SPECTOR CHIROPRACTIC

WELCOME TO OUR OFFICE

We are so glad you chose Spector Chiropractic to help you improve your health. Your New Patient Paperwork needs to be completed prior to your first appointment. We understand this packet is long, but these are standard medical questions to help us get to the root cause of your concerns. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

Patient Information

First Name:		**Last Name:**	
Date of Birth:		**Gender:**	**male** ☐ **female** ☐ **other:**
Street Address :			
City:		**State:**	**ZIP:**
Phone Number:			
How did you hear about our office?			
Emergency Contact Name:		**Emergency Contact Phone:**	

Select your Insurance Company
PLEASE GIVE YOUR ID CARD(S) TO THE FRONT DESK TO COPY WHEN YOU COME IN

- ☐ **Blue Cross/ Blue Shield**
- ☐ **United Healthcare**
- ☐ **Cigna**
- ☐ **Aetna**
- ☐ **Humana**
- ☐ **Medicare**
- ☐ **No insurance/ CASH PAY**
- ☐ **Other:** _____

Group Number:	
Member ID:	

Is the primary insured person someone other than yourself? If yes, please give their NAME and DATE OF BIRTH.

Yes ☐ **No** ☐ **Name:** _____ **Date of Birth:** _____

Policies in Our Office

Statement of Understanding and Financial Responsibility

I understand and agree to the following: My case may not be accepted for treatment at this clinic. If the doctor(s) believe I may respond to their care, additional services may be recommended and I will be advised of applicable costs. There is no guarantee that my health insurance will pay for all or any part of my care. All payments are due at time of service rendered.

In return for services rendered to me by Spector Chiropractic, I promise to pay in accordance with bills or invoices presented. If I participate in a health benefit plan, I acknowledge financial responsibility in accordance with the terms of the plan for any services rendered that my plan may exclude from payment for any reason.

ASSIGNMENT OF BENEFITS
I understand that benefits quoted from my insurance carrier to Spector Chiropractic are only an estimate and not a guarantee of payment. I assign Spector Chiropractic all benefits payable to me under my insurance policies and health benefit plans. I shall be personally responsible for any unpaid balance to Spector Chiropractic, PLLC.

MEDICARE I acknowledge that Spector Chiropractic is a Medicare Provider, but Medicare ONLY covers acute injuries/exacerbations that are treated with a chiropractic manipulation to the spine. Exams, therapies, and treatments to extremities are not covered benefits by Medicare.

Please initial to indicate you understand our financial responsibility policy. _____

Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed, as well as how you may have access to the information.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, with whom we shared it, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the last page.
- You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again. Spector Chiropractic does not participate in Fundraising efforts.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

- *Treat you*
  We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- *Run our organization*
  We can use and share your health information to bill and get payment from health plans or other entities. Example: We use health information about you to manage your treatment and services.
- *Bill for your service*
  We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- Help with public health and safety issues

We can share information about you for certain situations such as:

- Preventing disease.
- Helping with product recalls.
- Reporting adverse reactions to medications.
- Reporting suspected abuse, neglect, or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety.
- Do research.
- We can use or share your information for health research only with your written permission.
- Comply with the law.
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services, if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests.
- We can share health information about you with organ procurement organizations upon your passing.
- Work with a medical examiner or funeral director.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests.

We can use or share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions, such as military, national security, and presidential protective services.
- Respond to lawsuits and legal actions.
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information.
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our offices, and on our website.

This Notice of Privacy Practices applies to the following organizations:
Spector Chiropractic, PLLC.

You may contact Spector Chiropractic's Privacy Officer, Dr. Ashley Spector, at:
9720 Coit Rd #240, Plano, TX 75025.
phone: 2148722442
fax: 2149722431
email: spectorchiro@gmail.com

The Effective Date of this notice is 5/1/2017.

Please initial to indicate you understand our Privacy Practices policy. _____

No show/ Cancellation Policy

We understand there may be circumstances which require you to cancel or reschedule an appointment, but our requirement is that you notify our office at least 24 hours before your scheduled appointment.
After one (1) "No Show" or two (2) "Less than 24 hours notice for cancellations", you will be limited to only Same Day Scheduling appointments. Same Day Scheduling means you can call in the morning to check for same day appointment availability.
Alternatively, you can choose to pay a fee of 50% of the missed treatment cost via invoice and to avoid this limitation.
To assist you in keeping your scheduled appointments, you may receive a reminder notification prior to your scheduled appointment via text and/or email provided.

