Confidential Case History

Date:____/____/____

Name:________________________________ Home # (   )_______________ Work # (   )__________________

Address:____ City:_________________________ State:_________ Zip:_________

SS#___________________ Sex: M F Age:______ # of Children: __________Email:________________________________

Employer:_______________________________ Occupation:______________________________________ DOB:_________

Marital Status: Single / Married / Divorced / Separated / Widowed Spouse Name:_______________________________

Primary Care Physician:______________________________________ Hobbies/Sports:______________________________

Vitamins, Supplements and herbs:_______________________________ Medication:_________________________________

Main Complaint(s)

What Symptom (s) do you have: □ Lower Back Pain □ Upper Back Pain □ Neck pain □ Shoulder Pain □ Hip Pain

List any other:____

When did it start:_________________________ How did it start:____

Do symptoms travel to other parts of your body: Y N If yes, where:___________________________________

Is your sleep affected: Y N, I am sleeping__________% less now

Are your symptoms: dull / sharp / burning / stabbing / throbbing , etc. _________________________________

Are your symptoms getting: better / worse / the same? Do your symptoms: come and go or constant?

What makes your symptoms feel better:_________________________ Worse:______________________________

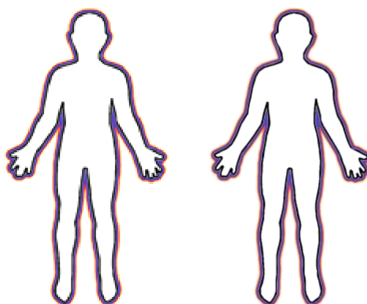
Have you tried home remedies? Y N What type of remedies? __________________________________Any relief:___________

Have any other doctors evaluated your symptoms? Y N Who:______________________ Test Performed:________________

Have you experienced this in the past? Y N Explain:____

Have you been able to work with your symptoms? Y N Days missed___________ Days restricted_______________

MARK AREAS ON THE DIAGRAM WHERE YOU HAVE PAIN



Past History

Have you been diagnosed with any other conditions? Y N If yes, Explain____

Are you under a doctor's care presently for any type of health problems? Y N ____

Have you ever had any broken bones? Y N What bone?_______________ When? _____________How?___________________________

Have you ever had any past significant auto accident, work injuries or falls? Y N When?____

Have you ever had any type of surgery? Y N What and When?____

Do you have any allergies?______________________ Any Medical conditions in your family?______________________________________

Have you ever seen a chiropractor in the past? Y N Dr._______________________ Last Seen ________________Symptoms____________

Please rate your diet from the following choices: exceptional / above average / average / below average/ junk food

How would you rate your recovery from illness, cuts and colds: excellent/ above average / average/ below average/ poor

How would you rate your pain tolerance: high/ above average / average / below average/ low

Rate your current physical fitness level for your age: excellent / above average/ average/ below average/ couch potato

How would you rate your stress level in your life at the present: low/ below average/ average/ above average/ maximum

Anything else that we need to know?____

Have you been diagnosed or are You aware of the following:

- Y N High blood pressure
- Y N Hardening of the arteries
- Y N Diabetes
- Y N Heart or blood vessel disease
- Y N Bone spur of the spine
- Y N Whiplash Injury
- Y N Blurred or double vision
- Y N Headaches
- Y N Arthritis
- Y N Cancer
- Y N any relatives ever suffer a stroke
- Y N Do you smoke
- Y N Have you smoked in the past

Have you experienced any of the following symptoms in the past year:

- Y N Slurred speech or other speech problems
- Y N Difficulty swallowing
- Y N Dizziness
- Y N Temporary lack of understanding
- Y N Loss of consciousness or blackouts
- Y N Numbness or tingling in face, arms or legs
- Y N Loss of sensation anywhere in your body
- Y N Weakness or incoordination in arms/legs
- Y N Sudden collapse without losing conscious
- Y N Sudden change of vision
- Y N Hearing loss or change
- Y N Loss of appetite
- Y N Difficulty with or excessive urination

Have you ever had these tests?

