Rockwall Elite HEALTHCARE

New Patient Information

Name: _____ Date: _____
Last First MI

DOB: _____ **Age**: _____ **Sex**: _____ **Social Security #** _____-_____-_____

Address: _____

City: _____ **State**: _____ **Zip code**: _____

Phone: (C) _____ (W) _____(H) _____

Email: _____

Emergency Contact: _____ **Relationship**: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Minor

Occupation: _____ **Employer**: _____

Name of Spouse: _____ **Spouses DOB**: _____

Insurance Carrier: _____ **Member ID#**: _____

Policyholder Name: _____ **DOB**: _____

What is the reason for your visit today? _____

Have you been treated for this condition before? Yes No

If so, When? How?_____

Results: _____

Is this visit due to an accident or injury? Yes No If yes, what type? _____

How did you hear about our practice? (Circle One)

Internet/Social Media/Search Engine (Specify): _____

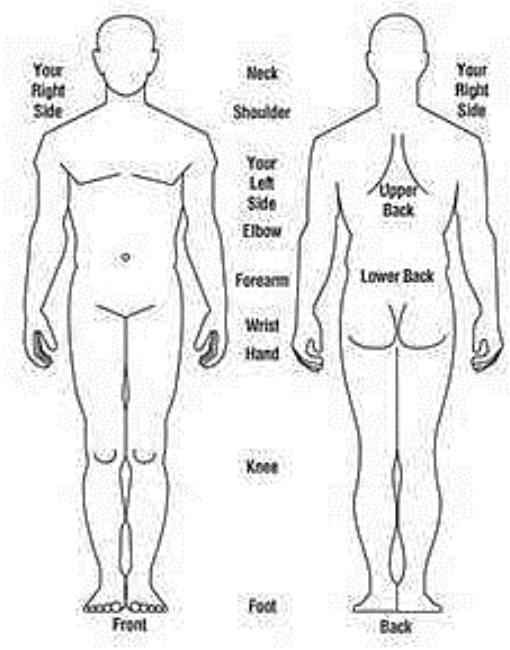
Referral from friend/family? (Specify): _____

Other (Specify): _____

(Continued on next page)

New Patient Information
(Page 2)

Draw on the diagram below where you have pain/symptoms:



How often do you experience your symptoms?

_____ Constantly (76-100% of the time) _____ Frequently (51-75% of the time)

_____ Occasionally (26-50% of the time) _____ Intermittently (1-25% of the time)

How would you describe your type of pain? (Circle most accurate)

Sharp Deep Ache Burning Shooting Numbness Stiff Tingly Dull

Radiating up/down If so, where? _____

What have you found makes it better or worse if anything?

_____

Are your symptoms getting worse, better, or staying the same? (Circle most accurate)

Rate your pain on a scale from 0-10: (0 being NO pain at all, 10 being the worst you have EVER had)

0 1 2 3 4 5 6 7 8 9 10

Has the problem interfered with your work? If so, specify the severity.

Not at all A little bit Moderately Quite a bit Extremely

Has your problem interfered with your social/family activities?

Not at all A little bit Moderately Quite a bit Extremely

(Continued on next page)

New Patient Information
(Page 3)

Who else have you seen for your problem? (Circle one or more)

Neurologist Primary Care Physician Orthopedist Massage Therapist Other Chiropractor

Other: _____

How long have you had this problem? _____

What do you think caused this problem? _____

Does it prevent you from doing any activities? _____

_____

What type of exercise would you say you do? (Circle most accurate)

Strenuous Moderate Light None

Do you or any of your immediate family members have any of the following:

Rheumatoid Arthritis Diabetes Lupus Heart Problems Cancer ALS

For each of the conditions listed below please circle if you have experienced them in the last six months:

