Personal Information:

Name: ____ **SS#:**______/_____/_______**DOB**______/_____/______M/F______
(First) (MI) (Last)

Address:____ **City**______________**State**___________**Zip** _______________

Home phone: (_______)________-_________**Cell phone:** (_____)______-________**Email address**:____________________________

Family Doctor / Primary Care Physician Name:____

□ Minor If minor, EMERGENCY CONTACT: ____
□ Married □ Divorced □ Widowed □ Separated □ Single

Employer:____**Occupation:** ____

Whom may we thank for referring you to us? ____

Insurance Information

Insured Name: ____ **DOB:**______/_____/_________
(First) (MI) (Last)

Relationship to Patient:
□ Self **□ Spouse** **□ Child** **□ Other** ___________________

Insurance Co. Name:______________________________ **Policy#:**______________________**Group#:** __________________
(Additional paperwork for Auto patients)

Insurance Phone:____**Employer:**____

Consent to Treatment of a Minor

I hereby authorize the doctor of Spinal Rehab and/or whomever they may designate as assistants, to administer treatment as deemed necessary to

Signature of Parent or Legal Guardian:_________________________________**Date:**_____________________________

Relationship:________________________________ **Witness Signature:**____________________________________

FINANCIAL POLICY

Spinal Rehab and Sports Medicine accepts a wide variety of insurance plans including:

- **Aetna (out of network)**
- **Blue Cross Blue Shield**
- **Humana**
- **United Healthcare**

Please contact your insurance company directly to find out if our providers are in network with your plan. Please note that our providers may not be in network with any of the new exchange plans. If you have further questions, you can also reach Spinal Rehab and Sports Medicine directly by calling 512-258-4425.

PATIENTS WITHOUT INSURANCE

We request that 100% of the private pay visit be paid at the time of visit. We also for your convenience offer keeping your credit card on file.

PATIENTS WITH GROUP INSURANCE

When possible, we will verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.

"ON THE JOB" INJURY (Workers' Compensation)

Spinal Rehab and Sports Medicine does not accept workers compensation. However if your medical insurance approves your care we will submit for you. You will be responsible for non-covered services, deductible or co-pays.

AUTOMOBILE ACCIDENTS (PIP or LOP)

Spinal Rehab and Sports Medicine does not accept PIP(personal injury protection) or LOP(letter of protection) for auto accidents. However we will treat patient under our private pay pricing and submit medical records to lawyer or insurance company for a small fee.

MEDICARE PATIENTS

Spinal Rehab and Sports Medicine is NOT a participating provider of Medicare. Any claim after July 2012 will NOT be billed to Medicare. You will NOT be able to submit or make an appeal to Medicare going forward. As a Medicare member you have the right to seek a Medicare Provider. If you choose Spinal Rehab and Sports Medicine to be your chiropractic provider you will pay private pay pricing.

APPOINTMENTS:

As a courtesy we email and or text reminders to our patients of their appointments 3 days before your appt. and a text 2 hours before your appt time. Please make certain that our records remain updated by providing us the best contact numbers for you.
Late appointments: ***Should you arrive 5 minutes late, your appointment will need to be rescheduled.***
No Show/Late Cancellation fee appointments: ***We ask for 24 hour notice to cancel your appointment during our business hours. If you do not show for an appointment without 24 hour notice you will be charged a No Show Fee. View our Website for office hours www.drbobspinalrehab.com***
No Show Fees/Late Cancellation Fee: ***$40 for 1st offense $60 for 2nd offense and $80 for 3rd offense***

I have read and understand the financial policy of Spinal Rehab and Sports Medicine. I understand that my insurance policy is an arrangement between myself and my insurance company, NOT between this office and my insurance company. I request that Spinal Rehab and Sports Medicine prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors of Spinal Rehab and Sports Medicine that fees will be due and payable immediately.

