chiropractic and Rehab to furnish you, my attorney, with a full report and records regarding case history, examination, diagnosis, treatment, and prognosis with regard to treatment related to my accident which occurred on _____.
(Date of incident)

I hereby give a lien and assignment to Texas Chiropractic and Rehab on the proceeds or any supplement, claim, judgment, or verdict which results from said incident. I further authorize, direct, and instruct you, my attorney, to pay directly to Texas Chiropractic and Rehab such sums as may be due and owning for services rendered me by reason of this incident and by reason of any other bills that are due, and to withhold such sums for such settlement, claim, judgment, or verdict that may be necessary to protect Texas Chiropractic and Rehab adequately and such sums as may be necessary to fully and completely pain Texas Chiropractic and Rehab any outstanding balance owed at the time of distribution of funds from any settlement, claim, judgment or verdict.

I agree never to rescind this document and that a recession will not be honored by my attorney. I also agree not to request a fee reduction regardless of the amount of total settlement. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon this case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to Texas Chiropractic and Rehab for all bills submitted by Texas Chiropractic and Rehab for services rendered to me, and this agreement is made solely for additional protection and in consideration of awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

To My Attorney: I directed that you be bound by this lien and treat it, irrevocably, as an assignment to Texas Chiropractic and Rehab of any sums that may be due to me, to the extent and according to the terms set forth above. Be advised that Texas Chiropractic and Rehab is relying upon this Lien, assignment, and directed to you, and as a result of such reliance, at my request is providing health care and treatment for which this lien, assignment, and directive to you provides security for payment. Moreover, it is my intention that Texas Chiropractic and Rehab be viewed as a third party beneficiary of this direction to you, and I intend thereby to impose upon you an obligation to Texas Chiropractic and Rehab to comply with the terms of this direction to you.

_____ _____
Patient Signature Date

_____ _____
Witness Signature - Printed Name Date

_____ _____
Attorney's Signature Date

TEXAS
SPINE & INJURY
CENTER

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient,
and "The Doctor" refers Aaron Smith DC, and/or staff.

I consent to the use or disclosure of my protected health information by The Doctor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of The Doctor. I understand that analysis, diagnosis or treatment of me by The Doctor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Doctor is not required to agree to the restrictions that I may request. However, if The Doctor agrees to a restriction that I request, the restriction is binding on The Doctor. I have the right to revoke this consent, in writing, at any time, except to the extent that The Doctor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of The Doctors and understand that I have a right that Notice 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of The Doctor. The Notice of Privacy Practices for The Doctor is also posted in the waiting room at 1603 Medical Parkway Suite 310 Cedar Park, TX 78613. This Notice of Privacy Practices also describes my rights and duties of the The Doctor with respect to my protected health information.

The Doctor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of The Doctor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative's Authority

1603 Medical Parkway, Suite 310, Cedar Park, TX 78613
Phone: (512) 918-2225 Fax: (512) 918-2229

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, chiropractic assistants and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment(s) (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment 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 strains/sprains and am therefore willing to accept and consent to the risk associated with the care that 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 my future conditions for which I seek treatment.

_____ _____
Patient's Name (Print) Patient's Signature

_____ _____
Date Relationship or authority if not signed by patient

_____
Witness