



## Patient Application Form

Welcome to our clinic. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural correction programs. Our approach is very different and more complete than other rehabilitative programs, which allows us to achieve superior correction as compared to other systems.

Please fill out the following information completely so the doctor can let you know if we can accept your case. Please feel free to ask any questions if you need assistance. We look forward to serving you.

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Patients Name

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Patients Signature

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Date

## ***PATIENT REGISTRATION***

Title: Mr./Mrs./Ms./Dr./Rev./Rank \_\_\_\_\_ Date \_\_\_\_\_  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Nickname \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Mobile Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
E-Mail \_\_\_\_\_ SSN \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender: M F Marital Status: S M W D  
Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_  
Spouse Name \_\_\_\_\_ Phone \_\_\_\_\_  
Spouses Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Children (names, ages) \_\_\_\_\_

## ***INJURY INFORMATION***

Date of injury: \_\_\_\_\_

Please write a brief description of how your injury occurred:

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*If you injury is NOT due to an automobile collision, please skip to the section titled "Areas of Complaint"*

Were you stopped? ( Yes / No ) If no, approximate speed: \_\_\_\_\_ mph

Was the other vehicle stopped? ( Yes / No ) If no, approximate speed: \_\_\_\_\_ mph

At impact, was your body straight in your seat? ( Yes / No ) If no, turned to the ( Left / Right )

At impact, were you looking straight ahead? ( Yes / No ) If no, was your head turned to the ( Left/Right /Up/Down )

Were you aware that you were about to be hit? ( Yes / No )

Were you wearing a seatbelt at the time of the accident? ( Yes / No )

Did your ( chest / head ) hit the steering wheel? ( Yes / No ) Did an airbag deploy? ( Yes / No )

Did your head hit the (Windshield / Side Window)? ( Yes / No ) Did your shoulder hit the door? ( Yes / No )

Did your knees hit the dashboard? ( Yes / No ) Did the seat break? ( Yes / No )

Do you have any (cuts / bruises) from the accident? ( Yes / No ) If yes, where? \_\_\_\_\_

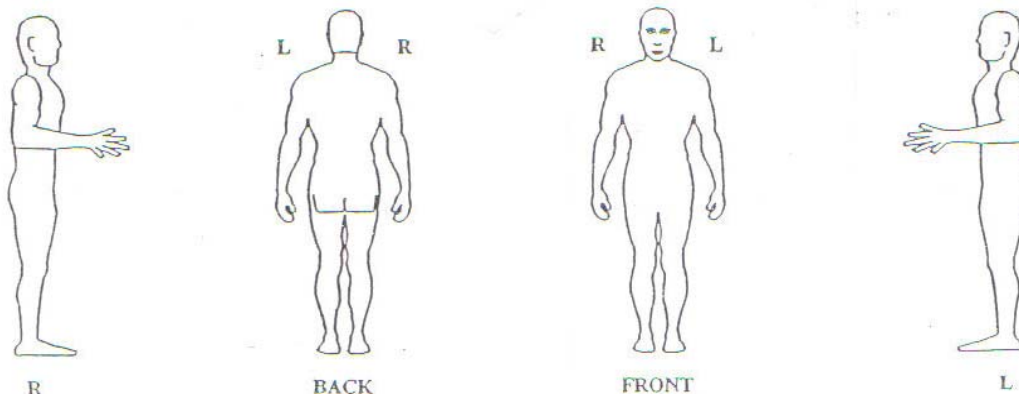
Was your car equipped with headrests? ( Yes / No )

If yes, at what height was the top of the headrest? ( Base of head / Mid head / Top of head )

Did you lose consciousness? ( Yes / No ) If yes, how long \_\_\_\_\_

## **AREA(S) OF COMPLAINT**

Place "X's" on the area(s) where you have pain and draw lines to where it radiates:



Did you have any of the above complaints before your injury? Yes No

Are you experiencing any of the following since your injury? (mark all that apply)

