Starwood Chiropractic

4851 Legacy Drive * Suite 307 * Frisco, Texas 75034 * (972) 377-3909

Patient Information

Date______________

Name ____
First M. Last Preferred Name

Address ____
____
City State Zip

Sex: ☐ M ☐ F Birthdate ___/___/___ Age______
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS # ______________________________
Occupation ______________________________
Employer ______________________________
Employer Address ______________________________
____
City State Zip

Spouse ______________________________
Occupation ______________________________
Whom may we thank for referring you?
____
____

Contact Information

Home Phone______________________________
Work Phone ____________________ Ext. ________
Cell Phone ______________________________
E-mail ______________________________

IN CASE OF AN EMERGENCY, CONTACT:
Name ______________________________
Phone ______________________________

Insurance Information

Insured's Name ______________________________
Insured's Birthdate ___/___/___
Relationship to Patient:
☐ Same Person ☐ Spouse ☐ Parent ☐ Other
Insurance Company______________________________
I.D./Policy # ________________ Group # __________

ASSIGNMENT AND RELEASE
I, the undersigned, certify that I (or my dependant) have insurance coverage with the above listed insurance company and assign directly to Starwood Chiropractic 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

____
Relationship to Patient Date

Accident Information

If Condition Due to an Accident
Accident Date ______________________________
Type Of Accident: ☐ Auto ☐ Work ☐ Other
To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker's Comp ☐ Other
Attorney Name (if applicable)____________________
Attorney Phone ______________________________

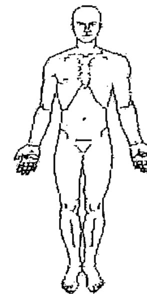
Patient Condition

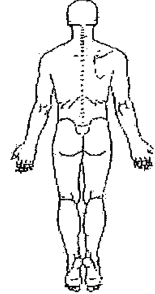
Height __________ Weight __________
Reason for visit ______________________________
When did your symptoms appear? ____________________
Is this condition getting progressively worse?
☐ Yes ☐ No ☐ Unknown
Rate the severity of your pain on a scale from 1 to 10
0--------------------------5--------------------------10
(no pain) (severe pain)

Type of Pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramping	☐ Stiffness	☐ Swelling	☐ Other

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





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

Additional Comments Concerning Your Condition:

____
____
____
____

Health History

What treatment have you already received for your condition? ☐ Chiropractic Services ☐ Medications ☐ Surgery
☐ Physical Therapy ☐ None ☐ Other ____

Name and telephone number of other doctor(s) who have treated you for your condition __________________________
____

Date of Last: ☐ Chiropractic Adjustment ________ ☐ Medical Appointment ________ ☐ Massage ________

Place a mark on "past", "present", or "never" to indicate if you have had any of the following:

Past	Present	Never	Condition
☐	☐	☐	AIDS/HIV
☐	☐	☐	Abnormal Weight Gain
☐	☐	☐	Allergy Shots
☐	☐	☐	Anemia
☐	☐	☐	Angina
☐	☐	☐	Anorexia
☐	☐	☐	Appendicitis
☐	☐	☐	Arthritis
☐	☐	☐	Asthma
☐	☐	☐	Bleeding Disorders
☐	☐	☐	Breast Lump
☐	☐	☐	Bronchitis
☐	☐	☐	Bulimia
☐	☐	☐	Cancer
☐	☐	☐	Chest Pains
☐	☐	☐	Constipation or Diarrhea
☐	☐	☐	Diabetes
☐	☐	☐	Dizziness
☐	☐	☐	Emphysema
☐	☐	☐	Epilepsy
☐	☐	☐	Excessive Thirst
☐	☐	☐	Fractures
☐	☐	☐	General Fatigue

Past	Present	Never	Condition
☐	☐	☐	Glaucoma
☐	☐	☐	Gout
☐	☐	☐	Heart Disease
☐	☐	☐	Hepatitis
☐	☐	☐	Hernia
☐	☐	☐	Herniated Disc
☐	☐	☐	High Blood Pressure
☐	☐	☐	High Cholesterol
☐	☐	☐	Kidney Disease
☐	☐	☐	Lazy Eye
☐	☐	☐	Liver Disease
☐	☐	☐	Loss of Bladder Function
☐	☐	☐	Migraine Headaches
☐	☐	☐	Mononucleosis
☐	☐	☐	Multiple Sclerosis
☐	☐	☐	Muscle Spasms
☐	☐	☐	Muscular Incoordination
☐	☐	☐	Osteoporosis
☐	☐	☐	Pacemaker
☐	☐	☐	Painful/Frequent Urination
☐	☐	☐	Parkinson's Disease
☐	☐	☐	Pinched Nerve
☐	☐	☐	Pneumonia

Past	Present	Never	Condition
☐	☐	☐	Polio
☐	☐	☐	Poor Circulation
☐	☐	☐	Prostate Problems
☐	☐	☐	Prosthesis
☐	☐	☐	Rheumatoid Arthritis
☐	☐	☐	Ringing in Ears
☐	☐	☐	Sensitivity to Light
☐	☐	☐	Stroke
☐	☐	☐	Thyroid Problems
☐	☐	☐	Tuberculosis
☐	☐	☐	Tumors/Growths
☐	☐	☐	Ulcers
☐	☐	☐	Visual Disturbance

Females Only

Past	Present	Never	Condition
☐	☐	☐	Birth Control
☐	☐	☐	Painful Periods
☐	☐	☐	Hormonal Replacement
☐	☐	☐	Currently Pregnant
☐	☐	☐	Trying to Become Pregnant
☐	☐	☐	Miscarriage

Please List All Surgeries and Major Injuries (fractures, motor vehicle accidents, etc.):

____
____

Medications
____
____

Allergies
____
____

Vitamins
____
____

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

LIFESTYLE
- ☐ Smoking — Packs/Day__________
- ☐ Alcohol — Drinks/Day__________
- ☐ Coffee/Caffeine — Cups/Day__________
- ☐ Water — Glasses/Day__________

Consent to Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures. This includes examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible), which are recommended by the doctor of Chiropractic who now, or in the future, renders treatment to me, while employed by, working for, associated with, or serving as backup for the doctor of Starwood Chiropractic.