Neck Pain	Diabetes	Headaches	Chest Pains	Loss of Bowel or Bladder
Upper Back Pain	Heart Attack	Cancer	Low Back Pain	Asthma
Ringing in the ears	Shoulder Pain	Stroke	Visual Disturbances	Elbow Pain
Angina	Dizziness	Upper Arm Pain	Kidney Stones	Wrist Pain
Abdominal Pain	Hand Pain	Gall Bladder Disorder	Hip Pain	Constipation
Leg Pain	Excessive Thirst	Ankle/Foot Pain	Sexual Dysfunction	High Blood Pressure
Jaw Pain	Joint Pain/Stiffness			

Please list any allergies: _____

Are you currently under any drug and/or medical care? Yes No
If yes, explain: _____

Please list any/all medications, supplements/vitamins, herbs etc. you are currently taking:

Name	Strength/Dosage	Frequency	What are you taking it for?

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

New Patient Information
(Page 4)

Please list any surgeries and/or hospitalizations you have had (type & date):

_____

_____

_____

X-Ray Questionnaire: (FOR WOMEN ONLY)

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

_____ There is a possibility that I might be pregnant
_____ Yes, I am pregnant
_____ No, I am definitely not pregnant at this time.

I request that x-rays not be taken because: _____

Date of your last menstrual period? _____

TO HELP US BETTER REACH YOUR GOALS, PLEASE CHECK ONE OF THE FOLLOWING:

_____ **RELIEF CARE -** Easing the pain and discomfort you are having.

_____ **CORRECTIVE CARE -** Addressing the *CAUSE* of the problem, correct the *SYMPTOMS* and decrease the *RECURRENCE* of the problem.

_____ **DOCTOR'S RECOMMENDATIONS -** Allowing our team of Doctors to weigh your needs and desires and recommend the best treatment plan.

Patient Signature: _____ **Date:** _____

Please take a moment to look through our patient testimonials in our waiting area that our patients have shared with us about their experience here at Performance Chiropractic. We look forward to you becoming a part of our Chiropractic family and hearing about your experience in the future to share with others.

RECORDS RELEASE AND ASSIGNMENT OF BENEFITS

FOR VALUE RECEIVED, I hereby assign to **Performance Chiropractic and Wellness**, Inc. hereinafter referred to as **PCW**, to the extent of my bill for health care services, any claims which I may have.

For benefits provided under any policy of insurance or other health care plan.

Against any other party whose negligence may have caused my injuries or who may be legally responsible for my injuries, illnesses, or health care costs.

I further hereby assign to PCW a lien in the amount of my bill for health services against any other party whose negligence may have caused my injuries, or who may be legally responsible for my injuries, illnesses, or health care costs.

I hereby direct payment to be made directly to PCW. I agree to cooperate with PCW in collecting any such amounts, including appearing in court if necessary. PCW is further empowered to request and receive from any insurance company or health care plan all information or supporting documentation concerning or touching upon handling, calculation, processing or payment of any claims.

All insurers and providers of health care benefits are hereby notified that this agreement is subject to the financial arrangements with PCW as set forth below.

I recognize payment for services rendered by PCW is due upon receipt of the services, but that PCW has agreed to accept this assignment is an accommodation to me and that PCW may revoke this assignment at any time. I hereby waive any applicable statute of limitations, which may affect PCW's right to collect for their services.

In the event that I receive directly any check, draft, or other benefits subject to this assignment at a time when there is still a balance due PCW, I agree to deliver such check, draft, or benefits to PCW, immediately upon receipt, and the proceeds thereof shall be applied to my bill.

I hereby authorize PCW to release and to permit the examination or copying of any of my medical records. X-rays, laboratory tests, and the results of all the tests or any tape or character to such persons, as PCW deems appropriate.

In the event that any provisions of this agreement are determined to be invalid or unenforceable, all other provisions shall remain enforceable.

IN WITNESS WHEREOF, Agreement has been entered the day and year set forth below.