Please initial to indicate you understand our No show/ Cancellation policy. _____

Informed Consent to Treatment

Doctors of chiropractic use treatments such as the spinal adjustments, manual therapy, myofascial release, active rehab exercises, kinesio-taping, cryotherapy (ice), and electrical stimulation should advise patients that there are or may be risks associated with such treatment. In particular you should note the following risks or complications:

A. Manual Therapy, Myofascial Release:

Explanation and Benefits: Manual therapy and myofascial release involve a licensed health care provider's hands or a treatment tool applying pressure on muscle tissue and manipulating joints. In particular, myofascial release involves the gentle sustained pressure into the myofascial connective tissue restrictions. The benefit of manual therapy and myofascial release is to restore normal tissue function, joint function, and aid in normal musculoskeletal biomechanics. Manual therapy and myofascial release have been shown to decrease patient reported pain levels, speed recovery, and restore range of motion. Risks: The risks of manual therapy and myofascial release include localized discomfort, skin reddening, superficial tissue bruising, release of emboli (rare), symptoms shifting to different body areas, post treatment soreness, or an increase in pain.
Alternatives: The alternatives to manual therapy and myofascial release include: prescribed and over-the-counter medication, joint or soft tissue injections performed by a physician, and rest.

B. Active Rehabilitation Exercises:
Explanation and Benefits: Active rehabilitation exercises are designed and prescribed for the sole purpose of facilitating appropriate mobility or stability within the musculoskeletal system. Such rehabilitation exercises include, but are not limited to, functional movements, stretches, self-myofascial release, and open and closed chain exercises.
Risks: The risks of active rehabilitation exercises include aggravation of a present condition, blood pressure changes, and increased heart rate.
Alternatives: The alternatives to active rehabilitation exercises include: prescribed and over-the-counter medication, joint or soft tissue injections performed by a physician, and rest.

C. Kinesio-Taping:
Explanation and Benefits: Kinesio-taping is the specialized taping of areas of the body. Kinesio-taping may aid normal muscle movement and provide stability by mimicking the effects of bracing.
Risks: The risks of kinesio-taping include skin reactions, itching, allergic reactions, hyper pigmentation (discoloration), and blistering.
Alternatives: The alternatives to kinesio-taping include: icing, bracing, athletic taping, and ace bandaging.

D. Cyrotherapy (ice):
Explanation and Benefits: Cryotherapy is the exposure to subzero temperatures to decrease inflammation. Cryotherapy can aid in decreasing muscle soreness, stiffness, swelling and bruising.
Risks: The risks of cryotherapy include skin reactions, itching, allergic reactions, burning, hyper pigmentation (discoloration), and blistering. Alternatives:
Alternatives to cryotherapy include: prescribed and over-the-counter medication, joint or soft tissue injections performed by a physician, and rest.

E. Spine and/or Extremity Adjustments:
Explanation and Benefits: Spine adjustments are the thrusts applied to the vertebra utilizing parts of the vertebra and contiguous structures as levers to directionally correct articular malpositions and improve or correct subluxation. The benefits of cervical spine adjustments include correction of vertebral subluxations, increased stability, and decreased pain.
Risks: The risks of spine adjustments include, but are not limited to, pain and discomfort, fractures, strokes, dislocations, sprains, and injury to a vertebral artery. Vertebral artery injuries may cause strokes, sometimes with serious neurological impairment, and on rare occasion result in death. The possibility of such serious injuries resulting from cervical spinal adjustment is extremely remote.
In addition, the nature of your injury may require the Spector Chiropractic provider(s) to perform treatment near or around sensitive areas (e.g., chest, groin, buttocks, etc.). The Spector Chiropractic providers will make every effort to safeguard your modesty and appropriately conceal the area.
The informed consent documents are used to communicate information about the proposed treatment along with disclosure of risks and alternative forms of treatment. The informed consent documents should not be considered all-inclusive in describing methods of care and all potential risks. Spector Chiropractic may provide you with additional or different information, which is based on the facts in your particular case and the current state of medical knowledge.
I understand that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment including, but not limited to the risks described above. Knowing that I have a condition requiring treatment, I voluntarily consent to treatment performed by Spector Chiropractic (including spinal manipulation). Although the treatment is usually beneficial and seldom causes problems, I understand and have been informed of the potential risks. I have been informed about the methods used by Spector Chiropractic, I and have had the opportunity to ask questions and express concerns prior to treatment. I do not expect Spector Chiropractic to be able to anticipate and explain all risks and complications of my treatment. Further, I wish to rely on the professional and clinical judgment of Spector Chiropractic during the course of my treatment.
I have read and fully understand the above statements. I authorize Spector Chiropractic personnel to administer treatment as deemed necessary. I intend this consent to apply to all my present and future care.