I have had an opportunity to discuss with the doctor and or with office personnel the nature, purpose and risks of Chiropractic adjustments and their recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed

I have read the above explanation of the Chiropractic adjustment and related treatment. By signing below I stat that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having had the opportunity to ask about the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

______________________ ______________________ ______________________
Patient Name | Patient/Legal Guardian Signature | Date

Starwood Chiropractic

4851 Legacy Drive * Suite 307 * Plano, Texas 75034 * (972) 377-3909

Appointment Policy

For the most convenient appointment times for you, we ask that you please schedule your appointments in advance. It is also recommended for fast and complete healing that you keep your appointments when scheduled. The Doctor has spent time creating a specific treatment plan for your condition. When an appointment is missed, healing is delayed and the treatment plan is interfered with. If you should need to reschedule an existing appointment, please contact us prior to your appointment time so that we are better able to find a time that works for you. We ask that you please provide us with 24 hours notice for any appointment cancellations; this office reserves the right to charge $45.00 for any missed, cancelled, or rescheduled appointments that do not meet these requirements. We understand that things come up and that you are busy, but please understand that we have most likely already told a patient that we have no appointments available for their treatment at that time.

Cell Phone Policy

As a courtesy to all patients, please silence and refrain from using your cell phones while in the office. If you should need to take a call, we ask that you please step outside until the call is complete. We thank you for your consideration in helping us to provide a completely relaxing atmosphere.

Fee Policy

Assignment of benefits for group insurance policies are accepted, and will be verified and discussed with you at the time of your first visit. Payment for services is due at the time of the office visit. Payment options include: cash, check, or credit card. Returned checks will be billed to the patient for the amount of the check as well as a returned check fee of $15.00.

Acknowledgment of Office Policies

By signing below, I herby acknowledge that I have read in full and understand the above mentioned office policies. I am also aware that the doctors, and/or staff, reserve the right to enforce these polices.

____	____	______ / ______/ ______
Printed Patient Name	Patient Signature	Date

Physician Reports

We have found that physicians, including pain management doctors and orthopedists, appreciate updated status reports and treatment notes for their patients. If you are currently seeing a physician who would like reports sent directly to their office, please list their information below:

Clinic Name:____

Doctor's Name:____

Address:____

City:____________________________________ State:______________ Zip:_____________________

Phone Number:______________________________ Fax Number:______________________________

By signing below, I herby acknowledge that my treatment information will be released in the form of physician reports to the above mentioned doctor and/or clinic.

______________________________	______________________________	_____ / _____/ _____
Printed Patient Name	Patient Signature	Date

STARWOOD CHIROPRACTIC'S HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

4851 Legacy Drive, Suite 307
Frisco, TX 75034
972.377.3909

By signing this form, I, ________________________________, authorize the use and use disclosure of my health information as described below:

1. *Description of information*: Disclosure of my condition, prognosis, and treatment plan

2. *Name or class of person(s) or class or persons authorized to make the use or disclosure*: Employees and Authorized Agents of Starwood Chiropractic
____
____

3. *Name or identification of person(s) or class of persons authorized to receive the information (please list all family members, spouse name, friends or representatives that we may discuss your medical condition with)*:
____

4. *Date or event when authorization expires*: This authorization does not expire unless:
____

5. *Description of each purpose of the requested use or disclosure*: Participation in the medical care of the patient or: ______________________________________
____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to Starwood Chiropractic at the address listed above.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the Federal Privacy Standards.

________*[Initials of patient or guardian]* I understand that Starwood Chiropractic may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization

____ ________________________
Signature of Patient or Guardian** Date

____
Print Name of Patient

____
Print Name of Guardian

**If an individual's personal representative signs an authorization, the representative's authority is based on:
____(e.g., state law, court order, etc.)

Copyright 2006 Starwood Chiropractic HIPAA Authorization

Starwood Chiropractic

4851 Legacy Drive, Suite 307
Frisco, TX 75034
972.377.3909

Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Starwood Chiropractic, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all 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 adjustor for purposes of processing my claim for benefits and payment for 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 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 benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and 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 Starwood Chiropractic, and send to 4851 Legacy Drive, suite 307, Frisco, TX 75034.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Starwood Chiropractic, and to send any and all checks to 4851 Legacy Drive, Suite 307 Frisco TX 75034.

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 cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above 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/UIM 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. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by me 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 the failure to do so may jeopardize my case.

Signature of Patient and/or Responsible Parties:

_______________________________________ Date:_________________________

Informed Consent Document

PATIENT NAME:____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures: *Patient should initial each procedure they are consenting to.*

__Spinal manipulative therapy

__Examination

__Hot therapy

__Electrical muscle stimulation

__Radiographic studies

__Other (please explain)

____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the take of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a casual relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory , muscle relaxants and pain killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

--------------------CONSENT TO TREATMENT (MINOR)--------------------

I hereby request and authorize **Theodore Maltezos, D.C.** to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter:____________________. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTILYOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Theodore Maltezos and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:__________________________ **Dated:** ____________________________

_________________________________ ____________________________________

Patient's Name **Doctor's Name**

_________________________________ ____________________________________

Signature **Signature**

____

Signature of Parent or Guardian (if a minor)