- |                                      |   |  |   |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Headaches   | <input type="checkbox"/> Blurry vision        | <input type="checkbox"/> Dizziness/Loss of balance | <input type="checkbox"/> Indigestion      |
| <input type="checkbox"/> Neck Pain   | <input type="checkbox"/> Rapid heartbeat      | <input type="checkbox"/> Blood/Lymph disorders     | <input type="checkbox"/> Shoulder Pain    |
| <input type="checkbox"/> Anxiety     | <input type="checkbox"/> Urinary difficulties | <input type="checkbox"/> Digestive Problems        | <input type="checkbox"/> Elbow Pain       |
| <input type="checkbox"/> Fatigue     | <input type="checkbox"/> Skin problems        | <input type="checkbox"/> Breathing Problems        | <input type="checkbox"/> Wrist/Hand Pain  |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Memory lapses        | <input type="checkbox"/> Hot/Cold Flashes          | <input type="checkbox"/> Upper Back Pain  |
| <input type="checkbox"/> Knee Pain   | <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Low Back Pain             | <input type="checkbox"/> Weight Loss/Gain |
| <input type="checkbox"/> Hip Pain    | <input type="checkbox"/> Mid Back Pain        | <input type="checkbox"/> Ankle/Foot Pain           |   |

## **TREATMENT INFORMATION**

Did you go to the Emergency Room? ( Yes / No ) If yes, when? \_\_\_\_\_

Name of the Hospital Emergency Room: \_\_\_\_\_

List any medications that you were given: \_\_\_\_\_

List any instructions that you were given: \_\_\_\_\_

From the following list, circle the treatment(s) that you received at the Emergency Room:

Exam / X-Ray / MRI / CT Scan / Back Brace / Neck Brace / Home Instructions / Other \_\_\_\_\_

List all the doctors that you have seen as a result of your injuries (other than at the ER):

	<u>Date</u>	<u>Doctor</u>	<u>Treatment</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Do you have any future appointments with any doctor regarding your injuries? ( Yes / No )

If yes, when and with whom? \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# ***POWER OF ATTORNEY TO ENDORSE CHECKS***

Known All Men By These Present: That the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint the **Corrective Chiropractic** and any of its duly authorized agents and employees as and to be the undersigned's true and lawful Attorney in Fact for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said **Corrective Chiropractic** which checks, drafts or money orders are to pay for chiropractic services or the like which have been made by **Corrective Chiropractic** at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

The undersigned by these presents does thus give and grant unto the said **Corrective Chiropractic** the full power and authority to do and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by the **Corrective Chiropractic** as Attorney In Fact, in accordance with this special power of attorney and shall do or cause to be done by virtue of these presents.

In Witness Whereof: The undersigned have hereunto set their hands, this

\_\_\_\_\_  
PATIENT SIGNATURE (or Parent/Guardian)

\_\_\_\_\_  
DATE

# ***AUTHORIZATION AND ASSIGNMENT***

Corrective Chiropractic, in consideration of your undertaking to care for me, I agree to the following:

- You are authorized to release my information you deem appropriate concerning my physical condition to any insurance company, attorney or adjustor in order to process any claim for reimbursement of charges incurred.
- I authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of 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 and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, 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 efforts to collect the amounts owed directly from me. I understand that whatever amounts you do collect from insurance companies' proceeds, whether it be all or part of what is due, I personally owe you.
- In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Texas.
- I further agree that this Authorization and Assignment is irrevocable until all monies owed Corrective Chiropractic, are paid in full.

\_\_\_\_\_  
PATIENT SIGNATURE (or Parent/Guardian)

\_\_\_\_\_  
DATE

# ***ACKNOWLEDGEMENT AND UNDERSTANDING***

I hereby acknowledge that I am receiving (or about to receive) healthcare services at, Corrective Chiropractic and that I have been advised that the doctor(s) providing the services is/are willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either:

- That there is no insurance company obligated to pay for services, or if the insurance company involved refuses to acknowledge an assignment to Corrective Chiropractic or make other provisions for the protection of the interest of; Corrective Chiropractic **or**
- If a liability claim exists, and my attorney refuses to agree to protect the interest of, Corrective Chiropractic or if I have not engaged the services of an attorney; then payment for services rendered by Corrective Chiropractic will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

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PATIENT SIGNATURE (or Parent/Guardian)

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DATE

## ***NOTICE OF PRIVACY PRACTICES***

We keep a record of the health care services provided to you. You may ask to see a copy of that record. We will not disclose your records to others unless you direct us to or unless the law authorizes or compels us to. You may see your record or get more information about it by contacting Dr. Jason Degenhardt, D.C.

