Taylor Family chiropractic™

8501 Wade Blvd Suite 240 | Frisco, TX 75034
Office (214) 387-7883 | Fax (214) 975-1122
info@drmarktaylor.com

TAYLOR FAMILY CHIROPRACTIC OFFICE POLICIES

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information (PHI) will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you, and created / received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent: You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, _____(print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my Personal Health Information (PHI) in accordance with the Privacy Practices.

I, _____(print) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier or other healthcare professionals. I do understand that PHI will be used **within** the office for purposes of my care, to those individuals designated by the doctor.

Assignment of Benefits

Our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. In the event that your insurance company does not pay in a timely manner, you may be asked to contact your insurance carrier. **If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.**

Assignment of Rights and Conveyance of Lien Interest

I hereby execute and provide Irrevocable Lien Interest and Assignment of Proceeds 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 for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed 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 to assist in the prosecution of such claims for benefits upon request.

Policies Continued

To any insurance company providing benefits or settlement of a claim, you are instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds to pay the total dollar amount of all sums which I owe on account to the above named doctor and treating facility within 30 days following your receipt of medical bills submitted by the doctor and/or treating facility. **I instruct checks to be made payable to Taylor Family Chiropractic, P.A. and payment to be sent to 8501 Wade Blvd. Suite 240 Frisco, TX 75034.** 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. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account and remit payment of all such sums directly to the above named doctor and/or treating facility upon receipt of my settlement award(s).

Informed Consent for Treatment

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

Consent for Treatment of a Minor

I hereby authorize Dr. Mark W. Taylor and whomever he may designate as assistants to administer therapy, examinations and chiropractic care as deemed necessary for: _____ (MINOR)

Authorization for X-Ray with Release

I understand, to the best of my knowledge, that there is no chance that I am pregnant or that I have no known limitations that would be contraindicated for an x-ray evaluation. By signing below, you consent to the taking of x-rays if there is a determined need.

Payment

I understand that it is usual and customary to pay in full for services rendered unless otherwise arranged. ***It is my responsibility to notify the office if I am unable to do so before being treated.***

Acknowledgement of Treatment Plan

By signing below, I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, supportive therapies, and corresponding procedures.

Completion of Care

I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he has complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I understand that failure to complete my recommended treatment plan may jeopardize my case.

Office Communications

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with reminders/information and understand that:

I may be contacted by: phone (home/work/cell), text message, e-mail, or postcard.

Messages may be left: on answering machine/voicemail at home, work, and on mobile phone. Or with individuals answering my phone at home, or work.

Family Medical Leave Act (FMLA) Policy and/or Veterans Affairs (VA) Paperwork

FMLA and/or VA paperwork is available to current patients (patients treated within the last 30 days in order to correctly diagnose and certify paperwork). There is a $50.00 fee per certification due at the time of the FMLA or VA paperwork request.

I hereby acknowledge that I have read and fully understand each of the policies listed above.

Patient or Parent Signature: X_____ Date: _____

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INTRODUCTION PATIENT CASE HISTORY

Date: _____

PATIENT INFORMATION

Name: *(First MI Last)* _____ **Preferred Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home: _____ **Mobile:** _____ **Mobile Carrier:** _____ **Work:** _____

Email: _____ **Gender:** M / F **Marital Status:** Single / Married / Other

Social Security #: _____ **Date of Birth:** _____

Student Status: Full Student / Part Student / Non-Student **Employed:** Y / N

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline **Preferred Language:** English / Decline / Other: _____

Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline

***Referred By:** *(Name):*_____ Family / Friend / Co-Worker / Doctor / Other Source

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* _____ **Primary Care Physician:** _____

Home: _____ **Mobile:** _____ **Doctor's Phone:** _____

Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION

❒ Insurance ❒ Worker's Comp ❒ Self-Pay (Cash) ❒ Personal Injury/Auto ❒ Other (please explain):_____

PRIMARY INSURANCE

Insurance Name:_____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name:_____ **Gender: M / F**

Address: _____

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

Phone: _____ **Date of Birth:** _____

SECONDARY INSURANCE

Insurance Name:_____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name:_____ **Gender: M / F**

Address: _____

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

Phone: _____ **Date of Birth:** _____

RESPONSIBLE PARTY

Who is responsible for payment? Self / Other - *(Relationship)* _____

Other than Self:

Name: *(First MI Last)* _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient No: _____

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Describe any Secondary Complaints: _____

Describe WHEN and HOW this began: _____

_____

Grade Intensity/Severity of Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)* _____

Head - Base of Skull / Forehead / Sides-Temple **R / L / Both** **Leg -** Hip / Thigh-Knee / Calf / Foot-Toes **R / L / Both**

Arm – Across Shoulder / Elbow / Hand-Fingers **R / L / Both** **Other Area:** _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition? *(Describe)* _____

For this CURRENT condition, have you:

- Received any other treatment? None / DC / MD / PT / Massage / ER / Other:_____Where? _____
- Had any diagnostic testing? X-rays / MRI / CT / Other:_____ When and Where? _____

HEALTH HISTORY (Please use the back side of this page if additional space is needed.)

