Cooley Chiropractic

Please Print Clearly **Date** _____

NAME: _____ Date of Birth _____

Male _____ Female _____

Married _____ Single _____ Spouse Name_____

Address:

Street _____ City _____ State _____ Zip_____

Home Phone_____ Cell Phone _____

E-mail _____

In Case of Emergency please contact:

Name _____

Phone _____ Relationship _____

Place of Employment:

Occupation _____

Work Phone _____

May we contact you at work? Yes _____ No _____

Health History:

Current Symptoms _____

When Symptoms began _____

Other physicians currently being seen for this condition _____

_____

Doctor's Name _____ Specialty _____

Address _____

Phone _____

6605 Precinct Line Rd, Suite 100B, North Richland Hills, TX 76182
www.cooleychiropractic.com
817-281-1995

Cooley Chiropractic

Past History:

Chiropractic Care: Yes _____ No _____

If yes, please list:

Reason for treatment _____

Date of last visit _____

Date of last x-ray _____

Please list any current health problems and current treatment:

_____

_____

_____

List Current Medications:

_____

_____

_____

List Past Surgeries, include dates:

_____

_____

_____

Who should we thank for your referral?

_____

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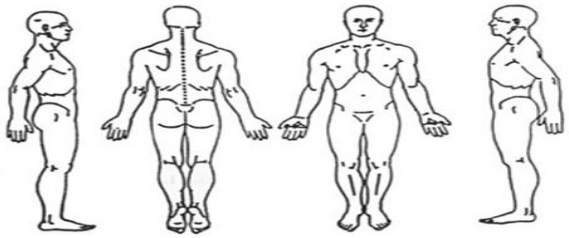
Please mark area of pain on the figure below



If you had the following, or if you suffer from the following, please check

Conditions, Symptoms or problem	Constantly or Frequently	Sometimes or Occasionally
Headache	☐	☐
Migraine	☐	☐
Neck Pain	☐	☐
Shoulder Pain	☐	☐
Arm/Hand Pain	☐	☐
Mid Back Pain	☐	☐
Low Back Pain	☐	☐
Hip Pain	☐	☐
Leg/Foot Pain	☐	☐
Disc Problems	☐	☐
Arthritis	☐	☐
Other Joint Pain	☐	☐
Numbness	☐	☐
Joint Swelling	☐	☐
Dizziness	☐	☐
Nausea	☐	☐
Weakness	☐	☐
Fatigue	☐	☐
Nervousness	☐	☐
Insomnia	☐	☐
Heart Problems	☐	☐
Cough	☐	☐
Chest Pains	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Osteoporosis	☐	☐

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TO EVALTUATE AND ADJUST A MINOR

I, _____being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Signature _____ Date _____

PREGNANCY RELEASE

This is to certify to the best of my knowledge I am not pregnant and the above doctor and his staff have my permission to perform X-rays.

Date of last menstrual period _____

Signature _____ Date _____

NOTIFICATION OF PACEMAKER

Please notify Dr. Cooley if you have a pacemaker. We will not do the interferential therapy on our patients with pacemakers.

I have a pacemaker_____

Signature _____ Date _____

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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient_____ Date _____

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AUTORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION

AND

AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We strongly feel that all patients deserve from us the very best chiropractic care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy

Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility

1. I hereby instruct and direct the _____insurance company to pay by check made out and mailed directly to:

COOLEY CHIROPRACTIC

6605 PRECINCT LINE ROAD, SUITE 100B

NORTH RICHLAND HILLS, TEXAS 76182

I authorize this office to release or receive any information necessary to expedite insurance claims. I hereby authorize this office to bill my insurance company directly for their service. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to Dr. Kent Cooley for which these fees are payable.

2. If I discontinue care before being released by Dr. Kent Cooley, any and all bills are immediately due and payable.
3. If you are a workers compensation patient, your worker compensation carrier is responsible.

I understand that I am directly and fully financially responsible to this clinic for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgement or insurance payment by which I recover said fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment within 60 days, it is my responsibility to pay my doctor's bill directly.

I further understand and agree that if I fail to make timely payments on my account. I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney fees.

Dated the _____ day of _____Year_____

Signature of Policy Holder _____ Witness _____

Signature of Claimant_____