- We may share your health information to run our office, collect payment, treat you, thank you for referring others, discuss your case with your family, include you in health care classes, help you collect from your insurance company, inform you about other services, provide assistance with your diagnosis or treatment from another provider or radiologist.
- We may use your health information for health and safety reasons, court hearings and filings, reporting to law officials and for reporting victims of abuse.
- We may call you by name in the reception area when the doctor is ready for to see you.
- A postcard may be mailed to you at the address provided by you.
- When telephoning your home we may leave a message with whomever answers or on your answering machine.
- We may include a photo of you on our referral wall.

You have the right to request a copy of your records, ask to limit the information we share, amend your health information, request a list of whom we share your records with, advise our management if you believe your privacy rights have been violated.

Our Notice of Privacy Practices, which you can request to view at any time, describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge that I have read, understand and agree to NOTICE OF PRIVACY PRACTICES.

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PATIENT SIGNATURE (or Parent/Guardian)

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DATE

# ***TERMS OF ACCEPTANCE***

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a chiropractic and rehabilitation facility we have one main objective, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this objective, thus preventing any confusion or disappointment.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

**Adjustment:** A specific application of force to facilitate the body's correction of vertebral subluxation.

We do not offer to treat symptoms, but rather to determine if a patient has subluxations. If present, we will recommend a course of treatment including adjustments and rehabilitation procedures in an effort to achieve maximum correction of this dysfunction.

## PROCEDURES

- No Charge Consultation- This is a brief meeting between you and the doctor to determine if you may benefit from the care we provide. There is no financial obligation in connection with this service.
- Exam- After your consultation, if the doctor believes you will likely benefit from the care we provide, a thorough orthopedic, neurologic, and chiropractic examination will be recommended.
- X-Rays- Based upon the exam findings, the doctor may recommend selected x-rays be taken.
- Report of Findings- Included in the cost of the examination is a report of findings. This is where the doctor presents his findings regarding your health to you. The doctor will explain what he feels to be the best and fastest approach to improved health for you, if any.
- Treatments- Include spinal and extra spinal adjustments, intersegmental traction, interferential therapy, curve restoration traction, core muscle training, rehabilitation, posture correction exercises, decompression, custom orthotics, nutritional recommendations and supplements.

## PAYMENT POLICY

- Payment is expected at the time of service unless some other arrangement has been made between you and the doctor prior to treatment.
  - Payment at the time of service entitles you to a 30% discount on all services.
- Health/Automobile Insurance
  - Your insurance coverage is a contract between you and your insurance company. We will gladly help you verify what your particular coverage is; however, we cannot take responsibility for what your insurance does or does not cover. Ultimately, all services rendered to you are charged directly to you and you are responsible for payment.
  - We will file your insurance claim for you and do everything we can do to ensure you receive proper reimbursement.
  - If your policy has a deductible feature, it is due at the time of service.
  - We will do our very best to answer any questions you may have in regard to your insurance.
- There will be a \$25 charge on any returned checks (plus the original amount of the check)

By my signature below, I acknowledge that I have read and agree to the above TERMS OF ACCEPTANCE.

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PATIENT SIGNATURE (or Parent/Guardian)

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DATE

# ***INFORMED CONSENT***

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, examination, traction, and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and/or by other office or clinic personnel.

## **POSSIBLE RISKS**

I understand and am informed that, as in all health care, in the practice of chiropractic, there are some risks to treatment. These include muscle strain, ligament sprain, fracture, disc injury, dislocation, paralysis, stroke, stiffness and soreness. The ancillary procedures could produce skin irritations, burns, or minor complications.

## **PROBABILITY OF RISKS OCCURRING**

The risks of complications due to chiropractic treatment have been described as rare, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

## **OTHER TREATMENT OPTIONS THAT COULD BE CONSIDERED**

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

## **RISKS OF REMAINING UNTREATED**

Can further reduce ranges of motion, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and delay of treatment allows formation of adhesions, scar tissue and other degenerative changes including arthritis. These changes make future rehabilitation more difficult.

## **CONSENT**

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Informed Consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor. I intend this consent to apply to all my present and future chiropractic care.

\_\_\_\_\_  
PATIENT SIGNATURE (or Parent/Guardian)

\_\_\_\_\_  
DATE

## **Pregnancy Release (Female Only)**

This is to certify that to the best of my knowledge I am not pregnant and Corrective Chiropractic has my permission to perform an X-Ray evaluation. I understand the risks of taking an X-Ray to an unborn child.

Date of last menstrual period \_\_\_\_\_ Initials \_\_\_\_\_