- Y N -MRI
- Y N -CT
- Y N -X-ray
- Y N -EMG
- Y N -Bone density test
- Y N -Bone scan

Women Only:

Are you Pregnant? Y N

Menopause Y N

Date of last period?___________

Men Only:

Sexual dysfunction: Y N

date of last prostate exam____________

Please read the following: I hereby consent to any procedures to treatment necessary for treatment or any condition as seemed reasonable by the attending doctor, I understand and agree that health and accident insurance policies are an arrangement between the insurance company and myself. I acknowledge that this office files billing forms and reports with relevant insurance companies, to insist me in making collection from the insurance carrier. I authorize insurance carriers to pay directly to the doctor's office, having any payment received will be credited to my account. However, I clearly understand and agree that all services rendered to me are charges directly to me and I am responsible for payment.

Patient Signature X____ Date:____________________

Guardian or Spouses Authorize Signature X____ Date:____________________

Emergency #_______________________________________

PATIENT HEALTH INFORMATION CONSENT FORM
MEDICAL RELEASE AUTHORIZATION

Greenville Spine & Joint • 2806 Mitchell St • Greenville, TX 75402
903-454-2225 • Fax: 903-454-4766
Daniel K. Reinboldt D.C.

We want you to know 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 the consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI/Medical Records) 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 companies or attorney's office (where applicable) 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 required for what the insurance companies and attorney's office (where applicable) need for payment.
2. The patient has the right to examine and obtain a copy (copy fee of $18.00 will apply) 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. The patient's written consent need only be obtained on 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 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 healthcare operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information (medical records) will be used and agree to these policies.

____

Print Name Patient Signature Date

____

Social Security Number Date of Birth

When this form is being used to release PHI to Attorney's, this form is acceptable whether the patient is represented by an attorney or Rolling Hills Chiropractic is being represented by an attorney, or both. _________(patient's initial)

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF CAUSE OF ACTION/ CONTRACTUAL LIEN

Greenville Spine & Joint Clinic •2806 Mitchell St.• Greenville, TX 75402
Ph: 903-454-2225 • Fax: 903-454-4766
Daniel K. Reinboldt D.C.

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 Greenville Spine & Joint, 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 my name for payment, and prosecute and receive penalties, interest, court loss or other legally compensable amounts owed by an insurance 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, you are hereby tendered demand to pay in full for the bill of 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 Greenville Spine & Joint, and to send all checks to 2806 Mitchell St., Greenville, Texas 75402.

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 services rendered, payable to Greenville Spine & Joint and send to any and all checks to 2806 Mitchell St., Greenville, TX 75402.

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 the power to endorse my name upon any checks, drafts or other negotiable instruments 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/facility named above any rejections in writing as they apply to my lack of MedPay, 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/facility named above, and to send any and all checks or financial instruments to 2806 Mitchell St., Greenville, Texas 75402.

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 reasonable period of time. If during my care, my insurance company requires me to have an examination from any other doctor, I will notify this physician/facility named above immediately. I understand that failure to do so may jeopardize my case.

Patient Signature or Representative: ____ 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 (Patient should initial each procedure they are consenting to)

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

___Spinal Manipulative Therapy ___Palpation ____Vital Signs ___Range of Motion Testing ____Orthopedic Testing

___Basic Neurological ___Muscle Strength Testing ___Postural analysis Testing ___Ultrasound ___Hot/Cold Therapy

___EMS ___Radiographic Studies ____Other (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 results from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and / or vertebral artery 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 a vertebral artery 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 painkillers.
- 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 there 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.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLICK 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. Daniel Reinboldt and have had my questions answered to my satisfaction. By signing below, I state that I have withed 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 the treatment.

Patient's Name: __________________________ Patient's Signature: ______________________________ Date:__________________

Doctor's Name: ____Daniel K. Reinboldt D.C.___________________ Date:_________________

Dr. Daniel K Reinboldt

Greenville Spine & Joint Clinic
2806 Mitchell St.
Greenville, TX 75402

Phone: 903-454-2225
Fax: 903-454-4766
Email: alineme@geusnet.com

Statement of payment Policy for
Health Insurance & Managed Care Payment Policy

Please present your insurance card to the receptionist. As a courtesy to our patients, our office will complete any necessary insurance forms at no charge and file them with your insurance company to help you collect. It is to be understood and agreed all services rendered are charged to you directly and you are personally responsible.

