PRACTICE MEMBER APPLICATION:

Today's Date:____/____ / _____

Your name:________________________________ ( )Male ( ) Female

Do you have a preferred nickname:____________________ DL#_______________________

Date of Birth ___ / ___ / _____ Age: ______ SS# ______________________________

Circle marital status: single married divorced widowed separated

Home Address:
___________________________________City_______________State_______Zip__________

Home phone (____) ______________________ Work phone(____)____________________
Cell phone (_____) ______________________

Email:____

May we email or text you (appointment reminders, etc.)? ( )Yes ( )No

Would you like to receive our monthly newsletter? ( ) Yes ( ) No

Occupation:_________________________________
Employer___________________________________

Address:___________________________________City___________________St.___Zip______

Emergency Contact: ___________________________
Phone:(_____)______________________________

Who can we thank for referring you to us?_________________________________

May we contact him/her? ( ) Yes ( ) NO

Name of Insurance Company:
____

Name of Insured (self, spouse, parent)__________________________

Their date of birth___________________

Are you covered by more than one insurance? Y / N

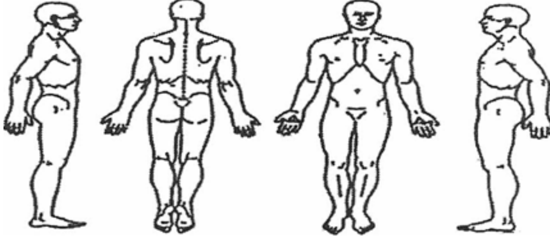
Second Insurance Name:____

PATIENT INTAKE FORM

Patient Name: ________________________________ Date: ____________________

1. **Is today's problem caused by**: o Auto Accident o Workman's Compensation

2. **Indicate on the drawings below where you have pain/symptoms**



3. **How often do you experience your symptoms?**
   - o Constantly (76-100% of the time)
   - o Frequently (51-75% of the time)
   - o Occasionally (26-50% of the time)
   - o Intermittently (1-25% of the time)

4. **How would you describe the type of pain?**
   - o Sharp
   - o Dull
   - o Diffuse
   - o Achy
   - o Burning
   - o Shooting
   - o Stiff
   - o Numb
   - o Tingly
   - o Sharp with motion
   - o Shooting with motion
   - o Stabbing with motion
   - o Electric like with motion
   - o Other: ____________________

5. **How are your symptoms changing with time?**
   o Getting Worse o Staying the Same o Getting Better

6. **Using a scale from 0-10 (10 being the worst), how would you rate your problem?**
   0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

7. **How much has the problem interfered with your work?**
   o Not at all o A little bit o Moderately o Quite a bit o Extremely

8. **How much has the problem interfered with your social activities?**
   o Not at all o A little bit o Moderately Quite a bit o Extremely

9. **Who else have you seen for your problem?**
   - o Chiropractor
   - o ER physician
   - o Massage Therapist
   - o Neurologist
   - o Orthopedist
   - o Physical Therapist
   - o Primary Care Physician
   - o Other: ___________
   - o No one

10. **How long have you had this problem?** ___________

11. **How do you think your problem began?**
    ____

12. **Do you consider this problem to be severe?**
    o Yes o Yes, at times o No

13. **What aggravates your problem?** ____

14. **What concerns you the most about your problem; what does it prevent you from doing?**
    ____

15. **What is your: Height ______feet _____inches Weight __________**
    Occupation ____

16. **How would you rate your overall Health?**
    o Excellent o Very Good o Good o Fair o Poor

17. **What type of exercise do you do?**
    o Stenuous o Moderate o Light o None

18. **Indicate if you have any immediate family members with any of the following:**

o Rheumatoid Arthritis   o Diabetes   o Lupus
o Heart Problems   o Cancer   o ALS

