BACK & BODY CHIROPRACTIC
Matthew W. Gilbert, DC, CCCN
487 Crockett Drive Lewisville, Texas 75057
www.backnbodychiropractic.com
p: (972) 436-9785 f: (972) 436-6068
info@backnbodychiropractic.com

CASE HISTORY & PATIENT INFORMATION

Date:_____

Name:_____SS#_____Age:_____Birth Date:_____

Address:_____APT#_____City:_____State:___Zip:_____

E-mail address:_____Contact Number:_____( ) Cell ( ) Home

Race:_____Ethnicity:_____ Marital: M S W D Who do you live with?_____

Occupation:_____ Employer:_____

Spouse:_____ SS#:_____ Employer:_____

Names and Ages of Children:_____

Emergency Contact Name:_____Contact Number:_____

How were you referred to our office?_____ Have you been treated by a Chiropractor before? Y N

If yes, please give details:_____

Family Medical Doctor:_____When doctors work together it benefits you.

May we have your permission to update your medical doctor regarding your care at this office?_____

HISTORY OF PRESENT ILLNESS:

Major symptom(s) or purpose of this appointment and date it appeared:_____

Please circle a frequency of pain: Constant Frequent Intermittent Occasionally

Please circle the number to indicate the severity of pain: (no symptom) 0 1 2 3 4 5 6 7 8 9 10 (extreme symptoms)

Please circle one or more descriptions of pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other_____

Have you ever had the same or a similar condition? If yes, when and describe:_____

_____

If this is a recurrence, when was the first time you noticed the problem and how did it originally occur?_____

_____

What does this prevent you from doing or enjoying?_____

What makes the problem worse?_____

What helps relieve the pain?_____

Are there other current conditions that may be related to your major symptom?_____

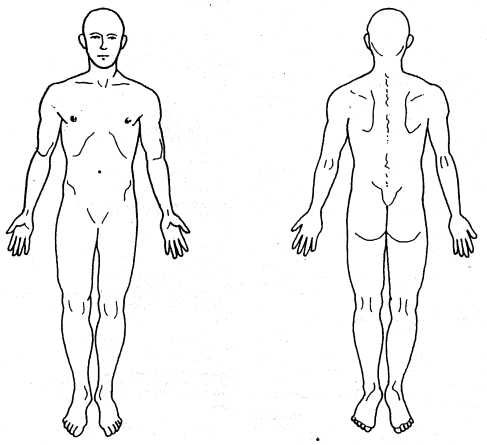
Days lost from work:_____ Date of last physical examination:_____

TELL US WHERE YOU HURT

Please read carefully: *Mark the areas on your body where you feel your problem. Include all affected areas. If your symptoms radiate, draw an arrow from where they start to where they stop. Please extend the arrow as far as the problem travels. Use the appropriate symbol(s) listed below.*

FOR OFFICE USE ONLY				
BP		O^2		
H/W		BMI		
P		%		

Ache > > > >
Numbness = = = =
Pins & Needles oooo
Burning xxxx
Stabbing ////
Throbbing ~ ~ ~ ~



AUTO ACCIDENT INFORMATION

Insurance company:_____Insurance adjustor:_____

Policy number:_____ Claim number:_____

Amount of PIP:_____ Have any charges been filed against your PIP? Y N If yes, how much?_____

Were you the driver of the vehicle in which you were injured? Y N If no, who was the driver of the vehicle?_____

If yes, please give us the other driver's: Insurance company:_____

Adjustor's name_____Policy number:_____Claim number:_____

Have you retained an attorney? Y N If yes, please provide their name and address:_____

_____

Please explain in detail how your accident happened (please include the date and time of the accident):_____

_____

_____

What way was your vehicle heading?_____ on what road?_____

What way was the other vehicle heading?_____ on what road?_____

Where was your vehicle struck?_____ What seat were you in?_____

Were you using a seatbelt? Y N Were the police notified? Y N Were you knocked unconscious? Y N

Where did you feel pain immediately after the accident?_____

Were you taken anywhere after the accident? Y N If yes, where were you taken?_____

Was a doctor consulted? Y N If yes, what is the name of the doctor?_____

What was the diagnosis?_____ What treatment was given?_____

Are your work activities restricted as a result of this accident? Y N

If yes, how are they restricted_____

Were you capable of working on an equal basis with others your age before the accident? Y N

