Stinnett Chiropractic

"we correct pinched nerves"

Date:_____

First Name:_____Last Name:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____

Gender: Male Female

Birth Date:_____ Marital Status: Single Married Divorced Widowed

Email Address:_____

Spouse Name:_____

Number of Children:_____Names:_____

Employer:_____Occupation:_____

Employer Phone Number:_____

Emergency Contact Information:_____

Phone Number:_____Relationship:_____

What is the condition related to?

❑ Auto Accident ❑ Home Injury ❑ Sports Injury ❑ Work Injury ❑ Other:_____

Date of accident: _____ Please describe what happened:

_____

_____

_____

AUTO ACCIDENT ONLY

Were you struck from: ❑ Behind ❑ Front ❑ Right Side ❑ Left Side

Were you: ❑ Driver ❑ Passenger ❑ Front Seat ❑ Back Seat ❑ Right Side ❑ Left Side

❑ Wearing a seat belt ❑ Knocked unconscious

Speed of your car: _____ MPH Other car _____ MPH Were police notified? ❑ YES ❑ NO

When did the symptoms first start?_____

Did you go to the hospital? ❑ YES ❑ NO

If yes what hospital?_____

Were x-rays taken? ❑ YES ❑ NO

Are you currently pregnant? ❑ NO ❑ YES I am due _____

I certify to the best of my knowledge I am not pregnant. _____ (initial please)

Have you lost time from work as a result of this accident? ❑ YES ❑ NO

If yes dates missed: _____ Date returned to work: _____

Chief Complaint:	Back Pain: lower-mid-upper		Neck Pain: lower-upper		Other:	
Pain location:	right / left / both		right / left / both		right / left / both	
Pain radiates to:	buttocks thigh calf foot toes		shoulder arm forearm hand fingers		buttocks thigh calf foot toes	shoulder arm forearm hand fingers
Severity:	mild | mod. | severe		mild | mod. | severe		mild | mod. | severe	
(circle one number)	1 2 3 | 4 5 6 7 | 8 9 10		1 2 3 | 4 5 6 7 | 8 9 10		1 2 3 | 4 5 6 7 | 8 9 10	
Frequency:	occasional	frequent	occasional	frequent	occasional	frequent
(Circle only one)	intermitter	constant	intermitter	constant	intermitter	constant
Description	dull	burning	dull	burning	dull	burning
(circle 1 or more)	sharp	throbbing	sharp	throbbing	sharp	throbbing
	tingling	numbness	tingling	numbness	tingling	numbness
	other:		other:		other:	
Pain increased by:	bending	sit to stand	bending	sit to stand	bending	sit to stand
(circle all that apply)	lifting	turn head	lifting	turn head	lifting	turn head
	sitting	coughing	sitting	coughing	sitting	coughing
	standing	sneezing	standing	sneezing	standing	sneezing
	other:		other:		other:	
Pain decreased by:	aspirin	ice	aspirin	ice	aspirin	ice
(circle all that apply)	ibuprofen	heat	ibuprofen	heat	ibuprofen	heat
	Tylenol	exercise	Tylenol	exercise	Tylenol	exercise
	prescriptions	rest	prescriptions	rest	prescriptions	rest
	Other:		Other:		Other:	

How is this symptom / condition interfering with your life?
(Check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work Exercise	❑	❑	❑	❑	Energy	❑	❑	❑	❑
Recreation	❑	❑	❑	❑	Attitude	❑	❑	❑	❑
Relationships	❑	❑	❑	❑	Patience	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	Productivity	❑	❑	❑	❑
Self - Care	❑	❑	❑	❑	Creativity	❑	❑	❑	❑
					Other_____	❑	❑	❑	❑

If you did not have this issue, what would you do more of?_____

If you did nothing about it, what do you think would happen?_____

What else should we know about your condition?_____

Current Medications (Check all that apply)

❑ Blood Pressure ❑ Insulin ❑ Muscle Relaxer ❑ Nerve Pills ❑ Pain Meds

Other:_____

Health History: (Please check the box next to any condition you have or have had.)