Medications and Supplements:

Allergies to Medications: *NONE*

NAME	REACTION

Current Medications & Supplements: *NONE*

NAME	DOSAGE	FREQUENCY	METHOD

Past Health History *(Please list any past...)*

Number of Falls in the last 24 months: ____ Injuries? Y or N

Surgeries *NONE*

DATE	AREA OF THE BODY	REASON

Major Injuries / Traumas / Hospitalizations: *NONE*

DATE	DESCRIBE

Family Health History:

List relevant major health problems of First degree relatives:

PROBLEM	PARENT (M or F)	SIBLING (B or S)	CHILD (S or D)

Social and Occupational History:

Smoking/Tobacco Use: Every Day / Some Days / Former / Never

HABIT	TYPE	AMOUNT	YEAR STARTED
Smoking			
Tobacco			
Alcohol			
Caffeine			
Rec. Drugs			

Education: High School / College Grad. / Post Grad. / Other

LIFESTYLE	DESCRIBE
Hobbies	
Recreation	
Exercise	
Diet	
Work	
Other	

Patient No: _____

HISTORY OF CURRENT CONDITION

Are you ***currently*** experiencing any of these symptoms? (Check all that apply)
Many of the following conditions respond to Chiropractic and Accupuncture treatment.

General: *(constitutional)*
- ❑ Recent Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ None in this Category

Musculoskeletal:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems
- ❑ Leg Problems
- ❑ Painful Joints
- ❑ Stiff/Swollen Joints
- ❑ Sore/Weak Muscles or Joints
- ❑ Muscle Spasms/Cramps
- ❑ Broken Bones
- ❑ Other: _____
- ❑ *None in this Category*

Neurological:
- ❑ Numbness or tingling sensations
- ❑ Loss of Feeling
- ❑ Dizziness or light headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or seizures
- ❑ Tremors
- ❑ Stroke
- ❑ Other: _____
- ❑ *None in this Category*

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ Other: _____
- ❑ *None in this Category*

Genitourinary:
- ❑ Sexual Difficulty
- ❑ Kidney Stones
- ❑ Burning/Painful Urination
- ❑ Change in force/strain w/ Urination
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Incontinence or Bed Wetting
- ❑ Other: _____
- ❑ *None in this Category*

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Blood in Stool
- ❑ Change in Bowel Movements
- ❑ Painful Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Frequent Diarrhea
- ❑ Constipation
- ❑ Other: _____
- ❑ *None in this Category*

Cardiovascular & Heart:
- ❑ Chest Pains
- ❑ Rapid or Heartbeat changes
- ❑ Blood Pressure Problems
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ Heart Problems
- ❑ Other: _____
- ❑ *None in this Category*

Respiratory:
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Lung Problems
- ❑ Other: _____
- ❑ *None in this Category*

Eyes and Vision:
- ❑ Wear contacts/glasses
- ❑ Blurred or double vision
- ❑ Glaucoma
- ❑ Other: _____
- ❑ *None in this Category*

Ears, Nose and Throat:
- ❑ Bleeding gums / mouth sores
- ❑ Bad Breath or bad taste
- ❑ Dental Problems
- ❑ Swollen throat or voice change
- ❑ Swollen glands in neck
- ❑ Ringing in the ears
- ❑ Ear - Ache/Ringing/Drainage
- ❑ Sinus / Allergy problems
- ❑ Nose Bleeds
- ❑ Hearing Loss
- ❑ Other: _____
- ❑ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Excessive Thirst or Urination
- ❑ Cold Extremities
- ❑ Heat or Cold intolerance
- ❑ Change in hat or glove size
- ❑ Dry skin
- ❑ Glandular or hormone problem
- ❑ Swollen Glands
- ❑ Anemia
- ❑ Easily Bruise or Bleed
- ❑ Phlebitis
- ❑ Transfusion
- ❑ Immune system disorder
- ❑ Other: _____
- ❑ *None in this Category*

Skin and Breasts:
- ❑ Rash or Itching
- ❑ Change in Skin Color
- ❑ Change in hair or nails
- ❑ Non-healing sores
- ❑ Change of appearance of a mole
- ❑ Breast Pain
- ❑ Breast Lump
- ❑ Breast Discharge
- ❑ Other: _____
- ❑ *None in this Category*

