1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID :: _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges 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 determining insurance benefits or the benefits payable for related services. This 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

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone(_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCLIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

5 PATIENT CONDITION

Reason for Visit _____

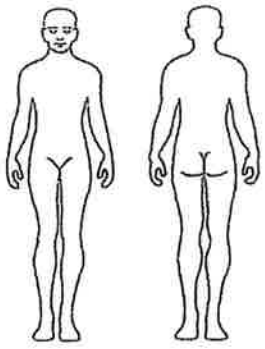
When did your symptoms appear? _____

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) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

- OVER -

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you ior your condition _____

Date oi Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

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

AIDS/HIV ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Measles ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Allergy Shots ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Migraine Headaches ☐ Yes ☐ No	Sexually Transmitted Disease ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Bleeding Disorders ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tumors. Growths ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Other _____
Chemical Dependency ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	
Chicken Pox ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	
		Rheumatoid Arthritis ☐ Yes ☐ No	

EXRCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

ABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? Yes No Due Date _____

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

7 MEDICATRONS

_____
_____
_____
Pharmacy Name _____
Pharmacy Phone (___) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

Bay Oaks Chiropractic

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

The undersigned patient and / or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, grants and conveys to JOEL D. DUCHON, D.C., a lien against the proceeds of the patient's insurance settlement with the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment of 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 doctor / facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the doctor / facility named above within 30 days following your receipt of such bill for the services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Bay Oaks Chiropractic, and send all checks to 17080 Highway 3, Webster, TX 77598.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable directly to Bay Oaks Chiropractic, and to send any and all checks to 17080 Highway 3, Webster, TX 77598.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the doctor / 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 doctor / facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment for treatment and healthcare rendered by the doctor/ 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 requesting in writing to the doctor / facility named above.

REJECTION IN WRITING: I hereby authorize the doctor / clinic named above to establish a PIP or UM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. If my carrier is unable to provide said rejections in a timely manner, I acknowledge that I am entitled to minimum levels of coverage, as per section 1952.152 of the Texas Insurance Code, and further instruct my carrier to pay up to available limits directly to doctor / facility named above, and to send any and all checks or financial instruments to 17080 Highway 3, Webster, TX 77598.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by caring doctor at this clinic, he/she has full and complete right to terminate responsibility 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 doctor / facility immediately. I understand that failure to do so may jeopardize my case.

Signature of patient and/ or responsible parties:

_____ Date_____

Signature

_____

Printed Name

Bay Oaks Chiropractic
Dr. Joel D. Duchon

Informed Consent Document

PATIENT NAME: _____ DATE:_____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.
The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument, an activator upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," known as a cavitations, much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
___ spinal manipulative therapy ___ palpation ___ vital signs
___ range of motion testing ___ orthopedic testing ___ basic neurological
___ muscle strength testing ___ postural analysis testing
___ ultrasound ___ hot/cold therapy ___ EMS
___ radiographic studies
___ Other (please explain)

_____
_____

The material risks inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and /or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening

procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.

The availability and nature of other treatment options.
Other treatment options for your condition may include:
- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW
I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *Dr. Duchon* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ **Dated:** _____

_____ _____
Patient's Name **Doctor's Name**

_____ _____
Signature

_____
Signature of Parent or Guardian (if aminor)

Bay Oaks Chiropractic
Dr. Joel D. Duchon
17080 Highway 3
Webster, Texas 77598

AUTHORIZATION TO LEAVE MESSAGES AND SEND INFORMATION VIA USPS

I authorize Dr. Joel D. Duchon and/ or her employees to mail information regarding my account and/ or care to my home. I also authorize the same to leave necessary telephone messages and/ or make necessary telephone calls relating to the same. I would prefer to be contacted at:

_____HOME

_____OFFICE

_____CELL PHONE NUMBER: _____

_____Email address: _____

GENERAL CONSENT FOR TREATMENT

I, knowing that I am suffering from a condition requiring diagnostic, chiropractic, physiotherapeutic, radiographic, and/ or rehabilitative procedures and/ or treatment, do voluntarily consent to such procedures and care and to such services under the general and specific instructions of DR. JOEL D. DUCHON or designee(s) as is necessary. I also acknowledge that I understand that the practice of chiropractic - as is true with all medically -related arts- is not exact science and no guarantees have been made or will be made as to the results of such treatments and/ or procedures.

I understand that I am to give 24 hours notice to cancel appointments and failure to do so will result in a $25 fee. The same fee applies to missed appointments.

DATED THIS_____DAY OF _____20____

SIGNATURE OF PATIENT: _____
(or parent/ guardian if a minor)

PRINTED NAME: _____

_____DO NOT WRITE BELOW THIS LINE _____

WITNESS: _____

Cancellation Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested, if you must cancel your appointment you must provide more than 24 hours notice. This will enable another patient who is waiting for an appointment to be scheduled in that appointment time. When a cancellation is made with less than 24 hours notice we are unable to fill your appointment time with another patient.

I _____ understand that I must call Bay Oaks Chiropractic and/or Weight Loss Webster 24 hours prior to my scheduled appointment. If I do not call 24 hours prior to a scheduled appointment that appointment will only be rescheduled after I pay a $75 fee. Bay Oaks Chiropractic and Weight Loss Webster cancellation policy has been reviewed with me and I understand the policy as written. I have asked all questions pertinent to this policy.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived, but only with management approval.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and good communication. Any questions regarding cancellation fees should be directed towards our billing department.

Please sign that you have read, understand and agree to Cancellation and No Show Policy.

_____ _____

Patient signature date

_____ _____

Doctor's signature date

How did you hear about
Bay Oaks Chiropractic?

RELATIVE/FRIEND: _____

NEWSPAPER: _____

INSURANCE CO: _____

CURRENT PATIENT: _____
if so, whom may we thank?

_____

Driving by/live in area _____

Other _____

LETTER OF NO ACCIDENT, INJURY, OR PREEXISTING CONDITION

I _____ hereby state with my signature that I was not involved in any auto accident, slip and fall, or work injury. My treatment is in no way associated with any 3rd party, and no other party is responsible or liable for the cost of my treatment.

I also hereby state that this is not a pre-existing condition for which I have been treated for in the past six months.

Please process and pay all claims immediately.

Sincerely,

_____ _____

Patient Signature Date