Lordex Spine Institute

212 Gulf Fwy. South, Suite G1, League City, TX 77573

Name_____❑Male ❑Female ❑Married ❑Single ❑Divorced Today's Date____/____/_____

Address_____ City _____ State_____ Zip_____

Home Phone: _____ Cell Phone_____[Carrier □AT&T □Verizon □Sprint □T-Mobile □_____]

D.O.B_____ SSN#_____ Referred by_____

Occupation_____Employer_____Work Phone:_____

E-mail _____ Driver's License # _____State_____

Have you ever received Chiropractic Care? ❑Yes ❑ No If yes, how long ago?_____

Have you sustained injuries from a motor vehicle accident? ❑Yes ❑No Date of Accident? _____/_____/_____

1. Chief Complaint: _____

Location of Complaint: _____

Complaint began when and how? _____

Please circle the quality of the complaint/pain**:**

dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____

Do you have any numbness or tingling in your body? Where? _____

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Have you ever had the same or a similar condition? ❑Yes ❑No If yes, when and describe:_____

_____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

_____

3. Past Health History:

A. Previous illnesses you've had in your life: _____

_____

B. Previous injury or trauma:_____

Have you ever broken any bones? Which? _____

C. Allergies:_____

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

Pregnancies and outcomes:

Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

What was the date of the beginning of your last menstrual period? _____

4. Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

5. Social and Occupational History:

Level of Education: ❑ high school ❑ some college ❑ college graduate ❑post graduate studies

A. Job description: _____

B. Work schedule: _____

C. Recreational activities: _____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):_____

_____

Please Check All Conditions You Currently Have or Have Had

GENERAL APPEARANCE
□ Weight Loss □ Weight Gain □ Change in Sleeping Patterns □ Change in Activity Capacity

NEUROLOGICAL
□ Anxiety □ Headaches □ Depression □ Meningitis □ Paralysis □ Seizure □ Stroke □ Tingling □Tremors □ Memory Loss □ Fainting spells
□ Dizziness □ Head injuries □ Blackouts or near blackouts □ Change in sensation anywhere on your body □ Localized weakness or numbness

EARS, EYES, NOSE, & THROAT
□ Hay fever □ Glaucoma □ Polyps □ Allergy □ Cataracts □ Goiter □ Hoarseness □ Double vision □ Gum problems □ Eye problems □ Ear Infections
□ Glasses/contacts □ Hearing Loss □ Ear discharge/pain □ Frequent nosebleeds □ Ringing in your ears □ Sinus infections □ Swollen glands

CARDIOVASCULAR
□ Angina □ Leg cramps □ Ankle swelling □ Awakening at night short of breath & getting out of bed □ Cardiac catheterization □ Cold hands or feet
□ Congenital heart defects □ Dizziness when standing up quickly □ Heart attacks □ Heart failure □ High or low blood pressure □ Irregular heart rate
□ Purple fingers or lips □ Leg pain that resolves with rest □ Heart palpitations □ Varicose veins □ Chest pains □ Murmurs

RESPIRATORY
□ Asthma □ Breathlessness when lying flat □ Prolonged cough □ Coughing up blood □ Emphysema □ Shortness of breath □ Tuberculosis □ Pneumonia
□ Frequent infections (bronchitis) □ Wheezing □ Pleurisy

SKIN
□ Abscess □ Dandruff □ Acne □ Oily skin □ Boils □ Rashes □ Hives □ Dry skin □ Lumps □ Psoriasis □ Jaundice □ Athlete's foot
□ Excessive body odor □ Excessive sweating □ Fungal infections □ Nail problems □ Moles- irregular □ Moles - change/new

KIDNEYS & URINARY TRACT
□ Blood in urine □ Brown urine □ Dribbling after urination □ Painful urination □ Excessive thirst □ Involuntary urination/incontinence □ Urinating frequently (day) □ Urinating frequently (night) □ Urine hesitancy □ Weak flow □ Frequent bladder infections □ Kidney disease □ Kidney stone

ENDOCINE
□ Diabetes □ Sickle cell □ Abnormal body hair □ Changes in skin texture □ Cold intolerance □ Heat intolerance □ History of "borderline" diabetes

MUSCULOSKELETAL
□ Anemia □ Arthritis □ Back pain □ Bursitis □ Gout □ Joint aches □ Neck pain □ Tendinitis □ Abnormal Blood Counts □ Blood clots in legs/lungs □ Bone Marrow Biopsy □ Easy Bleeding □ Easy bruising □ Joint swelling □ Morning stiffness □ Muscle aches

GASTROINTESTINAL
□ Diarrhea □ Reflux □ Ulcers □ Hepatitis □ Abdominal pain □ Anal fissures □ Black tarry stools □ Vomiting blood □ Constipation □ Nausea □ Problems swallowing □ Hiatal Hernia □ Intestinal obstruction □ Liver disease □ Hemorrhoids □ Red blood after bowel movements □ Gallstones □ Vomiting □ Heartburn □ Indigestion

MALE & FEMALE
□ Painful sexual intercourse □ Loss of sexual interest □ Unprotected sex □ Groin itching □ Sexually transmitted diseases

MALES ONLY
□ Hernia □ Sterility □ Bloody ejaculation □ Inability to complete intercourse □ Lump on testicle □ Penile discharge □ Problems maintaining or keeping an erection
□ Prostate disease □ Sores on penis or warts □ Testicular pain □ Testicular swelling

FEMALES ONLY
□ D & C □ Hot flashes □ Hernia □ Fibroids □ Abnormal bleeding between cycles □ Abnormal pap smear □ Bleeding after intercourse □ Complications w/ pregnancy □ PMS □ Endometriosis □ Heavy bleeding during cycles □ Discharge from breast □ Ovarian cysts □ Pelvic Inflammatory Disease □ Postmenopausal symptoms □ Vaginal discharge □ Vaginal Dryness □ Vaginal warts

Not Listed Above:_____

_____

_____ _____
I the above signed affirm the above is true ***(patient signature)*** date

Provider's Comments: _____

_____

_____

Dr. Brandt Spies _____

History Documentation - Review of Systems:
99202 = P/N for system 99203 = 2-9 systems 99204/99205 = 10 systems

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**

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 affect 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.

_____ _____ _____

Printed Name **Signature** **Date**

Lordex Spine Institute

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 assigns to BRANDT L. SPIES, D.C., 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 y name for 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 providing any kind of benefits 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 following 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 Lordex Spine Institute, and to send all checks to 212 Gulf Freeway South, Suite G1 League City, Tx 77573.

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 Lordex Spine Institute, and to send any and all checks to 212 Gulf Freeway South, Suite G1 League City, Tx 77573.

STATUTE OF LIMITATIONS: I waive my right 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 cost 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 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 request 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 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. 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 physician/clinic named above, and to send any and all checks or financial instrument to 212 Gulf Freeway South, Suite G1 League City, Tx 77573.

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 that failure to do so may jeopardize my case.

_____	_____	_____
Printed Name	**Signature**	**Date**