Please initial to indicate you understand our Informed Consent to Treatment policy. _____

Consent to Treat Minor (without Guardian present)

a) I specifically give consent to allow the above named patient to receive any of the above listed treatments when I am not present because I feel that they are sufficiently mature and intelligent enough to understand and appreciate the benefits, risks, and alternatives of the proposed treatments; and can make a voluntary and rational choice on whether to pursue or deny these treatments.
b) I realize that I may be responsible for any charges the above named patient incurs from treatments provided when I am not present.
c) I also understand that unless specifically requested, I may not be notified for each date of service that the above named patient receives treatment.
d) I am aware that I can restrict this consent to a specific time frame if I chose.
e) I have the legal authority to sign this authorization/consent form.

Please print your name (legal guardian)	
If there are restrictions to this consent please list/describe below:	

Health Complaints

What is your primary area of concern?
Please describe your issue/ injury and the purpose of your visit. The more details you give us, the better we can serve you. Please take your time with this section. If you have more than one complaint, please number your complaints in order of severity (#1= bothers you the most). Be specific on what side (right, left, both) and what area(s).

How did your complaint happen?
- ☐ Traumatic/ All of a sudden
- ☐ Gradual/Over time
- ☐ Chronic
- Other: _____

How long ago did it start?
- ☐ Less than 14 days ago
- ☐ 2 weeks to 12 weeks ago
- ☐ 12 weeks to 1 year ago
- ☐ More than 1 year ago
- Other:

Please rate your current pain level.

	0	1	2	3	4	5	6	7	8	9	10	
no pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	worst pain ever

Please rate your average pain level.

	0	1	2	3	4	5	6	7	8	9	10	
no pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	worst pain ever

Please rate your worst pain level.

	0	1	2	3	4	5	6	7	8	9	10	
no pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	worst pain ever

Please rate your level of dysfunction

1	2	3	4	5	6	7	8	9	10
no pain or discomfort	slight discomfort	pain that does not affect my activity	pain that affects my daily activity	pain that prevents performing my daily activities	pain that limits my work schedule	pain that prevents working at all	pain that preventsworking and all personal activity	pain that keeps me bed ridden	pain that causes thoughts of suicide

How frequently does your injury cause you issues?
- ☐ 0-25% intermittent
- ☐ 26-50%
- ☐ 51-75%
- ☐ 76-100% constant

What best relieves your pain?
- ☐ medication
- ☐ rest
- ☐ heat
- ☐ activity
- ☐ cold/ice
- Other: _____

What makes your pain worse?
- ☐ standing
- ☐ activity
- ☐ sitting
- ☐ rest
- Other: _____

What best describes your pain?
- ☐ Ache
- ☐ Burning
- ☐ Dull
- ☐ Sharp
- ☐ Shooting
- ☐ Stabbing
- ☐ Throbbing
- ☐ Tingling
- ☐ Numbness
- Other: _____

Please describe what prior treatments/evaluations you have had for this injury/issue.

What are your goals for care in our office?
Example: reduce pain level to _ out of 10. Example 2: want to be able to walk for 30 minutes so I can go to the store. Example 3: to be able to lift my grandkid. List as many goals as you wish.

Please list all medications that you are taking below:
- ☐ Pain medication
- ☐ Steroids
- ☐ Diabetic
- ☐ Anti-depressant
- ☐ Allergy
- ☐ Muscle relaxants
- ☐ Blood thinner
- ☐ Cholesterol
- ☐ Anti-inflammatory
- ☐ Hypertension
- ☐ GI tract
- ☐ Cardiac
- ☐ None
- ☐ Birth control
- Other: _____

Please list all vitamins/supplements that you are taking below:

- ☐ multi-vitamin
- ☐ fish oil
- ☐ vitamin D
- ☐ vitamin C
- ☐ probiotic
- ☐ vitamin B12
- ☐ B Complex
- ☐ None
- Other: _____

Please comment on any other medications and/or supplements not listed above.

Do you have any of the following medical conditions?

- ☐ **tuberculosis**
- ☐ **kidney disease**
- ☐ **shortness of breath**
- ☐ **prostate issues**
- ☐ **birth defects**
- ☐ **arthritis**
- ☐ **epilepsy**
- ☐ **kidney stone(s)**
- ☐ **hypoglycemia**
- ☐ **hernia**
- ☐ **rheumatic fever**
- ☐ **heart attach**
- ☐ **thyroid disease**
- ☐ **hepatitis**
- ☐ **gall bladder issues**
- ☐ **bronchitis**
- ☐ **anemia**
- ☐ **lung disease**
- ☐ **stroke**
- ☐ **AIDS/HIV+**
- ☐ **bone or joint disease**
- ☐ **gout**
- ☐ **meningitis**
- ☐ **sinus infection**
- ☐ **migraine headaches**
- ☐ **recurrent headaches**
- ☐ **multiple sclerosis**
- ☐ **irregular heartbeat**
- ☐ **pancreatitis**
- ☐ **seriously depressed**
- ☐ **unexplained weight loss**
- ☐ **high blood pressure**
- ☐ **venereal disease**
- ☐ **colon infection**
- ☐ **cancer**
- ☐ **asthma**
- ☐ **heart disease**
- ☐ **heart trouble**
- ☐ **diabetes**
- ☐ **NONE**
- **Other:** _____

