PROSPER CHIROPRACTIC & WELLNESS CENTER

2024

John H. Perriton, D.C.
Travis W. Sullivan, D.C.
101 E Broadway St
Prosper, TX 75078

Blue or Black Ink ONLY

PATIENT INFORMATION

Today's Date:_____ **Completed By (circle one):** Self / Guardian / Power of Attorney

Patient Legal Name:_____ **Preferred Name:** _____

DOB:_____ **SS#**_____ **Sex:** ☐ **Male** ☐ **Female**

Address:_____ **City**_____ **State**_____ **Zip Code**_____

Marital Status: ☐ Married ☐ Single ☐ Minor **Employment:** ☐ Employed ☐ Student ☐ Retired ☐ Other

Cell / Phone: (_____) _____-_____ **Work Phone:** (_____) _____- _____

Email: _____ **How did you hear about us:** _____

Emergency Contact Name:_____ **Ph:** (_____) _____- _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

At your request, we will provide ONE copy of your Patient Health Information (PHI) at no cost. Additional copies are subject to state regulated medical record fees. In addition - Due to HIPAA regulations, we must have your permission to leave detailed voicemails and/or send you emails regarding your care and/or payment records. **Please indicate, by initialing or checking below if you wish to authorize.** Your authorization will include any person(s) and their method of contact listed below. This release is in effect for one year from the time of your signature.

_____ I authorize to receive communication **via text** related to appointment reminders or change in appointment scheduling.

_____ I authorize to receive communication **via email** i.e. copies of medical records, receipts for payments and billing related information. I understand that Prosper Chiropractic is not responsible for breaches of confidentiality caused by the patient or any other entity outside of the clinic.

_____I authorize to receive **detailed voicemails** related to the course of care and/or financial information related to the course of care. I understand that Prosper Chiropractic is not responsible for breaches of confidentiality caused by the patient or any other entity outside of the clinic.

OTHER PERSONS AUTHORIZED TO MEDICAL & FINANCIAL RECORDS

Please indicate below the name(s) **of other persons authorized to all medical and financial records**. If you wish for your records to be sent to another provider or entity, a separate form is required.

Full Legal Name:_____ Ph:_____ Authorize Email? Y / N

Full Legal Name:_____ Ph:_____ Authorize Email? Y / N

Name of Person Completing Registration (PRINT):_____

Patient Signature (Guardian sign if patient is minor):_____ Date: _____

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PRINT PATIENT NAME: _____ DOB: _____

FINANCIAL AGREEMENT

As a courtesy, will bill your health insurance. Please be sure to always provide the most up to date information in order to ensure your bill is submitted to your insurance company within insurance regulated guidelines.

Even if your spouse, significant other, child etc, is a patient here, we still need your insurance information written below per office policy

PRIMARY INSURANCE

Policy Holders Name:_____ Policy Holders DOB:_____

Relationship to Patient:_____ Policy Holders SS# _____

Policy Holders Employer:_____ Name of Insurance Company:_____

Member ID:_____ Group ID: _____

SECONDARY INSURANCE

Policy Holders Name:_____ Policy Holders DOB:_____

Relationship to Patient:_____ Policy Holders SS# _____

Policy Holders Employer:_____ Name of Insurance Company:_____

Member ID:_____ Group ID: _____

Please indicate, by initialing or checking below that you agree to the following:

_____ I understand that I am financially responsible for all charges regardless of any applicable insurance payments. If health insurance is applicable, I assign and convey directly to Prosper Chiropractic & Wellness Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered at Prosper Chiropractic & Wellness Center. I understand this assignment is irrevocable.

_____ I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I authorize any and all applicable insurance companies and/or attorneys to release any plans documents, insurance policy and/or settlement information to Prosper Chiropractic & Wellness Center. If this account is assigned to an outside attorney, collection agency and/or suit – Prosper Chiropractic & Wellness Center shall be entitled to reasonable attorney's fees and/or collection fees.

_____ It is our policy to collect at the time of service all applicable copays, deductibles and/or co-insurances as per your plan benefits. We will collect based on the information available to us at the time of service. Should your benefits differ from what we were quoted by your insurance company, we will collect additional amounts due or issue a refund if necessary. If there are changes made to the patient's insurance plan and/or attorney representation it your responsibility to notify the clinic of such changes. Should you fail to provide current information within 15 days of receiving treatment, you may be fully responsible for unpaid balances due to limitations in place by your insurance company for timely claim filing.

Patient Signature (Guardian sign if patient is minor):_____ Date: _____

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PRINT PATIENT NAME: _____ DOB: _____

CONSENT TO TREAT

I, the undersigned, give this office and its provider(s) permission and authority to provide care in accordance with standard chiropractic tests, analysis, diagnosis and treatment. 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 will not give or recommend any treatment or care if he is aware that such care may be contra-indicated. It is the responsibility of the patient (or their guardian) to make it known or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come up to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non – duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. By signing below, you acknowledge that if you are accepted as a patient by a physician at Prosper Chiropractic & Wellness Center, you are authorizing the clinic to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to you upon your request.