❑ Circulation Issues	❑ AIDS/HIV	❑ Headaches/Migraines	❑ Scoliosis
❑ Depression	❑ Alcoholism	❑ Heart Disease	❑ Shoulder Issues
❑ Diabetes	❑ Anxiety	❑ Hip Issues	❑ Stroke
❑ Digestive Issues	❑ Asthma/Allergies	❑ Multiple Sclerosis	❑ TMJ Issues
❑ Elbow/Wrist/Hand Issues	❑ Back Pain	❑ Neck Pain	❑ Urinary Issues
❑ Endocrine Issues (Thyroid)	❑ Cardiovascular Issues	❑ Reproductive Issues	❑ Osteoporosis
❑ Foot/Ankle Issues	❑ Cancer	❑ Ringing In Ears	❑ Other _____

General (Check all that apply)

❑ Fainting ❑ Loss of Appetite ❑ Sudden Weight Gain ❑ Fatigue ❑ Loss of Sleep

❑ Weakness ❑ Sudden Weight Loss

Surgical History (check all that apply) ❑ Cancer ❑ Bypass ❑ Hernia ❑ Other:_____

Fractures Yes No If yes when? _____

Spinal Surgery Yes No If yes when? _____

Hospitalization Yes No If yes why? _____

How committed are you to achieving your maximum health potential?

(Circle one)

0 1 2 3 4 5 6 7 8 9 10

Not Interested Very Interested

How do you want us to handle your problem?

(Circle one)

Temporary Relief Max Correction

Please read the following carefully before signing.

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom and power. Our only method is a specific chiropractic adjustment to correct vertebral subluxations: which interfere with the body's wisdom and power. We believe that the greatest Doctor is the one already inside of each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.

Signature_____Date_____

Patient Health Information Consent Form

We want you to know your patient health information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you 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 more detailed account of our policies and procedures concerning the privacy of your personal health information we encourage you to read the HIPPA procedures that are in our front waiting area.

1. The patient understands and agrees to allow this chiropractic office to use their patient health information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As the example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) proved 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 agrees to allow this chiropractic office to use their image, likeness, and/or sound of their voice as recorded on audio or video tape, without payment or any other compensation from Stinnett Chiropractic, for educational, marketing, or social media publishing.
3. The patient has the right to examine and obtain a copy of his/her 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.
4. A patient's written consent need only be obtained one time for the subsequent care given to the patient by this office.
5. The patient may provide a written request to revoke consent. This request would not apply to care given prior to when the written request was presented.
6. For your security and right to privacy, all the staff has been trained in the area of patient records 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.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these procedures and policies.
8. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Full Name_____ Signature_____ Date_____

Witness Name_____ Signature_____ Date_____

For Insurance Recipients Only

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand Stinnett Chiropractic will file claims to my insurance carrier as a courtesy and will prepare any necessary reports and forms to assist in making collections from the insurance carrier. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Full Name_____ Signature_____ Date_____

Stinnett Chiropractic
224 Charles St, Humble, TX. 77338
281-446-4045

Assignment of Benefits, Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and coveys, to Stephen Stinnett, a lien and assignment of any and all claims, cause of action, and right to any proceeds and/or benefits, including and Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

Release Of Information: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purpose processing my claim for benefits and payment for service rendered to me.

Irrevocable Assignment Of Rights: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for the payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

Demand For Payment: To any insurance company benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code to cooperate, and Article 21.55 of Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Stinnett Chiropractic, and send to 224 Charles St, Humble, TX. 77338

Third Party Liability: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Stinnett Chiropractic, and to send any and all checks to: 224 Charles St. Humble, TX. 77338.

Statute Of Limitations: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney and any court cost incurred.

Limited Power Of Attorney: I hereby grant the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment form any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon requesting it in writing to the physician/facility named above.

Rejection In Writing: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not proof of rejection, and are invalid to establish rejection, and instruct my carrier to provided only copies of my original signature regarding rejection of PIP or UM/UIM.

Termination Of Care: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/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 this physician/facility immediately. I understand the failure to do so may jeopardize my case

Printed Name:_____

Signature:_____Date:_____