LAKEWAY SPINE CENTER

Patient Name: _____ Date: ___/___/_____

Birthdate: ___/___/____ Age: ____ SS# _____-___-_____ Sex: ❑ M ❑ F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Email: _____

Driver's License # :_____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Spouse's Name: _____ Birthdate: ___/___/____

Do You Have Children? ❑ Yes ❑ No

Name	Sex	Age	Medical Problems

In Case of Emergency Notify: _____ Phone: _____

Your Occupation: _____ Employer:_____

Who referred you to Lakeway Spine Center? _____

Primary Care Physician: _____ Phone:_____

Are you currently under the care of another Doctor? Who? _____ Condition: _____

Account Information:

Method of Payment: ❑ Cash / Check / CC ❑ Health Insurance ❑ Personal Injury Protection

❑ Other: _____

Insurance Company: _____ Phone: _____

Name of Insured: _____ Policy #: _____

Group #: _____

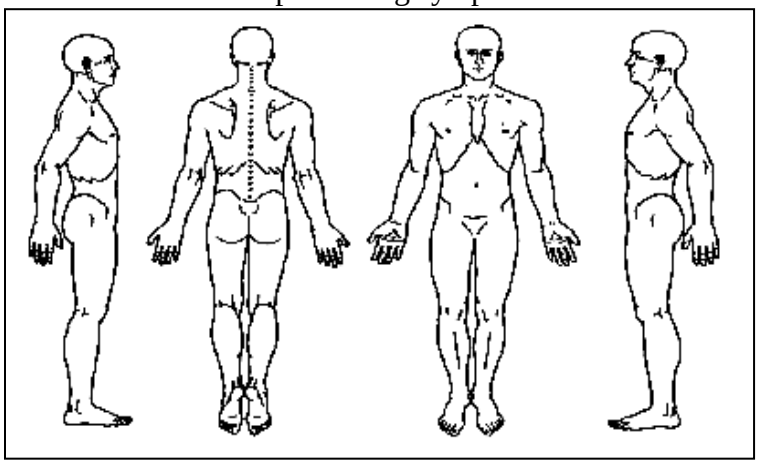
**** Please present your Insurance Card and Driver's License

Presenting Complaint(s): _____

_____

Date of Onset: _____

Please indicate below where you are currently experiencing symptoms.



Please describe your symptoms:

- ❑ Sharp / Stabbing
- ❑ Dull ache
- ❑ Numbness / Tingling
- ❑ Throbbing
- ❑ Stiffness
- ❑ Grabbing
- ❑ Radiating to: _____
- ❑ Other: _____

How often do you experience these symptoms?

- ❑ Constantly (75-100% of the time)
- ❑ Frequently (50-75% of the time)
- ❑ Occasionally (25-50% of the time)
- ❑ Intermittently (0-25% of the time)

Indicate intensity of your symptoms: Average: _____ Best: _____ Worst: _____

(Pain Scale 0-10: 0 = No pain 10 = Unbearable Pain)

Have seen anyone else for this? Who : _____ When: _____

What tests or treatment did you receive? _____ Did it help? _____

Medical History: Are you currently taking any medication or vitamins? Please indicate name and how long you have taken them: _____

_____

Systems Review: Please **CIRCLE** any symptoms or conditions that you are currently experiencing. Please **UNDERLINE** any that you have had in the past.

General
Headache
Unexplained fevers
Night sweats
Loss of appetite
Excessive fatigue
Dizziness
Depression

Musculoskeletal
Scoliosis
Low back pain
Neck pain
Joint swelling / pain
Disc herniation
Muscle pain
Joint Dislocation

Gastrointestinal
Abdominal pain
Nausea
Vomiting
Persistent diarrhea
Constipation
Bleeding on stools

Genitourinary
Kidney stones
Kidney Disease
Blood in urine
Difficult urinary control
Painful / burning urination
Frequent night urination

Cardiovascular
Heart disease
Hypertension
High cholesterol
Rapid heart beat
Heart Attack / M.I.
Poor Circulation
Swollen Ankles

E.E.N.T.
Vision problems
Double vision
Ringing in ears
Ear discharge
Enlarged glands
Sinus infection
Jaw pain / Clicking

For Women Only:
Lumps in breast
Pregnant Y / N
Date of last period:_____
Date of last PAP:_____
Breast implants Y / N

For Men Only:
Prostate trouble
Testicular Pain / Lump

Other
Cancer: _____
Diabetes
Arthritis:_____
Stroke
Appendicitis
Gout
Emotional Disorders
HIV / AIDS

Other: _____

Surgeries / Hospitalizations: _____

Injuries / Fractures / Dislocations / Auto Accidents: _____

LAKEWAY SPINE CENTER
APPOINTMENT POLICIES AND CONSENT TO TREATMENT

Chiropractic Appointments: Patients who are 15 or more minutes late will lose their scheduled appointment time. We will, however, gladly work you into the schedule as quickly as possible. Patients who no-show for their chiropractic appointment, or who do not call to cancel at least 30 minutes prior to their appointment time, may be charged a missed appointment fee of $25.00. This fee will **NOT** be payable by your insurance company.

Massage Appointments: Due to the high overhead costs associated with clinical massage therapy, massage **appointments not cancelled at least 24 hours in advance** will be billed to the patient in **the amount of $30.00. This fee will NOT be payable by your insurance company.**

Patient Consent Form: Regarding the Use & Disclosure of Protected Health Information. For the purposes of this Consent Form, Office shall refer to: Lakeway Spine Center. I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures; I should refer to the Office's privacy notice entitled, "Our Privacy Practices". I understand that I may review this privacy notice at any time prior signing this form. I understand that over time the "Office's Privacy Practices" may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy. I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing. I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Informed Consent to Chiropractic Treatment: Chiropractic, as with any other type of medical care, is associated with potential risks in the delivery of treatment. While Chiropractic treatment is remarkably safe, it is necessary to inform you of suck risks prior to consenting to treatment. These risks include, but are not limited to fractures, disc injuries, stroke, dislocations, and sprains. I understand that it is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of treatment, which the doctor feels at the time based on the facts then known, is in my best interest. I understand, and am informed, of these risks. I have had the opportunity to discuss with Dr. Andrea Luise-Williams the nature and purpose of Chiropractic manipulation and other treatments administered at this office.

Benefits Verification Policy: As part of patient services, we call your insurance company and verify your eligibility and the chiropractic benefits of your plan. Often the chiropractic benefits will differ from the medical benefits of your plan. If you have questions, you may check the information in your plan benefit book or call the telephone numbers listed on the back of your insurance card. All insurance companies state a disclaimer at the time of verification similar to the following: "THIS IS NOT A GUARANTEE OF COVERAGE AND/OR PAYMENT." All claims are subject to review for medical necessity. Ultimately, it is your responsibility to pay for any services that your insurance company denies. Once our office receives the insurance payment and/or explanation of benefits, any remaining balance will be billed to you. If the balance is not resolved by the date that it is due, or a payment plan arrangement initiated, I understand that I will be subject to a late fee, which will not be payable by my insurance. In the event that your chiropractic care is not covered by insurance, payment is expected at the time of service. We will be happy to assist you in working out a payment plan if needed. We want to ensure that all of our patients receive the necessary treatment and that our office is paid in a timely manner. It is our desire to give you the highest quality of care possible, and keeping the lines of communication open is an important part of the process. Please feel free to ask questions or address concerns at any time. I hereby acknowledge that the above referenced insurance and payment policies have been explained to my understanding.

Patient Name (please **print**)

Patient **Signature** Date