United Chiropractic and Medical

LOCATION ____________
DOCTOR ____________
DATE ____________
FILE# ____________

PATIENT RECORD

NAME ____________

STREET ADDRESS ____________

CITY/STATE/ZIP ____________ EMAIL ____________

HOME PHONE ____________ CELL PHONE ____________

EMPLOYER / OCCUPATION ____________

DATE OF BIRTH ____________ SSN ____________

DRIVER'S LICENSE # ____________

MARITAL STATUS (CHECK) ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

SPOUSE'S NAME ____________ EMPLOYER / OCCUPATION ____________

OF CHILDREN _____ AGES _____ NAME OF NEAREST RELATIVE ____________ PHONE ____________

PATIENT STATEMENT OF PROBLEM ____________

WHAT IS CONDITION RELATED TO (CHECK) ☐ EMPLOYMENT ☐ AUTO ACCIDENT ☐ OTHER ____________

DATE CONDITION / ACCIDENT BEGAN ____________ WAS IT GRADUAL? (CHECK) ☐ YES ☐ NO

HAVE YOU EVER HAD SAME OR SIMILAR SYMPTOMS? (CHECK) ☐ NO ☐ YES, DESCRIBE ____________

LOST WORK TIME (CHECK) ☐ NO ☐ YES If YES, date you returned to work ____________

WERE YOU REFERRED BY ANOTHER PHYSICIAN? (CHECK) ☐ NO ☐ YES, NAME ____________

Have you seen another doctor for this condition? (CHECK) ☐ NO ☐ YES, DESCRIBE ____________

Have you seen a chiropractor for this condition? (CHECK) ☐ NO ☐ YES

What medications are you taking? ____________

Are you pregnant? (CHECK) ☐ NO ☐ YES

Referred by: (CHECK) ☐ Yellow Pages ☐ Sign/Loction ☐ TV/Radio ☐ Mailer ☐ Online ☐ Social Media ☐ Friend

Insurance Information (CHECK) ☐ No Insurance ☐ Medicaid ☐ Medicare ☐ BCBS ☐ Champus ☐ Personal Injury ☐ Other, Major Medical, Health Insurance (Name) ____________ ☐ Workman's Compensation (On the Job Injury)

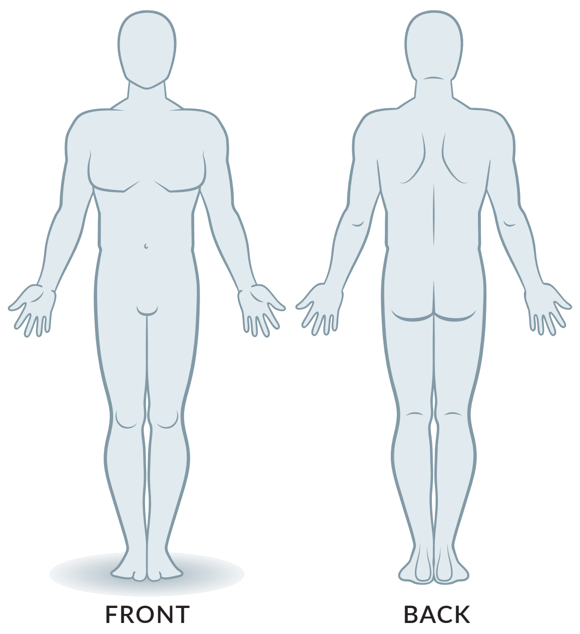
I understand and agree to authorize United Chiropractic and Medical and all employees to administer whatever examination procedures and treatments as they deem necessary.

Patient's Signature ____________ Date: ____________

Guardian or Spouse's SIgnature
Authorizing Care ____________ Date: ____________

If this injury is related to an auto accident or work injury, please fill out reverse side.

PLEASE MARK ALL AREAS OF PAIN (BE SPECIFIC)



If this injury is related to an auto accident or work injury, please complete the following questions.

