WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services 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 determining insurance benefits or the benefits payable for related services. This 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

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

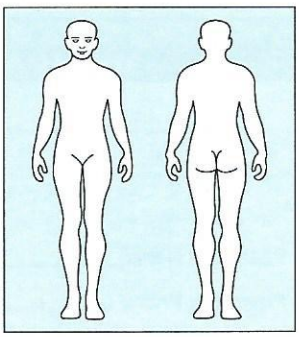
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray _____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other _____		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE

☐ None

☐ Moderate

☐ Daily

☐ Heavy

WORK ACTIVITY

☐ Sitting

☐ Standing

☐ Light Labor

☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____

☐ Alcohol Drinks/Week _____

☐ Coffee/Caffeine Drinks Cups/Day _____

☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name_____		
Pharmacy Phone (____) _____		

INFORMED CONSENT

Patient Name_____

Shine Chiropractic

And/or Dr. Dori Bonitatibus, DC

1422 W. Main Street, Suite 205, Lewisville, TX 75067

972-221-2225

We will be using our hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as “Spinal Manipulation” or “Spinal Adjustment” . As the joints in your spine are moved with a manual adjustment, you may experience a “pop” as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner’s syndrome also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

We are aware of these complications, and in order to minimize their occurrence we will be taking precautions. These precautions include, but are not limited to taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell us when we take your clinical history.

Date_____

_____

Printed Name

_____

Signature

_____

Signature of Parent or Guardian (if a minor)

Patient Acknowledgement and Notice of Privacy Practices

Pursuant to HIPAA and Consent for Use of Health Information

Printed Patient's Name_____

The undersigned does hereby acknowledge that he or she understands this office abides by Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

I hereby give permission to _____, to access or obtain a copy of my medical records or medical bills, if needed. This release of information will remain in effect until terminated by me in writing.

Please Contact me at: ___Home ___Work ___Cell ___Any

If unable to reach me please:

____Leave a detailed message ___leave a message asking for a call back

__Do not leave a message

_____(Initial) I authorize Shine Chiropractic to send me information via email

Dated this_____day of _____, 20_____

by _____

Patient's signature

If patient is a minor or under a guardianship order as defined by State law:

By_____

Signature of Parent/Guardian (circle one)

Shine Chiropractic, PLLC

Financial Agreement

We are honored that you have chosen us for your healthcare needs. This document serves to clarify the financial aspects of your care so we can direct all our attention to balancing your body. Outlined below is our Financial Agreement.

Third Parties:

If you have health insurance or were in an automobile accident, you may have other options. We expect payment of deductibles, co-payments and co-insurance at the time of each visit, or at the end of the week when multiple visits per week are occurring.

We will supply you with information regarding deductibles, co-payments, covered charges, secondary insurance and usual and customary charges, but keep in mind that your carrier will state that stated benefits are not a guarantee of payment. The patient is responsible for obtaining all required referrals for service. You are responsible for all non-covered services. You are responsible for updating your health insurance information with our office. Our office is restricted to a "timely filing period". Any claim unpaid because you did not supply the office with health information in a timely fashion is your responsibility. The office will do its best to inform you of any service that may or may not be covered. However, benefits are not determined by an insurance carrier until after the claim is submitted; therefore, there is no guarantee of payment by your carrier. As a courtesy to you, we will gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and, ultimately you are personally responsible for payment of 100% of these charges regardless of any insurance reimbursement or settlement you may or may not receive. Appointments are scheduled to give optimal time and individual attention. If you need to reschedule an appointment, please give 24 hours notice. If you do not, you will impact another patient's ability to be seen during that time and may be charged at $25 missed appointment fee.

Outstanding balances are billed monthly and considered past due 30 days after the invoice date. Balances older than 90 days will accrue interest charges of 1.5% per month plus any legal or collection fees or if a credit card is required to secure care you will be notified that the credit card will be billed. Accounts may be turned over to collections after notification. Returned checks are subject to a $25 fee.

_____ (initial) I authorize Shine Chiropractic, PLLC to charge my balance directly to my credit card on file. Since the payment amount may vary, I will be notified in person or by phone to inform me of the amount being charged. The authorization is valid until the patient provides Shine Chiropractic, PLLC with a written cancellation.

Patient acknowledgement:

I have read and understood this agreement.

Signature of Patient/Responsible Party Date