Austin Sports & Wellness CHIRO CENTER

WELCOME

Dr. Tyler Begley, DC Dr. Russell Jepson, DC
11614 Bee Cave Rd. Suite A-100,
Austin, TX 78738
Phone: (512) 263-9961
Fax: (512) 263-9963
www.austinsportsandwellness.com

Patient Information

Date_____
SSN_____
Patient Name_____
Preferred First Name_____

Sex [ ] M [ ] F Age_____
Birthdate_____ Ht:_____Wt:_____
Email:_____

Address:_____
City:_____
State:_____Zip:_____

Home Phone: (_____)_____
Cell Phone: (_____)_____
[ ] Married [ ] Widowed [ ] Single [ ] Minor
[ ] Separated [ ] Divorced [ ] Partnered for____years.
Spouse's Name:_____
Spouse's Birthdate:_____

Occupation:_____
Patient Employer/School_____

Whom may we thank for referring you?
_____

Insurance Info

Relationship to Patient_____
Insurance Co._____
Group #_____
Subscriber ID#_____
Birthdate:_____
Relationship to Patient:_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with_____and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I'm financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and deterring insurance benefits of the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Emergency Information

In case of emergency, contact:
Name:_____

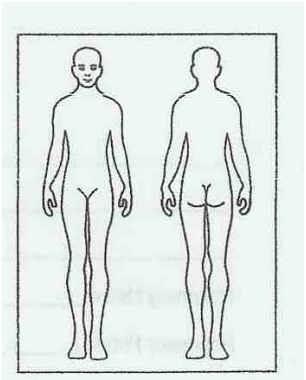
Relationship:_____
Phone: (____)_____

Accident Information

Is condition due to an accident? [ ] Yes [ ] No
Date_____
Type of accident [ ] Auto [ ] Work [ ] Home [ ] Other
Coverage under Personal Injury Protection (PIP) or Liability Coverage?
Attorney Name (if applicable)_____

Patient Condition

Reason for your visit?_____
When did your symptoms appear?_____
Is this condition getting progressively worse? [ ] Yes [ ] No [ ] Unknown
Mark an X on the picture where you continue to have pain, numbness, or tingling.
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) 0 1 2 3 4 5 6 7 8 9 10
Type of Pain: [ ] Sharp [ ] Dull [ ] Throbbing [ ] Numbness [ ] Aching [ ] Burning
[ ] Shooting [ ] Cramps [ ] Tingling [ ] Swelling [ ] Stiffness [ ] Other



How often do you have this pain?_____
Is it constant or does it come and go?_____
Does it interfere with your [ ] Sleep [ ] Work [ ] Recreation [ ] Daily Routine
Activities that are painful to perform [ ] Sitting [ ] Standing [ ] Bending [ ] Walking [ ] Lying Down

Health History

What treatment(s) have you already received for your condition? [ ] Medications [ ] Surgery [ ] Physical Therapy
[ ] Chiropractic Services [ ] Massage Therapy [ ] Other_____

Name of other doctor(s) who have treated you for this condition:_____
Do you have any pending procedures or tests related to this pain?_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	[ ] Yes	[ ] No	Headaches	[ ] Yes	[ ] No
Allergy Shots	[ ] Yes	[ ] No	Hernia	[ ] Yes	[ ] No
Asthma	[ ] Yes	[ ] No	Multiple Sclerosis	[ ] Yes	[ ] No
Bleeding Disorder	[ ] Yes	[ ] No	Osteoporosis	[ ] Yes	[ ] No
Cancer	[ ] Yes	[ ] No	Arm Numbness	[ ] Yes	[ ] No
Concussion	[ ] Yes	[ ] No	Leg Numbness	[ ] Yes	[ ] No
Diabetes	[ ] Yes	[ ] No	Stroke	[ ] Yes	[ ] No

Heart Disease [ ] Yes [ ] No Other Health Issue. Please describe:_____
Herniated Discs [ ] Yes [ ] _____
High Cholesterol [ ] Yes [ ] No _____

Work Activity	Exercise	Family Health History
[ ] Sitting	[ ] None	Please Circle:
[ ] Standing	[ ] Moderate	
[ ] Light Labor	[ ] Daily	Heart Disease Diabetes
[ ] Heavy Labor	[ ] Heavy	
		Stroke Cancer

Are you pregnant? [ ] Yes [ ] No
Due Date:_____

Injuries/ Surgeries you have had:	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
	_____	

Medications	Allergies	Vitamins/ Herbs/ Supplements
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____

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OFFICE FINANCIAL POLICY

1. **Cash Visit/ Exam Fee:**

Initial Chiropractic Exam	$120
Chiropractic Adjustment	$40
Chiropractic Therapy (30mins)	$65
Rehab Therapy (45mins)	$85
Decompression Therapy (30mins)	$95
Massage Therapy (60mins)	$85
Initial Acupuncture Exam	$115
Acupuncture Therapy (60mins)	$85

2. **If You Do Not Have Covered Insurance:** All cash payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time (unless on an authorized payment plan) or care may be terminated.