Date of Accident ____________ Hour ________ ☐ AM ☐ PM Location ______________________________

How did the accident occur? ☐ Auto Collision ☐ On-the-job ☐ Other ____________________

Please describe the accident or injury ____

____

____

Work Related Information ____

Did you report the injury to your employer or foreman? ☐ Yes ☐ No

Name and phone number of foreman or authorized person ________________________________

Name and phone number of your workplace ____

Address of your workplace ____

AUTO ACCIDENT INFORMATION

Were you ☐ Driver ☐ Passenger ☐ Pedestrian

Were you struck from ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was parked

Did your car strike the other(s) involved? ☐ Yes ☐ No ☐ Undetermined

As a result of the accident were traffic citations issued to you? ☐ Yes ☐ No

To the driver of the other car? ☐ Yes ☐ No; To the driver of your car? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No ☐ Unsure

INJURIES

List the extent of the injuries (or pains) as you know them ______________________________

Did you request post-accident hospitalization? ☐ Yes ☐ No; Were you taken by ambulance? ☐ Yes ☐ No

Were you treated in the Emergency Room? ☐ No ☐ Yes; Describe

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

☐ Headache	☐ Neck Pain	☐ Shortness of Breath	☐ Numbness in Toes
☐ Irritability	☐ Chest Pain	☐ Buzzing in Ears	☐ Numbness in Fingers
☐ Dizziness	☐ Back Pain	☐ Ears Ring	☐ Pins & Needles in Arms
☐ Fainting	☐ Neck Stiffness	☐ Sleeping Problems	☐ Pins & Needles in Legs
☐ Fatigue	☐ Cold Sweats	☐ Lights Bother Eyes	☐ Loss of Balance
☐ Nervousness	☐ Hands Cold	☐ Stomach Upset	☐ Loss of Memory
☐ Depression	☐ Feet Cold	☐ Constipation	☐ Loss of Smell
☐ Tension	☐ Face Flushed	☐ Diarrhea	☐ Loss of Taste
☐ Fever	☐ Head seems to Heavy		

Symptoms other than the above ____

____

Have you had similar accidents or injuries before? ☐ No ☐ Yes, When? ____________________

Have you lost any days of work? ☐ No ☐ Yes, Dates: ______________________________

INSURANCE OR ATTORNEY INFORMATION

Do you have an attorney that has advised you in this case? ☐ No ☐ Yes If yes, Name: ____________

Address ______________________________ Telephone ______________________

Are you covered by Personal Injury Protection on your car insurance? ☐ Yes ☐ No

Your insurance company name & phone number ____________________________________

Responsbile parties insurance party & phone number ______________________________

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ Yes ☐ No

United Chiropractic and Medical

607 S. Mason Rd.
Katy, TX 77450
(281)392-6550

"The Most Trusted Name in Chiropractic"

AUTHORIZATION, ASSIGNMENT
CONSENT TO TREAT AND POWER OF ATTORNEY

In consideration of your undertaking to treat me, I agree to the following:

Medical Release
You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster, in order to process any claim for reimbursement of charges incurred by me.

Assignment of Benefits
I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign any such company (the pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromie, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and effort to collect amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

Power of Attorney
I, the undersigned, do hereby appoint United Chiropractic, and any of its duly authorized agents to serve as lawful attorney invested with all powers and authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned above or as co-payee with United Chiropractic and Medical when said payments are due for services rendered on behalf of the undersigned by the clinic.

Authorization to Treat
I, undersigned, hereby authorize United Chiropractic, (and whomever may be designated as assistants) to administer such examinations and treatment as they deem necessary.

A photocopy of this assignment shall b valid and have the same effect as the original.

______________	______________________	______________________
DATE	PATIENT'S SIGNATURE	WITNESS

Sheppard Entities, Inc.
607 S. Mason Road, Katy, TX 77450

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

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocable and exclusively assigns, grants, and conveys, to William L. Shepphard, DC, a lien and assignment of any and all claims, causes of action, and right to any 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 ot 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 of attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payabel to Sheppard Entities, Inc. and to 607 S. Mason Road, Katy, TX 77450.

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 Sheppard Entities, Inc., and to send any and all checks to 607 S. Mason Road, Katy, TX 77450.

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 physican/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 ot 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 my caring at this clinic, he/she has full and complete right to terminate responsbility 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 _______________

HEALTH CARE AUTHORIZATION FORM

Patient Name: ______________________________

Patient SSN: ____________________ Date of Birth: ____________________

THE PATIENT IDENTIFIED ABOVE AUTHORIZES UNITED CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give United Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

- By signing this form, you are giving United Chiropractic permission to use and disclose your protected health information in accordance.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the exten that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of United Chiropractic. The written notice must contain the following:

Your name, Social Security Number, and Date of Birth; A clear statement of your intent to revoke this AUTHORIZATION, the date of your request; and your signature.

This AUTHORIZATION is requested by United Chiropractic for its own use/disclosure of PHI (Minimum necessary standards apply.)

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON REQUEST

______________________________ ____________________

Patient Signature Date

United Chiropractic
and Medical

MISSED APPOINTMENT POLICY
FOR MASSAGES & DRX

If you are unable to keep your scheduled appointment, please give us at least 24 hrs. advance notice to fill your slot. We understand emergencies happen, but please contact us to cancel or reschedule your appointment. There will be a $25 fee for no call/no show appoinments!