Women Only:
Are you pregnant?
Yes - Due Date ____/____/____
No - Last Menstrual Period
____/____/____
- ❑ Infertility
- ❑ Painful or Irregular periods
- ❑ Vaginal Discharge
- ❑ Other: _____
- ❑ *None in this Category*

Pregnancies:

Date	Outcome
_____	_____
_____	_____
_____	_____
_____	_____

Comments: _____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____

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FUNCTIONAL RATING INDEX

In order to properly assess your condition, we must understand how much your symptoms have affected have your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Severely Disturbed Sleep	Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No Pain No Restrictions	Mild Pain No Restrictions	Moderate Pain Need to go slowly	Moderate Pain Need assistance	Severe Pain Need 100% Assistance

4. Travel (driving, etc.)

0	1	2	3	4
No Pain on long trips	Mild Pain on long trips	Moderate Pain on long trips	Moderate Pain on short trips	Severe Pain on short trips

5. Work

0	1	2	3	4
Can do usual work Plus extra work	Can do usual work No extra work	Can do 50% of Usual work	Can do 25% of Usual work	Cannot Work

6. Recreation

0	1	2	3	4
Can do All Activities	Can do Most Activities	Can do Some Activities	Can do Few Activities	Cannot do Any Activites

7. Frequency of Pain

0	1	2	3	4
No Pain	Occasional Pain 25% of day	Intermittent Pain 50% of day	Frequent Pain 75% of day	Constant Pain 100% of day

8. Lifting

0	1	2	3	4
No Pain with heavy weight	Increased Pain with heavy weight	Increased Pain with moderate weight	Increased Pain with light weight	Increased Pain with any weight

9. Walking

0	1	2	3	4
No Pain Any Distance	Increased Pain After 1 mile	Increased Pain After ½ mile	Increased Pain After ¼ mile	Increased pain With All Walking

10. Standing

0	1	2	3	4
No Pain After several hours	Increased Pain After several hours	Increased Pain After 1 hour	Increased Pain After ½ hour	Increased pain With Any Standing

Patient Signature _____ Date _____

Print Name _____

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ACCIDENT/INJURY QUESTIONNAIRE

Name (Last, First MI): _____ Today's Date: _____

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

Was anyone else in the vehicle with you? ❑ No ❑ Yes – (Number of people) : _____

You were? ❑ Front seat – Driver / Passenger

❑ Rear Seat– Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row

Name of Driver, if not self: _____

Name of Driver of other vehicle: _____

Did airbags deploy? ❑ No ❑ Yes Did Police arrive? ❑ No ❑ Yes Using Seatbelt? ❑ No ❑ Yes

Did you strike the windshield or object in car? ❑ No ❑ Yes – (Describe) _____

Were you knocked unconscious? ❑ No ❑ Yes (How long?)_____

Where was your vehicle impacted? ❑ Front ❑ Rear ❑ Passenger Side ❑ Driver's Side ❑ Other: _____

Where was the other vehicle impacted? ❑ Front ❑ Rear ❑ Passenger Side ❑ Driver's Side ❑ Other:_____

Your Auto Ins:_____ Policy #:_____

Claim #:_____ Phone #: _____

Address: _____City:_____State:_____Zip:_____

Other's Auto Ins:_____ Policy #:_____

Claim #:_____ Phone #: _____

Address: _____City:_____State:_____Zip:_____

GENERAL ACCIDENT/INJURY INFORMATION – *(Please use the reverse side of this page if additional space is needed)*

Date of Accident: _____/_____/_____ Time: _____:_____ AM / PM

Please describe the accident in as much detail as possible: _____

_____

_____

_____

BEFORE THE ACCIDENT/INJURY:

Have you ever had any complaints in the involved area before? ❑ No ❑ Yes

If yes - Were they present at the time of the accident/injury? ❑ No ❑ Yes

If yes - Summarize these complaints prior to the accident: _____

Were you capable of performing all of your work activities without restriction? ❑ No ❑ Yes

AT THE TIME OF THE ACCIDENT/INJURY:

Did you feel pain immediately after the accident? ❑ No ❑ Yes ❑ Later that day ❑ Next day ❑ When?

Were you taken anywhere after the accident? ❑ No ❑ Yes ❑ Later that day ❑ Next day ❑ When?

If yes, How? _____ Where? _____

If yes, Did you receive treatment? ❑ No ❑ Yes – (Describe) _____

SINCE THE ACCIDENT/INJURY: Are your symptoms: ❑ Improving? ❑ Getting Worse? ❑ The Same?

Are your work activities restricted as a result of this accident/injury? ❑ No ❑ Yes

If yes, How? _____

Have you missed any work since this accident? ❑ No ❑ Yes – (Dates?): _____

Have you retained an Attorney? ❑ No ❑ Yes - Name: _____ Phone: _____

Address: _____City:_____State:_____

PATIENT NUMBER: _____