_____ _____

{Print Name} {DOB}

_____ _____

{Signature} {Date}

RECORDS RELEASE AND ASSIGNMENT OF BENEFITS

FOR VALUE RECEIVED, I hereby assign **to Rockwall Elite Healthcare** hereinafter referred to as **REH**, to the extent of my bill for health care services, any claims which I may have.

For benefits provided under any policy of insurance or other health care plan.

Against any other party whose negligence may have caused my injuries or who may be legally responsible for my injuries, illnesses, or health care costs.

I further hereby assign to REH a lien in the amount of my bill for health services against any other party whose negligence may have caused my injuries, or who may be legally responsible for my injuries, illnesses, or health care costs.

I hereby direct payment to be made directly to REH. I agree to cooperate with REH in collecting any such amounts, including appearing in court if necessary. REH is further empowered to request and receive from any insurance company or health care plan all information or supporting documentation concerning or touching upon handling, calculation, processing or payment of any claims.

All insurers and providers of health care benefits are hereby notified that this agreement is subject to the financial arrangements with REH as set forth below.

I recognize payment for services rendered by REH is due upon receipt of the services, but that REH has agreed to accept this assignment is an accommodation to me and that REH may revoke this assignment at any time. I hereby waive any applicable statute of limitations, which may affect REH's right to collect for their services.

In the event that I receive directly any check, draft, or other benefits subject to this assignment at a time when there is still a balance due REH, I agree to deliver such check, draft, or benefits to REH, immediately upon receipt, and the proceeds thereof shall be applied to my bill.

I hereby authorize REH to release and to permit the examination or copying of any of my medical records, X-rays, laboratory tests, and the results of all the tests or any tape or character to such persons, as REH deems appropriate.

In the event any provisions of this agreement are determined to be invalid or unenforceable, all other provisions shall remain enforceable.

IN WITNESS WHEREOF, Agreement has been entered the day and year set forth below.

_____ _____

{Print Name} {DOB}

_____ _____

{Signature} {Date}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Performance Chiropractic and Wellness, Inc
Rockwall Elite Healthcare

I have read this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly involved in providing my treatment.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and accreditation.

_____

Name (Please Print)

_____ _____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt or our Notice of Privacy Practices but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgment
- An emergency prevented us from obtaining acknowledgment
- Other (Specify): _____

_____ _____

{Staff Signature} {Date}

INFORMED CONSENT TO TREATMENT

Physicians, Chiropractors, Osteopaths, and Physiotherapists using manual manipulation are required to advise their patients:

1. With neck problems there have been extremely rare incidents of injury to the vertebral artery during the course of treatment. These have caused Strokes or Stroke-like occurrences, which are usually of a temporary nature. The chances of this happening are approximately 2 in 1 million treatments.

2. With back or neck problems there have been rare incidents of rib separation or fracture, and more common pain, bruising, swelling, or aggravation of symptoms.

APPROPRIATE TESTS WILL BE PERFORMED ON YOU TO MINIMIZE YOUR RISK.

I hereby consent to the chiropractic treatment indicated as needed and explained to me. If during the course of treatment unforeseen conditions are discovered or unusual conditions develop, I further consent to such additional diagnostic measures and treatments as may be indicated by sound and prudent chiropractic practice which may require additional x-rays, chiropractic, orthopedic, neurological and or laboratory testing, or consulting another doctor.

No guarantee or warranty has been made to me that results will be to my complete satisfaction.

IF YOU HAVE ANY QUESTIONS ABOUT THIS PLEASE ASK YOUR CHIROPRACTOR.

I HAVE READ THE ABOVE, UNDERSTAND AND CONSENT TO TREATMENT.

_____

{Signature} {Date}

_____

{Witness}

CONSENT TO TREAT A MINOR

I, undersigned, hereby authorize the doctors of Performance Chiropractic & Wellness, LLC and Rockwall Elite Healthcare to administer chiropractic care as deemed necessary to my son or daughter (other _____).

_____

{Child's Name}

_____

{Signature of Parent/Guardian} {Date}