19**. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

Past	Present	Past	Present	Past	Present
o	o Headaches	o	o High Blood Pressure	o	o Diabetes
o	o Neck Pain	o	o Heart Attack	o	o Excessive Thirst
o	o Upper Back Pain	o	o Chest Pains	o	o Frequent Urination
o	o Mid Back Pain	o	o Stroke	o	o Smoking/Tobacco Use
o	o Low Back Pain	o	o Angina	o	o Drug/Alcohol Dependance
o	o Shoulder Pain	o	o Kidney Stones	o	o Allergies
o	o Elbow/Upper Arm Pain	o	o Kidney Disorders	o	o Depression
o	o Wrist Pain	o	o Bladder Infection	o	o Systemic Lupus
o	o Hand Pain	o	o Painful Urination	o	o Epilepsy
o	o Hip Pain	o	o Loss of Bladder Control	o	o Dermatitis/Eczema/Rash
o	o Upper Leg Pain	o	o Prostate Problems	o	o HIV/AIDS
o	o Knee Pain	o	o Abnormal Weight Gain/Loss		
o	o Ankle/Foot Pain	o	o Loss of Appetite	**For Females Only**	
o	o Jaw Pain	o	o Abdominal Pain	o	o Birth Control Pills
o	o Joint Pain/Stiffness	o	o Ulcer	o	o Hormonal Replacement
o	o Arthritis	o	o Hepatitis	o	o Pregnancy
o	o Rheumatoid Arthritis	o	o Liver/Gall Bladder Disorder		
o	o Cancer	o	o General Fatigue		
o	o Tumor	o	o Muscular Incoordination		
o	o Asthma	o	o Visual Disturbances		
o	o Chronic Sinusitis	o	o Dizziness		
o	o Other: ___________________________				

20. **List all prescription medications you are currently taking:**

____

21. **List all of the over-the-counter medications you are currently taking:**

____

22. **List all surgical procedures you have had:**

____

23. **What activities do you do at work?**

o Sit:	o Most of the day	o Half the day	o A little of the day
o Stand:	o Most of the day	o Half the day	o A little of the day
o Computer work:	o Most of the day	o Half the day	o A little of the day
o On the phone:	o Most of the day	o Half of the day	o A little of the day

24. **What activities do you do outside of work?**

____

25. **Have you ever been hospitalized?** o No o Yes

ifyes,why ____

26.**Have you had significant past trauma?** o No o Yes

27.**Anything else pertinent to your visit today?** ______ ____

Patient Signature _____________________________________ **Date:** ____________________

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future, to pay directly to, and exclusively in the name of, *Burow Chiropractic*. *Burow Chiropractic* such sums may be owing to *Burow Chiropractic* for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the office. I further grant a contractual lien to *Burow Chiropractic* with respect to my charges, applicable to all payers, however, I understand that nothing in this agreement shall be construed as an election by *Burow Chiropractic* to claim protection under any statutory lien law. For the purposes of this agreement, "benefits" shall include, but shall not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay *Burow Chiropractic*, I herein assign, insofar as permitted by law, all of my rights, remedies, and benefits to *Burow Chiropractic* to extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name or in the Office's name, and to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this Office. I further direct each attorney to provide immediate notice of to the Office regarding any funds received by the attorney relating to my accident, to promptly pay such Office, and to provide a full accounting of such funds to the Office upon its request.

I hereby direct payers to release to *Burow Chiropractic* any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize *Burow Chiropractic* to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize *Burow Chiropractic* to apply any credit balances incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due *Burow Chiropractic* for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take action to collect any outstanding balance on my account, I will be responsible for payments and will reimburse *Burow Chiropractic* for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of *Burow Chiropractic* and myself. I hereby revoke any previously sign authorization, whether executed at this Office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of *Burow Chiropractic* and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (please Print): ____

Patient Signature: ____Date: _____/_____/_____

Name of Custodial Parent or Legal Guardian (please print): ___________________________________

Parent/Guardian's Signature: ______________________________________ Date: ____/_____/_____

BUROW CHIROPRACTIC
Dr. Paul Burow
612 N. Main
Taylor, TX 76574
(512) 352-5584
Fax (512) 365-3113

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient with Burow Chiropractic we may use or disclose personal and health related information about you in the following ways:

- Your personal information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO or PPO, or your employer if they are or may be responsible for the payment of your services.
- Your name, address, phone number and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization it will not affect the care provided to you or the reimbursement avenues associated with care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain consent after attempting to do so.
- If there are substantial barriers to communicate with you, but in our professional judgment we believe that your intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of you health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: **Dr. Paul Burow.**

This notice is effective as of ______________________________. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

______________________________ ______________________________ ____________

Name (print) Signature Date

If you are a minor or if another party is representing you.

________________________________ ________________________________ ____________

Personal Representative (print) Personal Representative (signature) Date

____

Description of the authority to act on behalf of the patient.