PERSONAL INFORMATION **DATE: _____**

Patient Name _____

Social Security # _____ Date of Birth ____/____/____ Age _____ ☐ Male ☐ Female Height:_____ Weight:_____

Address _____ Apt # _____ City _____ State _____ Zip:_____ Home # _____

Cell # _____ Email _____ Marital Status: _____

Emergency Contact_____ Emergency Relation _____ Emergency Phone: _____

Occupation_____ Employer _____

Family Physician _____

How did you hear about our office? ☐ Doctor Referral (Referring Physician Name) _____ ☐ Online Search/Google ☐ Insurance

☐ Social Media ☐ Family Member/Friend Referral ☐ Other:_____

INSURANCEINFORMATION

Please provide a copy of your insurance cards. If your plan requires a referral, please provide a copy.

Primary Insurance: _____ ID# _____ Group # _____

Secondary Insurance:_____ ID# _____ Group # _____

Claim# _____ Claim Contact: _____ Claim Phone#: _____

Attorney Name: _____ Attorney Phone# _____

COMPLAINT INFORMATION

Injury Occurred: ☐ Automobile ☐ Work ☐ Third Party ☐ Other: _____ Date of Onset/Injury Date:_____

Injury Origin:_____

Describe Discomfort: _____

Frequency: ☐ Always ☐ Hourly ☐ Daily ☐ Occasionally Interferes with Activities: ☐ Yes ☐ No Affected Sleep: ☐ Yes ☐ No

Missed Worked: ☐ Yes ☐ No Explain:_____ Reduced Work: ☐ Yes ☐ No Explain:_____

Aggravates Condition: _____

Improves Condition: _____

Received Treatment: ☐ Yes ☐ No Explain:_____ X-rays or diagnostic imaging taken? ☐ Yes ☐ No

Same Condition Before: ☐ Yes ☐ No Date: _____ Practitioner: _____

AUTHORIZATION

I hereby authorize the release of all my medical records to both Spring Physical Therapy and/or Spring Sport & Spine Medical Management where necessary or as required for the purposes of my examination and/or treatment.

I further authorize payment be made directly to Spring Physical Therapy and/or Spring Sport & Spine Medical Management, as an assignment of my benefits, for services rendered that would otherwise be payable to me.

I agree that in the event my outstanding bills are unpaid by a third-party source, I am responsible for payment of all services performed. I have read and understand the above statements and attest that the information I have provided is correct.

TREATMENT COMPLIANCE POLICY

The outcome of your treatment could be negatively affected by your inability or unwillingness to abide by and/or maintain the proposed course of treatment. Just as you expect our office to be considerate of your time, we ask for the same courtesy. If you are unable to make a scheduled appointment, please contact our office so that we may provide another patient with that time slot. Success with your treatment in our office is our primary concern and compliance with our treatment plan is essential.

The undersigned patient hereby acknowledges that he/she is seeking care and treatment from Spring Physical Therapy and/or Spring Sport & Spine Medical Management, and that the doctor(s) will rely on the patient for giving truthful statements regarding the facts and circumstances surrounding his/her illness and/or injury. Any untruthful statements can possibly lead to the rendering of an improper diagnosis and/or unnecessary treatment. I, the patient, therefore attest that the questions responded to above and throughout my paperwork are truthful and accurate.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Printed Name of Patient or Guardian _____

PATIENT HISTORY

Last Physical Exam: _____ PCP: _____ Phone#: _____

Health Conditions: _____

Previous Chiropractic Care: ☐ Yes ☐ No Date: _____ Explain: _____

Chance Pregnant: ☐ Yes ☐ No Planning: ☐ Yes ☐ No

Current Medications: _____

Supplements: _____

Broken Bones: ☐ Yes ☐ No Treatment: ☐ Yes ☐ No

Sprains/Strains: ☐ Yes ☐ No Treatment: ☐ Yes ☐ No

Hospitalized: ☐ Yes ☐ No Explain: _____

Surgery: ☐ Yes ☐ No Explain: _____

Auto Accident: ☐ Yes ☐ No Treatment: ☐ Yes ☐ No Explain: _____

Struck Unconscious: ☐ Yes ☐ No Treatment: ☐ Yes ☐ No Explain: _____

Eating Disorder: ☐ Yes ☐ No Explain: _____

Stroke: ☐ Yes ☐ No Explain: _____

Family Health History: _____

PATIENT SOCIAL

Alcohol:	☐ Daily	☐ Weekly	☐ Occasion	☐ Never	Caffeine:	☐ Daily	☐ Weekly	☐ Occasion	☐ Never
Diet Food Products:	☐ Daily	☐ Weekly	☐ Occasion	☐ Never	Drugs:	☐ Daily	☐ Weekly	☐ Occasion	☐ Never
OTC Stimulants:	☐ Daily	☐ Weekly	☐ Occasion	☐ Never	Exercise:	☐ Daily	☐ Weekly	☐ Occasion	☐ Never
Homemade Food:	☐ Daily	☐ Weekly	☐ Occasion	☐ Never	Processed Food:	☐ Daily	☐ Weekly	☐ Occasion	☐ Never
Soft Drinks:	☐ Daily	☐ Weekly	☐ Occasion	☐ Never	Tobacco:	☐ Daily	☐ Weekly	☐ Occasion	☐ Never
Water:	☐ Daily	☐ Weekly	☐ Occasion	☐ Never					