Thank you for your cooperation,

***Also, there is a fee ranging from $10 - $25 for any forms to be filled out including but not limited to FMLA, disiability, AFLAC.

______________________________ ______________________________

Patient Signature   Witness

United Chiropractic
and Medical

REVIEW OF SYSTEMS

Patient Name ______________________________

Date ______________________________

General

Weight loss or gain	Y	N
Fatigue	Y	N
Fever or chills	Y	N
Weakness	Y	N
Trouble Sleeping	Y	N

Skin

Rashes	Y	N
Lumps	Y	N
Itching	Y	N
Dryness	Y	N
Color Changes	Y	N
Hair and Nail changes	Y	N

Head

Headache	Y	N
Head Injury	Y	N

Ears

Decreased Hearing	Y	N
Earache	Y	N
Drainage	Y	N

Eyes

Glasses or contacts	Y	N
Pain	Y	N
Redness	Y	N
Blurry/Double Vision	Y	N
Glaucoma	Y	N

Nose

Allergies	Y	N
Nosebleeds	Y	N
Sinus Pain	Y	N

Throat

Teeth	Y	N
Gums	Y	N
Bleeding	Y	N
Dentures	Y	N

Last dental exam ____________________

Neck

Lumps	Y	N
Swollen Glands	Y	N
Pain	Y	N
Stiffness	Y	N

Respiratory

Cough	Y	N
Coughing up Blood	Y	N
Shortness of Breath	Y	N
Wheezing	Y	N
Painful Breathing	Y	N
Sudden Awakening w/ SOB	Y	N
Snoring	Y	N

Cardiovascular

Chest Pain / Tightness	Y	N
Palpitations	Y	N
Short of Breath w/Activity	Y	N
Difficult breathing lying down	Y	N
Swelling	Y	N

Gastrointestinal

Problem Swallowing	Y	N
Heartburn	Y	N
Nausea	Y	N
Rectal Bleeding	Y	N
Constipation	Y	N
Diarrhea	Y	N

Urinary

Frequency	Y	N
Urgency	Y	N

Burning or Pain	Y	N
Blood in Urine	Y	N
Incontinence	Y	N
Male		
Penile Discharge	Y	N
Sores	Y	N
Mass or pain	Y	N
STDs	Y	N
Female		
Itching or Rash	Y	N
Discharge	Y	N
Breast Self Exam	Y	N
Musculoskeletal		
Muscle Pain	Y	N
Joint Pain	Y	N
Warm, red, swollen joints	Y	N
Trauma	Y	N
Neurologic		
Dizziness	Y	N
Fainting	Y	N
Seizures	Y	N
Weakness	Y	N
Numbness	Y	N
Tingling	Y	N
Endocrine		
Increased thirst	Y	N
Frequent urination	Y	N
Psychiatric		
Nervousness	Y	N
Depression	Y	N
Stress	Y	N

Please explain all Yes Answers below:

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Patient Name: ______________________ *DOB:* ____________

PHYSICIANS

Please list the names of physicians that you have seen during the last year along with their phone numbers and addresses.

Doctor	Address	Phone
1.		
2.		
3.		

MEDICATIONS

Name of Medication	Dosage	Frequency (how many times per day)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Allergies:

Also please list any and all vitamins/supplements you are currently taking along with the dosage and frequency per day:

CONSENT TO MEDICAL TREATMENT

Patient Name ______________________________ DOB __________

1. I, ______________________, am suffering from conditions requiring diagnosis, procedures, and/or office care by Dr. William Sheppard and/or their assistants or designess in their judgement.
2. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments and/or examination in the office.
3. This form has been duly explained to me and I certify that I understand its contents and consents.
4. Permission is granted for prescriptions to be packaged in containers without chid-resistant safety caps.
5. It has been explained to me and I understand that the intravenous (IV) treatments, including vitamin and mineral supplements at this clinic are not covered by Medicare, Medicaid, or other health insurers.
6. I agree that if I accept treatment, I shall be responsible for payment of all cost at the time of service. Filing insurance claims for non-covered treatments shall be my own responsibility. I have come to this clinic soley as a patient seeking treatment and I am not an investigating agent of any federal, state, or local agency.

Patient Signature ______________________________ Date __________

Witness Signature ______________________________ Date __________

______________________ is unable to sign this consent because ______________________
__________, I ______________________, am their legal representative.

Representative Signature ______________________________ Date __________

Witness Signature ______________________________ Date __________