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (**P** for past and **C** for current)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder	__Excessive Bleeding
__Circulatory Problems	__Epilepsy	__Alcoholism	__Ruptures
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction	__Hepatitis
__Seizures/Convulsions	__Strokes	__HIV Positive	__Ulcers
__A Congenital Disease	__Diabetes	__High Blood Pressure	__Low Blood Pressure
__Cancer	__Gall Bladder	__Depression	__Constipation/Diarrhea

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe:_____

What medications or nutritional supplements are you currently taking?_____

_____

_____

Do you have any medicinal, environmental, or food allergies? Yes No

If yes, describe:_____

Please list any other health problems you have, no matter how insignificant they may be:_____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?_____ If so, how much per week?_____

Do you use any tobacco products?_____ Are you a current or former smoker? _____ If current, packs per day: _____

Do you use any recreational drugs?_____ If so, please list:_____

Do you consume caffeine?_____ If so, how much per day:_____

Do you exercise?_____ If yes, what is the frequency and type of exercise?_____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes No Uncertain

What are your hobbies?_____

What percentage of time during the day (at home or at your job away from home) do you spend:

lifting_____ sitting_____ bending_____working at a computer_____

FAMILY HISTORY:

FAMILY DISEASES (indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

____Tuberculosis	____Cancer	____Mental Illness
____Diabetes	____Heart Disease	____Liver Disease
____Stroke	____Kidney Disease	____Lung Disease
____Arthritis	____Liver Disease	

Other _____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

BACK & BODY CHIROPRACTIC

ASSIGNMENT AND INSTRUCTIONS FOR DIRECT PAYMENT TO DOCTOR

Patient Name: _____

Address:_____

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

Insurance Co.:_____**Employer:**_____

Claim or Group #:_____**SS# or ID#:**_____

I hereby instruct the above named Insurance Company to pay by check made payable and mailed directly to:

Matthew W. Gilbert, D.C.
Back and Body Chiropractic
487 Crockett Dr.
Lewisville, TX 75057

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to me and mail it as follows:

Matthew W. Gilbert, D.C.
Back and Body Chiropractic
487 Crockett Dr.
Lewisville, TX 75057

for professional or medical and expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I fully acknowledge that Dr. Gilbert will not "cut" nor negotiate my bill neither at my request nor the request of any person speaking on my behalf.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance. **I specifically authorize the insurance company through which I have PIP coverage to divulge the amount of my PIP coverage to Dr. Gilbert and/or his staff.**

I further authorize Matthew W. Gilbert, D.C. and/or Back & Body Chiropractic, its authorized agents and employees to endorse any and all check, drafts, or money orders which are made payable to the undersigned alone or to the undersigned and the said offices of Back & Body Chiropractic, which checks, drafts or money orders are issued as payment for chiropractic services or the like which have been performed by the office of Back & Body Chiropractic at the request or within the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

This is my PIP insurance (Personal Injury Protection through my auto insurance)? ☐YES ☐NO
This is my only medical insurance? ☐YES ☐NO
This is my primary insurance but I also have a secondary insurance? ☐YES ☐NO
Name of Secondary Insurance?_____

Dated at_____**County, this** _____**day of** _____**, 20**_____

_____ _____
Signature of Policy Holder **Witness**

_____
Signature of Claimant, if other than Policyholder

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OFFICE POLICY

Welcome to Back & Body Chiropractic Center. We appreciate the confidence you have shown by allowing us to be involved with your healthcare. It is our goal to do everything possible to make your care here as trouble-free as possible.

Because everyone prefers to "know the rules" in the beginning, we have attempted to set forth guidelines in regard to payment procedures. If you have questions **at any time** in regard to your account, please do not hesitate to ask.

1. **Payment in full is required** at the time services are rendered unless other arrangements are made.

2. There is a **$25.00 returned check fee**.

3. Copies of **medical records require an advanced notice of 3-5 business days** and **pre-payment of $30.00 minimum**. **Note**: These are usually requested by the insurance company and/or attorneys, and they are usually the ones to pay for these services.

   Additional forms required from your insurance company (i.e. disability reports, questionnaires, etc.) will be charged as follows:
   1st form: Free
   Any additional forms: Up to $30.00 per form. Pre- payment is required.

   In regard to the completion of additional forms and requests for medical records by other entities not directly related to the coordination of care or the reimbursement for services rendered by this office:
   1st form: Free
   Any additional forms: Up to $30.00 per form. Pre- payment is required.

4. **No refunds on credit balances are issued until all treatments are completed**, and the patient has been released from care unless other arrangements are made with the back office.