HEALTH CHECKLIST

☐ Allergies ☐ Alcoholism ☐ Anemia ☐ Arteriosclerosis ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Breast Lump

☐ Bronchitis ☐ Bruise Easily ☐ Cancer ☐ Chest Pain ☐ Cold Extremities ☐ Constipation ☐ Cramps ☐ Depression

☐ Diabetes ☐ Digestion Problems ☐ Dizziness ☐ Excessive Menstruation ☐ Eye Pain or Difficulties ☐ Fatigue

☐ Frequent Urination ☐ Headache ☐ Hemorrhoids ☐ High Blood Pressure ☐ Hot Flashes ☐ Irregular Heart Beat

☐ Irregular Menstrual Cycle ☐ Kidney Infection ☐ Kidney Stones ☐ Loss of Memory ☐ Loss of Balance ☐ Loss of Smell

☐ Loss of Taste ☐ Nosebleeds ☐ Pacemaker ☐ Polio ☐ Poor Posture ☐ Prostate Trouble ☐ Sciatica

☐ Shortness of Breath ☐ Sinus Infection ☐ Insomnia ☐ Spinal Curvatures ☐ Stroke ☐ Swelling of Ankles ☐ Swollen Joints

☐ Thyroid Condition ☐ Tuberculosis ☐ Ulcers ☐ Varicose Veins ☐ Venereal Disease

☐ Other: _____

Are you currently being treated or have you recently been treated by another physician for any of these symptoms? ☐ Yes ☐ No

If yes, who? _____

What is the nature of the treatment? _____

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Printed Name of Patient or Guardian _____

AUTHORIZATION FOR TELEPHONE CONTACT

I authorize the office of Spring Physical Therapy and/or Spring Sport & Spine Medical Management, to contact me at my home, cell, or any other alternate phone number that I have listed. ☐ Home ☐ Work ☐ Cell ☐ Other:_____

_____ (Initial) I authorize Spring Physical Therapy and/or Spring Sport & Spine Medical Management, to leave a voicemail on the above phone in reference to any items that assist the practice in carrying our Treatment, Payments and Healthcare Operations (TPO), such as appointment reminders, insurance items, and any other calls pertaining to my clinical care, including lab results among others.

AUTHORIZATION FOR U.S. MAIL AND EMAIL

_____ (Initial) I consent for Spring Physical Therapy and/or Spring Sport & Spine Medical Management to mail to my home or email any item is that assist the practice in carrying out TPO, such as appointment reminders, documentation to refer out for services, documentation requested by myself and patient statements. I understand that as with any Internet service, there is a risk sending information through email. All records are kept in our Electronic Medical Record.

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 multiple healthcare providers who may be Involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I agree to receive an electronic copy of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request In writing that you restrict how my private Information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, that you are bound to abide by such restrictions.

By acknowledging below I give my consent for Spring Physical Therapy and/or Spring Sport & Spine Medical Management to use and disclose my protected health information (PH) in the ways described in the Notification and to carry out treatment, payment, and healthcare operations (TPO).

_____ (Initial) I have read or been given the opportunity to read the Notification of Privacy Practices and agree as indicated above.

Due to the privacy laws mentioned above, we are unable to discuss your PHI (Including appointment information) with any family member without your expressed consent. If you would like us to be able to discuss any aspect of your PHI with a spouse, parent or other family member please list them below. For minor children we will follow any applicable state or federal laws regarding release of information.

I authorize Spring Physical Therapy and/or Spring Sport & Spine Medical Management and all of its healthcare providers to discuss issues regarding my visits, any lab or test results, my appointments or insurance with the following people and understand that this authorization will remain In effect until I notify the office in writing of any changes.

Name of Individual to release Information to: _____ Relation:_____

OR

_____ (Initial) I do not wish to designate anyone to have access to my information.

STATE-REQUIRED ETHNICITY AND RACE QUESTIONS

You may choose not to disclose. If you do choose **not** to identify your own race & ethnicity, our team will use their best judgment to make the identification for reporting purposes. The state uses this data to assist researchers in determining whether or not all citizens are receiving adequate health care.

ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Choose not to disclose

☐ Black ☐ White Choose note to disclose

RACE: ☐ American Indian/Eskimo/Aleut ☐ Asian or Pacific Islander

☐ Other (including all responses not listed above. Patients who consider themselves as multiracial or mixed should choose this category)

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Printed Name of Patient or Guardian _____

DISCLOSURE OF PHYSICIAN OWNERSHIP INTEREST NOTICE TO PATIENTS

Dear Patient, Please carefully review this notice.

In order to allow you to make a fully-informed decision about your healthcare, the physicians of Spring Physical Therapy and Spring Sport & Spine Medical Management would like to inform you that at some point during the course of your treatment, the providers may refer you to laboratories, diagnostic imaging centers, surgical centers or hospitals to perform diagnostic studies or surgical procedures. The practice wishes to advise you that some or all of the doctors of Spring Chiropractic & Rehab and Spine Sport & Spine have a direct ownership interest in:

Vision Park Premier Imaging	**Spring MRI**	**Spring Spine and Wellness**
111 Vision Park Blvd, Ste 130, Shenandoah, TX 77384	20639 Kuykendahl Rd, Ste 250, Spring, TX 77379	19510 Kuykendahl Rd, Spring, TX 77379

All of the practice's physicians will make referrals to laboratories, diagnostic imaging centers, surgical centers or hospitals, based upon the best interest of a patient's health and any other factors that a patient would like his or her physicians to consider, regardless of any ownership, interest or compensation arrangement that a physician may have with a particular laboratory or other facility.

You, as a patient, have the right to choose the provider of your healthcare services and the diagnostic facilities where you receive services or treatment.

If you have any questions concerning this notice, please feel free to ask your physician or any member of our staff. We welcome you as a patient and value our relationship with you.

By signing below, you acknowledge that you have read and fully understand this notice.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Printed Name of Patient or Guardian _____

ASSIGNMENT OF BENEFITS: ASSIGNMENT OF CAUSE OF ACTION: CONTRACTUAL LIEN

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered grants and conveys to:

SPRING PHYSICAL THERAPY – 19510 KUYKENDAHL RD, SUITE C, SPRING, TX 77379

AND/OR

SPRING SPORT & SPINE MEDICAL MANAGEMENT– 19510 KUYKENDAHL RD, SUITE A, SPRING, TX 77379

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 adjuster for purposes of processing my claim for benefits and payment of services 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 payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 22.55 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 providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 30 days allowing your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the 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 the above facility name and send all checks to the above address.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to cut a separate draft to pay in full all services rendered, payable directly to the above facility name and send any and all checks to the above address.

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 fees and court costs incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts or other negotiable instrument representing payment from any insurance company 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 request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/facility named above to establish a PIP or UM claim on my behalf. I also instruct my insurance carrier to provide upon request to the physician/facility named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. If my carrier is unable to provide said rejections in a timely manner, I acknowledge that I am entitled to minimum levels of coverage, as per section 1952.152 of the Texas Insurance Code, and further instruct my carrier to pay up to available limits directly to the physician/facility named above, and send any and all checks or financial instruments to, the address listed above.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as prescribed to me by my treating physician at this facility, 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 treatment, my insurance company requires me to take an examination from any other doctor; I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Printed Name of Patient or Guardian _____

Cancellation and No Show Policy

When a patient does not make it to a scheduled appointment, this is a time that another patient could have taken to receive the care they need. Please help us deliver the care our patients need as efficiently as possible. Read the following policies, and then sign and date at the bottom of the page.

Thank you for choosing Spring Chiropractic & Rehab and/or Spring Sport & Spine and /or Spine & Rehab Affiliates, to treat your needs.

CHIROPRACTIC & MASSAGE CANCELLATION and NO-SHOW POLICY:

Please be courteous and call our office promptly if you are unable to attend your appointment, we require that you give us at least 24-hour notice so that we have the opportunity to offer your appointment to another patient.

A "No-Show" is someone who misses an appointment without notice. We have voicemail which can receive messages 24 hours a day. No-Shows inconvenience patients that are in need of our services. A failure to cancel a scheduled appointment without 24-hour notice will be recorded in the patient's file and a cancellation fee of $35.00 will be charged. If you fail to be present for your scheduled appointment you will be charged a "No-Show" fee of $35.00. All fees will be due prior to seeing the doctor at future visits. Further multiple No-Shows may result in suspension of care with the practices.

LATE ARRIVALS

If you arrive late to your appointment, we will do our best to fit you into the schedule, however, it is likely there will be a wait, or we will need to reschedule your appointment for another time. If you are scheduled for a massage it is likely that your massage time will be decreased and or we will need to reschedule if it is not doable.

INAPPROPRIATE BEHAVIOR POLICY

Massage therapy is for relaxation and therapeutic purposes only. There is absolutely, no sexual component to massage whatsoever. Any insinuation, joke, gesture, conversation, or request otherwise will result in immediate termination of your session and a refusal of any and or all services in the future. You will be charged in full for service regardless of the length of your session. Depending on the behavior exhibited we may also file a report with the local authorities if necessary. Treat your therapist with respect and dignity and you will be treated the same in return.

