DALLAS CHIROPRACTIC METRICS

10 Medical Pkwy, Plaza 3 - Suite 201 - Farmers Branch, TX 752347840
Phone: (214) 272-9509 • Fax: (855) 831-9205

Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Email: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Cell Phone: _____ Provider: _____ Work Phone: _____ Preferred Name: _____

Maiden Name: _____ Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

Employment Information

Employer: _____ Occupation: _____

Address: _____ (City, State, Zip): _____

Responsible Party Information

Name: _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Responsible Party's Phone #: _____ Relationship to Patient: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security #: _____ Phone: _____

Insurance Company: _____ Group #: _____ ID Number: _____

Address: _____ (City, State, Zip): _____

Spouse Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Employer: _____ Employer Phone: _____

Relative to Contact in Case of Emergency

Name: _____ Phone: _____ Relationship to Patient: _____

Address: _____ (City, State, Zip): _____

Is Your Illness or Injury Related to Any of the Following?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident (State of Auto Accident)

If Employment related, has employer been notified? ☐ Yes ☐ No Employer Contact Name: _____

Employer Contact Phone and Extension: _____

How Were You Referred to Our Office?

☐ By an Attorney ☐ By a Doctor ☐ By a Patient ☐ Yellow Pages ☐ Other ☐ Online Advertising ☐ Event or Health Fair

Please print the name of your source: _____

Consent to Treatment / Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Dallas Chiropractic Metrics all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____ Date: _____

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Consent for Chiropractic Services

By reading below I have been made aware: **1.** The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually, with a table mechanism, or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible, pop or click sound; **2.** As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold; **3.** On occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, and/or swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment; **4.** The chiropractor has made no guarantee of a positive outcome from treatment. Additionally: I have been afforded many opportunities for questions and answers. Therefore, by signing below: I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case; I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case.

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below items. If you refuse to sign this form the doctor reserves the right to refuse care. **AUTHORIZATION:** By signing below you authorized this office/provider to complete a consultation and examination on the above individual.

AUTHORIZATION FOR X-RAY WITH RELEASE:

By signing below, you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below, you have declared that you 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.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS:

By signing below, you have acknowledged that you are fully responsible for all services rendered. By signing below, you further acknowledge you understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some, or all the fees charged to your account. By signing below, you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below, you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office. CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: **"INSURED'S OR AUTHORIZED PERSON'S** SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

We are very concerned with protecting your personal health information. There may be times our office needs to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters in the following ways: work, home or mobile phone, e-mail, and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your work, home, or mobile phone. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliged to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the

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disclosure of your personal health information and your rights as a patient. By signing below, you have acknowledged that you have been made aware of this document and your right to request it.

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, and supportive therapies and procedures. ACKNOWLEDGEMENT: By signing below you acknowledge that you understand and agree with the policies and procedures outlined in these TERMS of ACCEPTANCE form. By signing below, you acknowledge and certify that all the information given to the office/provider in the INTAKE forms is a true and accurate to the best of your knowledge

Notices of Privacy Practices HIPAA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and updated laws on 9/23/2013, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. *Obtain payment from third-party payers. *Conduct normal healthcare operations such as quality assessments and physician certifications. You and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information have informed me. I have been given the right to review such Notice of Privacy Practices prior to signing this consent I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization on at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions. I further authorize disclosure of all or any part of my patients record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinics charge including, and not limited to, hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds or the patient's employer. I understand that I may revoke this consent in writing at any time, except to the extent that you have acted relying on this account.

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, orthopedic and neurological evaluation, visual inspection, palpation, X-ray studies, laboratory procedures, chiropractic care, or any clinic services that he deems necessary in my case. The undersigned also consents to observation of therapeutic or diagnostic procedures by staff personnel or medical personnel in training as permitted by the attending practitioner and allowed by clinic policy. Treatment procedures that may be used in your treatment include, but are not limited to, manipulative therapy, activator, joint mobilization, myofascial release, trigger-point therapy, electrical therapy, intersegmental traction, muscle stretching, and any directional handouts. Cases will be managed with all due concern and with the evaluation of response to previous care provided. Home care instructions will be given as appropriate to enhance your treatment program. Compliance with the recommendations for home care and follow-up care is necessary for the resolution of your complaint. Because of modern techniques and equipment, examination and therapeutic procedures involve a very low risk of complication. Even though serious problems rarely occur with these procedures, risks must be recognized and considered. Any procedure that is intended to help may also do harm. While examination and therapeutic procedures used in this clinic are considered remarkably safe and effective, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are extremely small, it is the

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practice of this office to fully inform and educate our patients. These complications include but are not limited to pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, bleeding, fracture, fainting, irregular heartbeat, heart attack, spinal cord damage, nausea, burns, soft tissue injury, stroke, dizziness, or weakness. A patient, in coming to Dallas Chiropractic Metrics, gives. Dr. Tina Bennett Burton (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 problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the Dr. Bennett-Burton. The doctor provides a specialized, non-duplicating health care service. Dr. Bennett-Burton is licensed in a chiropractic practice and is available to work with other types of providers in your health care regimen. I understand that if a physician at Dallas Chiropractic Metrics accepts me as a patient. I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request. No guarantee or warranty for a specific cure or result is implied by the acceptance of your case. All patients respond differently to the treatment procedures. Each case must be evaluated separately. If you do not fully understand the above or have questions about anything mentioned in this document, please do not sign it until these matters have been resolved with further discussion. I have read the above explanation of treatment and diagnostic procedures used in this clinic and have myself decided that it is in my best interest to submit to these procedures. I declare that, to the best of my knowledge, (I am not pregnant, my child is not pregnant), nor are there any known complicating limitations which would forbid taking x-rays. I understand that in the event x-rays are taken and need a second opinion, that they will be referred out for further interpretation and give consent for their release. I understand that there will be a fee for this service of $25.00. Clinical Summary Report (CCR) regarding EHR I understand that a clinical summary report is created after each visit for EHR and is available for my review. Now, I am asking Dallas Chiropractic Metrics to save these electronically for me and not print them out after each visit. I understand that, upon request that these reports are available to be printed or emailed to me for review.

Assignment of Benefits

I understand and agree 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 Chiropractic Office will be credited to my account upon re kept. However, 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 and treatment, any fees for professional services rendered to me will be immediately due and payable.

No Show Policy

We take patient care very seriously. If there is ever a time that you are not able to make it to your appointment, please be sure to call the office 24 hours in advance to reschedule. This way we can get other patients in need scheduled. Dallas Chiropractic Metrics will charge a fee of $25.00 for any no call no show patients due at following appointment. On the 3rd no show we will kindly move you to a walk-in patient only. We want to thank you for your corporation and understanding.

Patient Name: _____

Patient Signature: _____

Date: _____

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Current Medications and Supplements

Name	Dosage	Frequency

Major Injuries / Traumas / Hospitalizations:

Date	Describe	Limitations

Social History

Habit	Amount	Year Started

Family Health History

Problem	Parent	Other

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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
Arm – Across Shoulder / Elbow / Hand-Fingers R / L / Both
Leg - Hip / Thigh-Knee / Calf / Foot-Toes 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: _____
When and Where? _____
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: _____
When and Where? _____

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General: *(constitutional)*
___Recent Weight Change
___Fever
___Fatigue
___*None in this Category*

Musculoskeletal:
___Low Back Pain
___Mid Back Pain
___Neck Pain
___Arm Problems
___Leg Problem
___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 / 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 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, 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
Eye disease or injury
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

*Number of Pregnancies*_____