____

Patient's Signature(or guardian of a minor) **Date**

____

Witness

Your Health History

(circle "C" if the problem is current one and "P" if you've had the problem in the past)

General
C P Allergy
C P Convulsions
C P Fatigue
C P Fainting
C P Headache
C P Sudden Weight Loss C
P High Blood Pressure

Vascular:
C P Nausea/Vomiting
C P Dizziness
C P Numbness on the side
Of the face or body
C P Difficulty Swallowing
C P Difficulty Speaking
C P Fainting/ Light Headed
C P Double Vision
C P Rapid Eye Movement
C P Neck or Head Pain
Like Never before

Muscle & Joint:
C P Arthritis
C P Bursitis
C P Low Back Pain
C P Neck Pain/Stiffness
C P Shoulder Pain
C P Spinal Curvature
C P Midback Pain

Pain or Numbness:
C P Shoulders/Arm
C P Elbows/Hands
C P Hips/Legs
C P Ankles/Knees/Feet

Genito-Urinary:
C P Bedwetting
C P Frequent Urination
C P Kidney Infection
C P Painful Urination
C P Prostate Trouble
C P Kidney Stones

Eyes, Ears, Nose & Throat:
C P Hearing loss
C P Ear-ache
C P Failing Vision
C P Nosebleeds
C P Sinus Infections
C P Strep Throat
C P Thyroid Problems

Skin Problems:
C P Bruise Easily
C P Hives or Allergic
Reactions
C P Skin Rash
C P Acne

For Women Only:
C P Cramps or Backache
w/cycle
C P Excessive Menstral Flow
C P Irregular Cycles
C P Lumps in Breast
C P Pain w/intercourse
C P Pelvic Inflammatory
Disease

Gastrointestinal:
C P Colon Problems
C P Constipation
C P Diarrhea
C P Gall Bladder
C P Hemorrhoids

Respiratory:
C P Asthma
C P Chest Pain
C P Chronic Cough
C P Spitting up Blood

Other:
C P Stroke
C P Rheum. Fever
C HIV/AIDS
C P Alcoholism
C P Cancer

Health Factors: (please circle which applies to you)

When you wake in the morning do you have pain? Y or N

Does pain awaken you from sleep during the night? Y or N

How often do you change position during the night (Very often) (Often) (Occasionally)?____________________

On what type of mattress do you sleep? Innerspring / Foam / Air / Water / Gel

How old is your mattress?___________Years

Do you smoke? Y or N if yes, how many packs a day?__________For how long? _____________

Do you consume alcoholic beverages? Y or N if yes, average drinks per day? __________

Do you exercise regularly? Y or N if yes, Daily / 3 x week / 1x week (please circle one)

PRIVATE PAY

Please ask which major medical plans Spinal Rehab, PA is participating with

•NEW PATIENT VISITS $155.00 •OFFICE VIST $95.00
•THERAPAY ONLY $65.00 •THERAPY One on One $75.00

INSURANCE PATIENTS

Spinal Rehab & Sports Medicine can no longer ABSORB the costs for NON-COVERED services by your insurance company. When appropriate, there will be a nominal increase to your bill.

Non Covered Services:

- ***Acupuncture $50.00***
- ***EndermoSport (LPG) $22.00***
- ***Cryo Therapy $10.00***
- ***EPAT/ACT shock wave therapy $105.00***
- ***Spinal Decompression $22.00***
- ***LED Laser $ 22.00***

Our goal is to deliver excellent quality healthcare at an affordable price. Spinal Rehab & Staff are devoted to the success of your health and quality of your life.

_______________________________ ________________________

Name ***Date***

Spinal Rehab, PA 1120 S. Capital of TX Hwy Bldg 1 Ste 250 Westlake Hills, TX 78746 PH (512)258-4425 FAX (512) 258-4553

Application for Treatment

Name:______________________ Date of Birth:______________ Date: ______________

Email:____ Referred by: ______________

Mark X's in all locations that you have PAIN or NUMBNESS

FRONT | LEFT SIDE | RIGHT SIDE | BACK

WORST PAIN
(Over the past week)

0 1 2 3 4 5 6 7 8 9 10

No Pain — Moderate Pain — Worst Possible Pain

LEAST PAIN
(Over the past week)

0 1 2 3 4 5 6 7 8 9 10

No Pain — Moderate Pain — Worst Possible Pain

Please describe your pain and/or problem: ______________________________

____

____

Sport and/or Activities: ______________ Occupation: ______________

X-ray's/MRI performed for your problem:______________ Surgeries:______________

Medications______________________________________

(Please complete reverse side)

For Doctor Use Only:

C/C	Recent	Chronicity	MOI	TX Received	VAS	Same/Better/ Worse
1	1	1	1	1	1	1
2	2	2	2	2	2	2
3	3	3	3	3	3	3

TX recommendations:

____

____

____

____

____

Exam finding:

____

____

____

____

____

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