I understand the terms of this form. I understand that these fees have nothing to do with my co-pay or deductible and in fact cannot be billed to my insurance company.

By signing below, you agree to abide by these policies.

_____ _____

Print Name Date

_____

Patient Signature

TO: PATIENTS OF Spring Physical Therapy and Spring Sport & Spine Medical Management

Spring Physical Therapy and Spring Sport & Spine Medical Management, specializes in the treatment of the spine and associated pain. We perform various treatments consisting of passive modalities, therapeutic interventions and spinal manipulation. The goal of our services is to reduce and/or eliminate your pain, however, with any chiropractic and/or physical medicine services there are risks associated with the services we provide.

As your healthcare provider, we feel that it is crucial that you understand these risks. By informing you of these risks, we are striving to more actively involve you in our care, as well as further assist you in making well informed decisions regarding your treatment options.

PASSIVE MODALITIES

Passive modalities consist of the following treatments: hot packs, cold packs, ultrasound, electrical stimulation, massage, traction and cold laser. The primary risks associated with passive modalities include skin irritation or electrical burns due to exposure to heat, cold or agents used in application or modalities (i.e. lotions and pads). If you have experienced skin sensitivity to heat, cold temperatures and/or lotions or similar products in the past, or are aware of any skin allergies, please inform our staff prior to treatment so proper precautions can be made prior to initiating treatment.

THERAPEUTIC INTERVENTIONS

Therapeutic interventions consist of the following types of treatments: stretching, flexibility exercises, strengthening exercises, joint mobilizations and myofascial release. Therapeutic interventions are generally quite safe, though there are risks associated with each of these procedures. The primary risk is potential aggravation of your current condition and/or underlying condition. As with any physical activity and/or exercise, there is also the risk of injury. Though this risk is minimal, as you are under the direct supervision of experienced clinical staff, it may still exist. Some responses to therapeutic interventions are muscle soreness, muscle fatigue, increased discomfort, overall tiredness and/or joint stiffness and/or pain. It is important that you inform your treating staff member of any of these responses following your treatment and more importantly, it is crucial that you continue to attend your appointments as scheduled so your condition can be documented and your symptoms effectively managed.

SPINAL MANIPULATION

Spinal Manipulation consists of adjustments that seek to restore normal function to the spine and other joints. Typically, this involves applying a specific, highly controlled treatment directly to a joint or muscle. This treatment often reduces or eliminates both local and referred pain, allows muscle spasms to relax and may even release the irritation from the nervous system, which may result in other health benefits. As with any healthcare service, there are potential reactions and risks, however as with any healthcare intervention, it is hoped that the expected benefits of spinal manipulation exceed the expected risks. These are unavoidable risks of spinal manipulation which, though rare, can occur.

DISK HERNIATION

The occurrence of disk herniation during spinal manipulation is highly unlikely. In fact, averaged disks withstand an average of 23 degrees or rotation and degenerated disks an average of 14 degrees of rotation before failure occurs. Furthermore, given the fact that during manipulation posterior facet joints limit rotation to a maximum of 23 degrees, this joint would have to fracture to allow any further rotation to occur.

CAUDA EQUINA SYNDROME

It is estimated that the rate of occurrence of the Cauda Equina Syndrome as a complication of lumbar spinal manipulation is about one case per 100 million manipulations. It Is probably higher in patients with a herniated nucleus pulposus and lower in patients without this anatomic abnormality.

VERTEBROBASILAR ARTERY COMPROMISE

Serious complications of cervical spine manipulation are also rare (none have been reported in any of the clinical trials), but appear to be more common and severe than complication of lumbar manipulation. The most serious complication of the cervical spine manipulation is related to compromise of the vertebrobasilar artery, leading to stroke or death. The risk Is higher for manipulation involving rotation plus extension of the vertical spine than for other types of manipulation and those persons who have suffered manipulation related vertebrobasilar artery compromise due to atherosclerotic disease. The best estimate of the incidence of vertebrobasilar artery compromise related to cervical spine manipulation is that it occurs one in a million manipulations (Hurwitz, 1996; McGregor, 1955).

PATIENT UNDERSTANDING AND ACCEPTANCE OF RISKS ASSOCIATED WITHTREATMENT

As your doctor, it is our responsibility to inform you of the potential risks and benefits of your treatment, but we also want to assure you that we strive to minimize these risks by providing thorough clinical examination and by performing diagnostics as clinically indicated. Furthermore, we continually review medical literature pertaining to current trends within our profession as well as throughout the entire medical community to ensure the safest and most effective care.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Printed Name of Patient or Guardian _____