



BACKBONE Health Restoration Center

3951 W. Parmer Lane Ste. 300
Austin, Texas 78727
Phone: 512-339-2663 Fax: 512-339-2664

Welcome!!! Please allow our staff to photocopy your driver's license and insurance or Medicare card (if applicable)

NEW PATIENT INFORMATION

First Appointment date: _____ Social Security# _____

Name Mr. / Mrs. / Ms. / Dr. _____

Address _____
Street City State Zip Code

Home # () _____ Work # () _____ Cell # () _____

Birth date _____ Age _____ Sex: male / female

E-Mail Address _____ @ _____

Employer _____ Occupation _____

Job Functions/Work Environment _____

Marital Status: (Please circle) Married Single

How did you hear about our clinic? Whom may we thank for referring you? _____

Primary Insurance Card Holder/Spouse's Information

Insurance Company _____ Phone # () _____

Name _____ Birth date _____

Occupation _____ Employer _____

Social Security # _____ Work # () _____

INSURANCE IS NOT A GUARANTEE OF PAYMENT; YOUR ESTIMATED PORTION MAY CHANGE IN RECEIPT OF THE INSURANCE EXPLANATION OF BENEFITS.

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

Have you been injured in a car accident? Yes/No Date of accident: _____

Person to notify in case of an emergency:

Name _____ Phone # () _____ Relationship _____

Address _____ City _____ Zip _____

Signature _____ Date _____

HEALTH CONCERNS: Please list your top health concerns in order of priority.

- 1.) _____
- 2.) _____
- 3.) _____

TREATMENT GOALS: (Please circle) Minimal-Patch up Resolve Symptoms-Fix Cause OptimalHealth&Wellness

Are you interested in receiving more information regarding: (Please circle)

- | | | | |
|------------------------------|--|-----------------------|---------------------------|
| a. Stretching/rehabilitation | b. Nutrition | c. Acupuncture | d. Massage Therapy |
| e. Ergonomics | f. Detoxification | g. Herbs | h. Pediatric Chiropractic |
| i. Changing Body Composition | j. Lowering Cholesterol/BP/Triglycerides | k. Metabolic Syndrome | |

1. Have you been treated by a chiropractor in the past? Yes/No
2. Did you have a good experience? Yes/No Please explain to us what you liked/did not like: _____
3. Do you exercise regularly? Yes/No How many times a week? _____
4. Are you healthier today than you were 5 yrs ago? Yes/No Why? _____
6. Does your current health situation prevent you from doing anything that you would normally enjoy doing? What? _____
7. In relation to your primary concern: Has another doctor treated you for this condition? Yes/No
If yes, whom? _____ Treatment? _____ X-ray/MRI? _____
8. If this is a recurrence, when was the first time you noticed? _____ # of episodes? _____
9. How did it originally occur? _____ Date: _____
11. Has it become worse recently? Yes/No/Same/Better/Gradually worse
12. How frequent is the condition? Constant Daily Intermittent Nightly only
13. Is this condition interfering with your: work/sleep/Daily routine, other: _____
14. Is there anything that can relieve the problem? Yes/No, Please describe: _____

What medications/vitamins are you currently taking, including over the counter drugs? _____

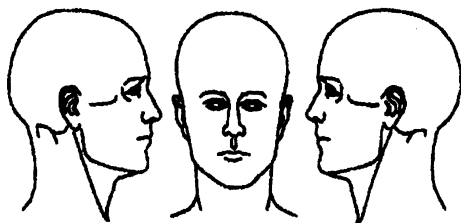
ALLERGIES: Please check and list all allergies.

Food/ Medications/ Seasonal/ Other: _____

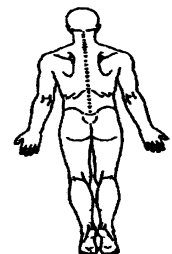
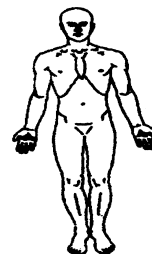
PAST SURGICAL PROCEDURES (also list scars): _____

PLEASE LIST FAMILY HISTORY ILLNESSES: _____

Please shade/mark in your areas of discomfort on the models below.



Stabbing/Cutting- III Tingling -:::
 Burning- XXX Cramping - <<<
 Numbness - === Dull - ###



Signature _____

Date _____



CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to myself while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during chiropractic adjustments. Those complications may include but may not be limited to: fractures, disk injuries, dislocations, muscle strain, Horner’s syndrome, 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. I do not expect the doctor to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

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 weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name and Address of Clinic:

Name of Treating Doctors:

**BackBone Chiropractic
3951 W. Parmer Lane Suite #300
Austin, TX, 78727**

**Dr. Kristy Clinton, DC, IAMA
Dr. Tracie Schwab, DC**

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE.

Consent to evaluate and adjust a minor child.

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle. _____

CONSENT TO X-RAY

I hereby authorize BackBone Chiropractic and whomever the clinician may designate as her assistant(s) to take x-rays of myself (or said minor) for diagnostic purposes. I hereby release BackBone Chiropractic from any liability.

Signature _____

Date _____



ASSIGNMENT OF BENEFITS/BILLING INFORMATION

I understand that all payments are due to BackBone Chiropractic at the time services are rendered, except when prior arrangements are made. All bills are due and payable in full.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctors specific recommendations.

PATIENTS WITHOUT INSURANCE:

1. 100% of the first visit is to be paid in full at time services are rendered.
2. We offer flexible, 0% interest payment programs to patients who qualify.
3. For your convenience, our office accepts cash, checks, VISA/MC/AMEX/DISC.

PATIENTS WITH INSURANCE:

1. After we have obtained a quote of benefits from your insurance, we will accept payments directly from your carrier. (This is to save you time from paying the total charges in full as services are rendered.)
2. **Patients are responsible for all uncovered services at the time of visits, (i.e. deductible, co-insurance, lab work, supplements, supports, etc.)**
3. Patients MUST stay current with their co-insurance payments.
4. **Your insurance is an agreement between YOU and your insurance company. Therefore, this clinic does not promise that your insurance company will pay the charges and will not enter into a dispute with the insurance company over reimbursement. If your carrier denies a payment, the patient is personally responsible for payment. Verification of coverage is not a guarantee of payment for services rendered. Please also provide any change in policy or insurance carrier.**
5. Our office gives an insurance company 60 days from an incurred charge to pay their portion. If for any reason they do not pay in 60 days, then the balance becomes the patient's responsibility and is due and payable at that time.
6. The patient is responsible for any and all attorney fees for collection of past due accounts.

PERSONAL INJURY PROTECTION:

1. This document serves to relinquish payment directly to the provider for my services covered under my Personal Injury Protection claim.

MEDICARE:

Backbone Chiropractic accepts assignment of Medicare benefits. Manipulation is the only covered service by Medicare. Although we are a Medicare provider we do not accept Medicaid assignment.

TERMINATION OF CARE WAIVER:

I hereby acknowledge and understand that if I DO NOT KEEP APPOINTMENTS as recommended by treating doctor at this chiropractic clinic, 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 the physician/facility immediately. I understand that failure to do so may jeopardize my case.

A photocopy of this instrument shall serve as original.

Signature _____

Date _____



HIPAA Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or healthcare operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest. **Your Personal Health Information (PHI) will never be given to any entity besides what is required for your treatment, payment and health care operations.**

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as radiologists that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name _____ Signature _____ Date _____

Patient/Legal Guardian: _____ Signature _____ Date _____

Signature _____

Date _____