5. Any change in address, phone numbers, employment, and/or insurance needs to be given to the front desk so that our records may be kept current. It is the **patient's responsibility to notify us of any changes**, and the patient agrees to be responsible for any balances that may be incurred due to these changes.

PATIENT TYPE

CASH:

Patients who do not have insurance coverage or who cannot provide us with complete insurance information will be considered cash patients. Payment is expected in full every visit, unless prior arrangements are made.

INSURANCE:

All patients having insurance coverage will be expected to pay their co-payment every visit. Payment for any item or deductible that insurance does not cover will also be expected at that time. Please remember that the insurance contract is between the insured and his/her insurance company. If payment has not been received from the insurance company within **60 days**, the patient will be responsible for the unpaid balance and will be given any necessary paperwork for him/her to obtain reimbursement from the insurance company.

PERSONAL INJURY:

Personal injury cases are handled in the following manner.

- We will file claims to the patient's PIP auto insurance.
- Once the PIP benefits have been exhausted, we will file claims to the patient's major medical insurance. or
- The patient will pay cash and seek any reimbursement available from the insurance company/companies.

WORKMAN'S COMPENSATION:

Effective March 01, 2005, we no longer accept Worker's Compensation cases. If you feel your injury may be work-related in any way, please let us know so that we may refer accordingly.

MEDICARE:

We accept Medicare assignment and are a participating provider. Government policy requires **all offices to file claims** for any services rendered to a Medicare patient. The services covered by Medicare and the supplementary insurance benefits vary. Our insurance department will be happy to verify coverage and discuss specific information.

ALL FINANCIAL ARRANGEMENTS MUST BE MADE THROUGH THE BILLING OFFICE

I understand, agree and acknowledge that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. **I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment**. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable.

Some insurance companies have recently begun to determine that some charges (including manipulations) are not "medically necessary". They have done this in spite of the fact that benefits were correctly verified and even after payment has been issued on these same services for prior dates of service. Therefore, we have found it necessary to add the following statement to our Office Policy. Please be aware that should this happen, you will be charged the current cash patient rate for these charges, and we will work with you any way that we can.

"Should my insurance company determine that any treatment I receive at this office is not medically necessary or not covered by my policy and states in writing that the member is not responsible for this charge unless they agreed to be responsible for the charge in writing before the service or supply was given, I hereby agree to be financially responsible for those charges."

I do understand that the above referenced office will release my Protected Health Information to insurance carriers and other health care providers for the purpose of treatment, payment and/or health care operations. This document shall act as my written authorization for this act of disclosure of my Protected Health Information. Without written authorization, information may be disclosed according to Texas Law that overrides HIPPA rules regarding: child abuse, neglect, domestic violence, or other accidents under Texas law, workers compensation cases, or an emergency.

I further authorize Matthew W. Gilbert, D.C. and/or Back & Body Chiropractic, its authorized agents and employees to endorse any and all checks, drafts, or money orders which are made payable to the undersigned alone or to the undersigned and the said office of Back & Body Chiropractic, which checks, drafts or money orders are issued to pay for chiropractic services or the like which have been performed by the office of Back & Body Chiropractic at the request or within the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Please sign and date below acknowledging that you have read, understand, and agree with the policies stated above.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Rev 10/8/12

BACK & BODY
CHIROPRACTIC

INFORMED CONSENT
DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC
It is important to acknowledge the difference between the healthcare specialties of chiropractic, osteopathy, and medicine. Chiropractic healthcare seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic healthcare services.

ANALYSIS
A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. ***Due to the complexities of nature, no doctor can promise you specific results***. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS
Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS, and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his own symptoms and should secure other opinions if he has any concern as to the nature of his total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
In coming to the doctor of chiropractic, a patient gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or healthcare if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through healthcare procedures the condition from which he is suffering: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regime.

PREGNANCY WAIVER
In the event that X-Rays are needed, I hereby acknowledge that Dr. Matthew W. Gilbert, of Back & Body Chiropractic has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own violation that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

RESULTS
The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions that do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answer to all problems. Both have made great strides in alleviating pain and controlling disease.

I have read and understand the foregoing. I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in my case. I further authorize him to disclose all or any part of my patient records to any person or corporation which is or may be liable under a contract to the office, the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

_____ _____

SIGNATURE DATE

Rev 10/8/12

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Patient Health Information Consent Form

We want you to know how 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 to 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 a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

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 an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided 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 has the right to examine and obtain a copy of his or her own health 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.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record 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.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician 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.

Signature Date

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