Patient Signature (Guardian sign if patient is minor):_____ Date: _____

X-RAY CONSENT

The x-ray examination is performed to analyze the spine for evidence of vertebral subluxation, rate and level of degeneration of the spine, and to determine the appropriateness of spinal adjustments. If the chiropractic physician discovers a non – chiropractic "unusual finding" when reviewing the x-rays, I will be informed. With the help of the chiropractic physician, I thus must determine if I will seek the services of an additional health care provider for advice, diagnosis, or treatment of the "unusual finding". I understand that seeking advice from another health care provider will likely not interfere with the subluxation correction care provided by this clinic. I fully understand the above and consent to the x-rays recommended by the chiropractic physician.

PREGNANCY RELEASE (WOMEN ONLY)

I certify that to the best of my knowledge I am not pregnant. I understand that there are harmful risks to having x-rays, that would affect an unborn child. I choose to continue with the x-ray examination.

_____I am or may be pregnant. _____I am **NOT** pregnant.

ALL patients must sign below if they wish to receive x-rays:

Patient Signature (Guardian sign if patient is minor):_____ Date: _____

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PRINT PATIENT NAME: _____ DOB: _____

PATIENT FINANCIAL AGREEMENT

Cancellations/No Show Policy:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel or reschedule an appointment, you may be preventing another patient from getting much needed treatment.

Equally the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit in their place.

If an appointment is not cancelled/rescheduled at least 24 hours in advance (or for an understandable reason) you will be charged a $30 fee for regular visit.

Late Arrivals:

If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length. As a courtesy, we send out reminders for your appointments. If you do not receive your reminder message, the cancellation policy will remain in effect.

If a patient is more than 15 minutes past their scheduled time, we will have to reschedule the appointment.

I have read and understand the Medical Payment and Cancellation Policy and agree to be bound by its terms.

You will be considered late for the following:

- New Patient that has arrived on or after their scheduled appointment time without completed paperwork (please note you will be considered late at this time and may have to wait longer to be seen, but we most likely will still see you that day)
- Personal Injury New Patient that has arrived less than 10 minutes prior to their scheduled appointment time without completed paperwork (please note that due to the paperwork and legalities of personal injury cases, we will most likely not be able to see you that day and will need to reschedule you)
- Established Patient who is 15 minutes late to their appointment (please note you may still be seen this day, but you may have to wait longer than usual)

By signing below, you agree to the above:

Name of person completing (Print): _____

Patient Signature (Guardian sign if patient is minor):_____Date: _____

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PRINT PATIENT NAME: _____ DOB: _____

PATIENT HISTORY OF ILLNESS/PAIN/INJURY

Describe your symptoms: _____

_____.

When did your symptoms start?_____.

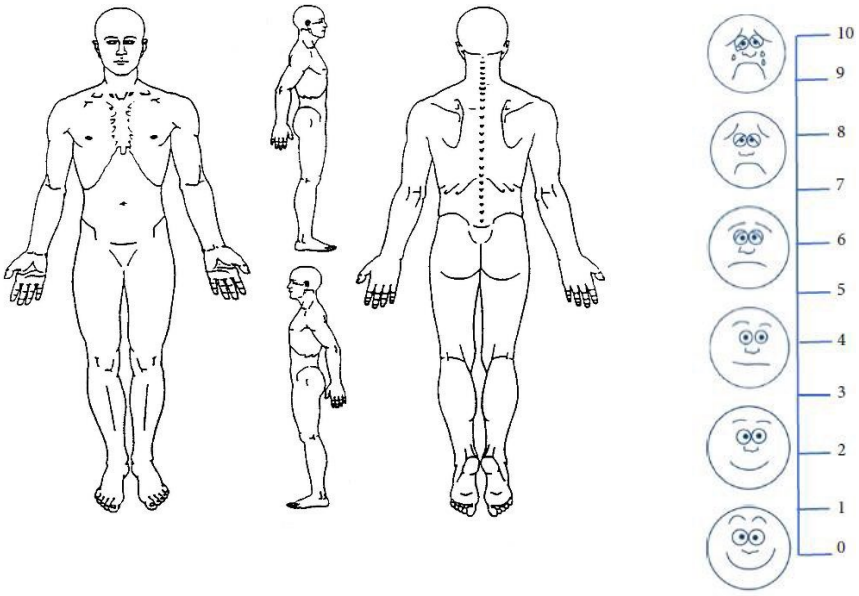
How often do you experience your symptoms? ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

Have you had a condition like this in the past?_____.

Have you previously had treatment for this symptom? If so, please list treatments: _____

_____.

PLEASE INDICATE BELOW ALL AREAS AFFECTED BY THESE SYMPTOMS AND RATE YOUR SYMPTOMS USING THE PAIN SCALE.



What makes your symptoms better? Worse?_____.

When was the last time you saw a chiropractor?_____.

When was the last time you had x-rays of your spine?_____.

What is your goal for consulting with the doctor?

☐ Temporary Relief ☐ Lasting Correction ☐ Let Dr. Recommend the best type of care for you

Patient Signature (Guardian sign if patient is minor):_____Date: _____