Do you have any allergies? If yes, please list:

Do you use tobacco? ☐ **Yes** ☐ **No** ☐ **Former user**

On average, how much alcohol you consume per day?

none ☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** more than 5 servings per day

On average, how much soda/coffee/tea you consume per day

none ☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** more than 5 servings per day

How often do you exercise? ☐ **I don't exercise** ☐ **daily** ☐ **weekly** ☐ **monthly**

Please list any injuries that you have had (auto collisions, sports injuries, etc.)

Please list any surgeries that you have had (gall bladder, tonsillectomy, hysterectomy, etc).

Do you have any implantable medical device(s)?

- ☐ **breast implant(s)**
- ☐ **joint replacement**
- ☐ **spinal hardware**
- ☐ **pacemaker**
- ☐ **NONE**
- **Other:** _____

Have you ever been knocked unconscious? ☐ **Yes** ☐ **No**

Have you ever had a spinal injection? ☐ **Yes** ☐ **No**

Family History: Please indicate if any of your blood relatives have the following:

	mother	father	sibling(s)	child(ren)	NONE
diabetes	☐	☐	☐	☐	☐
heart disease	☐	☐	☐	☐	☐
cancer	☐	☐	☐	☐	☐
stroke	☐	☐	☐	☐	☐
arthritis	☐	☐	☐	☐	☐

FOR WOMEN ONLY: Please give additional information on your pregnancies, if you had delivery complications, and/or menstrual problems.

System Review

Mark the following conditions that are currently a concern for you.

General

- ☐ fainting and/or
- ☐ seizures/convulsions
- ☐ weight loss
- ☐ weight gain
- ☐ chills
- ☐ fatigue
- ☐ fever
- ☐ night sweats
- ☐ depression
- ☐ dizziness
- ☐ loss of sleep
- ☐ headache
- ☐ anxiety
- ☐ low libido
- ☐ NONE

Skin or Allergies

- ☐ bruise easily
- ☐ sensitive skin
- ☐ eczema
- ☐ rash and /or hives
- ☐ NONE

Other: _____

Gastrointestinal

- ☐ constipation
- ☐ diarrhea
- ☐ nausea
- ☐ vomiting
- ☐ liver and/or gallbladder problems
- ☐ kidney problems
- ☐ frequent urination
- ☐ urgency
- ☐ leakage and/or incontinence
- ☐ abdominal pain
- ☐ heartburn
- ☐ bloody stool
- ☐ NONE

Other: _____

Muscles/Joints/Bones

- ☐ spinal curvature
- ☐ painful tailbone
- ☐ weakness
- ☐ poor balance
- ☐ joint swelling
- ☐ restricted motion
- ☐ NONE

Other: _____

Cardiopulmonary

- ☐ chest pain and /or pressure
- ☐ shortness of breath
- ☐ chronic cough and/or difficulty breating
- ☐ spitting blood and/or phlegm
- ☐ arrhythmia and/or palpitations
- ☐ peripheral edema (swollen fingers and/or feet)
- ☐ blood clots
- ☐ varicose veins
- ☐ NONE

Other: _____

Eye/Ear/Nose/Throat

- ☐ asthma and/or wheezing
- ☐ ear noises and'/ or ear pain
- ☐ sinus issues
- ☐ sore throat
- ☐ hearing loss/ deafness
- ☐ vision changes and/or problems
- ☐ frequent colds
- ☐ NONE

Other: _____

Anything else we haven't asked?

FOR WOMEN ONLY:

- ☐ cramps
- ☐ excessive flow
- ☐ irregular cycle painful
- ☐ periods painful
- ☐ intercourse NONE

Other: _____

Are you pregnant?

☐ **Yes** ☐ **No** ☐ **Maybe**

☐ **By Submitting this form, I certify that the information provided is true and accurate and it is my responsibility to notify my doctor if any of my information has changed/needs updating.**
I understand and agree to consultation, history, examination, and treatment.

Please save a completed form and send it to: spectorchiro@gmail.com

SPECTOR
CHIROPRACTIC