We are not certain if your insurance covers chiropractic, although most policies **DO** provide coverage. The best ability will be taken to inform you of your benefits on your 1st visit, sometimes it is out of this office's control and benefits are not able to be provided. The office will at this time make it priority to get the benefits to you. Insurance companies have in the past quoted wrong benefits. In the case where a patient has over paid, the patient will be reimbursed any funds due by the 10th of the following month of receiving overpayment. If your insurance company quotes benefit incorrectly and this office is not paid for all or quoted amount for services rendered, this office will bill directly to the patient for payment.

This office allows your insurance company 60 days to pay claims. If payment has not been received within 60 days, the office will contact you with the unpaid information, at which time payments are due by the patient.

By signing this form, the patient understands they are responsible for all monies due not paid regardless of reasons.

If you have any questions, please ask office staff.

____

Signature of Patient or Representative **Date**

____

Witness **Date**

Activities of Daily Living Functional Survey

Please help us evaluate your condition by identifying functions that you have difficulty performing. First circle either **yes (Y)**--indicating the function has been affected by your condition, or **no (N)** if it has not. Please make sure to respond to **ALL** functions listed below. Then, return to the top and further define each **YES answer only** by circling the most appropriate description of how much your condition has affected that function.

1) Y N **Getting up from sitting:** mild/ moderate/ severe/ excruciating/ unable without assistance
2) Y N **Standing for**: <1/2 hr. / 1 ½ -1hr. / 1-3 hrs. / 3-6 hrs. / >6hrs.
3) Y N **Lifting:** <5 lbs. / 5-10 lbs. / 10-25 lbs. / 25-50 lbs. / >50 lbs.
4) Y N **Pushing or pulling:** <5 lbs. / 5-10 lbs. / 10-25 lbs. / 25-50 lbs. / >50 lbs.
5) Y N **Bending, stooping or squatting:** mild/ moderate/ severe/ excruciating/ unable without assistance
6) Y N **Reaching overhead:** mild/ moderate/ severe/ excruciating/ unable without assistance
7) Y N **Childcare for children:** mild/ moderate/ severe/ excruciating/ unable without assistance
8) Y N **Performing your job:** mild/ moderate/ severe/ excruciating/ unable without assistance
9) Y N **Climbing steps:** mild/ moderate/ severe/ excruciating/ unable without assistance
10) Y N **Getting out of bed in the morning:** mild/ moderate/ severe/ excruciating/ unable without assistance
11) Y N **Driving or riding in a vehicle:** <1/2 hr. / 1 ½ -1hr. / 1-3 hrs. / 3-6 hrs. / >6hrs.
12) Y N **Walking:** <1/2 hr. / 1 ½ -1hr. / 1-3 hrs. / 3-6 hrs. / >6hrs.
13) Y N **Dressing or undressing:** mild/ moderate/ severe/ excruciating/ unable without assistance
14) Y N **Making quick movements:** mild/ moderate/ severe/ excruciating/ unable without assistance
15) Y N **Performing household chores:** mild/ moderate/ severe/ excruciating/ unable without assistance
16) Y N **Performing yardwork:** mild/ moderate/ severe/ excruciating/ unable without assistance
17) Y N **Manipulating object with hands:** mild/ moderate/ severe/ excruciating/ unable without assistance
18) Y N **Personal hygiene care:** mild/ moderate/ severe/ excruciating/ unable without assistance
19) Y N **Sleep loss due to current symptoms:** mild/ moderate/ severe/ excruciating/ unable without assistance
20) Y N **Performing hobbies:** mild/ moderate/ severe/ excruciating/ unable without assistance
21) Y N **Intimate relations:** mild/ moderate/ severe/ excruciating/ unable without assistance
22) Y N **Performing sports:** mild/ moderate/ severe/ excruciating/ unable without assistance
23) Y N **Computer use:** mild/ moderate/ severe/ excruciating/ unable without assistance
24) Y N **Coughing, sneezing or straining:** mild/ moderate/ severe/ excruciating/ unable without assistance
25) Y N **Hearing, vision or mental function:** mild/ moderate/ severe/ excruciating/ unable without assistance
26) Y N List any other function significantly affected:____
mild/ moderate/excruciating/unable without assistance

Name:____ Date:______________________________