3. **If You Do Have Covered Insurance:** All deductibles, co-insurances, and co-payments are expected at the time of service. Your insurance balance may not exceed $100 at any time (unless on an authorized payment plan) or care may be terminated. We collect the coinsurance rate at the time of your treatment. Coinsurance is a % of the days billed codes which may change from treatment to treatment. After reviewing your submitted claims should the amount collected be wrong a correction will be made at the next visit. We ask you to look for these errors as well in your first few claims as you will receive this info before our office does. We make every effort to get this amount right and collect according to what your insurance tells us to collect. You are allowed a # of visits per year by your insurance. It is your responsibility to double check your status of your visits remaining. Any visits that goes over the allotted amount will be your financial responsibility.

4. **Cancellation Policy:** Patients that do not honor their appointments will be charged a cancellation fee. Should there be an issue with you "No-showing" for yourappointments we reserve the right to cancel future appointments. The fees are as follows:

Massage Therapy:

***Must be cancelled 24HRS before the appointment time

$40 fee for an Hour Massage

I understand that Austin Sports and Wellness will file insurance claims to the carrier for all services rendered. If your insurance denies a claim for any reason, it is your responsibility to pay the outstanding balance of the charges.

Patient's Printed Name:_____

Signature:_____Date:_____

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INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I (we) hereby consent to the performance of examination and treatment by the licensed Doctor of Chiropractic, Chiropractic Assistants, Acupuncturists and/or Licensed Massage Therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the Chiropractic Doctor(s) or other clinic personnel the nature and purpose of the different therapeutic modalities offered here, including physiotherapy procedures, chiropractic treatment(s), (manipulations/adjustments), massage therapy, and nutritional counseling. I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to doctors. The doctor uses this judgment to attempt to anticipate or explain risks and complications and undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend the best course of treatment, based upon facts known, that are in my best interest. A proper referral will be issued should there not be an improvement seen. I further understand that there are certain degrees of risk associated with chiropractic care and rehabilitation, which rarely includes but are not limited to supplement reactions, soreness, disc injuries, strokes, and soft tissue strains/sprains. I am therefore willing to accept and consent to the risk associated with the care that I am about to receive. These are highly unlikely, and the doctors take all precautions to avoid these issues.

I also understand that the care received at Austin Sports and Wellness Chiro Center is specialized and complementary in nature to the care that I receive from my primary care physician. I understand that I should maintain my relationship with my primary care physician. I understand that I should maintain my relationship with my primary care physician for all other routine medical services that are not offered at this specialty clinic.

I have read, or the above information has been explained regarding consent. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for my future conditions for which I seek treatment.

_____	_____
Signature of Patient or Personal Representative	Printed Name of Patient
_____	_____
Date of Signing	Description of Personal Representative's Authority

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HIPAA

In this document, "I" and "my" refers to the patient, and "providers" refers to Austin Sports and Wellness Chiro Center Chiropractors, Chiropractic Assistants, Massage Therapist, and Acupuncturist.

I consent to the use or disclosure of my protected health information by the providers for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the providers. I understand that analysis, diagnosis or treatment of me by the providers may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The providers are not required by law to agree to the restrictions that I may request as long as they are following HIPAA guidelines. Should a request be requested please notify the staff of this restriction.

I understand that my "protected health information" means health information collected in this office or other offices by the providers or my primary health physician. These records would include personal demographics, health related conditions, treatments procedures and records, imaging records, and other related information. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand that my records will be stored on a protected healthcare cloud-based internet software and your insurance will be sent to my insurance through a protected medical clearinghouse if I have insurance. I understand that Austin Sports and Wellness Chiro Center and alt staff will abide by all HIPAA related guidelines and protect your personal health information.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative's Authority

Quadruple Visual Analogue Scale

Printed Name: _____ Date:_____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Notes: If you have more that one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worse.

Example:

Headache Neck Low Back

No Pain _____ **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

1- What is your pain RIGHT NOW?

No Pain _____ **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

2- What is your TYPICAL or AVERAGE pain?

No Pain _____ **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

3- What is your pain level AT ITS BEST (Howa close to "0" does your pain get at its best)?

No Pain _____ **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

4- What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain _____ **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

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