

Performance Sports Chiropractic, PC

Gregory W. Nelson, BSN, RN, DC, CCSP
2828 Thousand Oaks, Suite 102
San Antonio, TX 78232 (210) 348-6377

file#: _____

Name: _____

Date of Birth: _____

Address: _____

Social Security #: _____ - _____ - _____

City, St, Zip _____

Sex: _____

Home Phone: _____

E-mail: _____

Your email is **NEVER** shared with any other party. It is used strictly to keep you apprised of clinic events and specials.

Alternate (mobile) Phone: _____

Marital Status: Married Single Divorced Widowed

How did you hear about us? Walk-by Yellow pages Friend _____

Occupation: _____

Employer: _____

Work phone: _____

Where do you have pain?: Neck Low back Between Shoulder Blades Arms
 Legs Shoulder Hip Other _____

Is your pain the result of a work/automobile injury? Yes No

Who will be responsible for payment of treatment: (check all that may apply)

Myself Health Insurance Auto Insurance

Worker's Comp (Employers Insurance)

Parent/Guardian (if applicable - please provide name/address below)

Parent/Guardian name: _____

Address (if different): _____

I certify that the above information is accurate to the best of my knowledge. I understand that I am ultimately 100% responsible for my account being paid in full, regardless of the responsible party listed above. This includes any amount denied by any insurance company for any reason unless other arrangements have been made with Performance Sports Chiropractic, PC. If at any time I pay any balance with a credit card for any expense such as a copay, I agree that my credit card information may be retained on file at Performance Sports Chiropractic, PC and any outstanding balance(s) 90 days past due will be collected from said card, and only for this purpose, unless I give other written authorization. I understand that failure to settle my account fully will subject my balance to interest charges of 18% (APR) and may result in legal action or transfer to a collection agency. I understand that I am responsible for all amounts incurred in attempting to settle my account should I become delinquent in payment.

Patient Signature (Parent if patient is minor): _____ Date: _____

Patient name: _____ **Date:** _____

Patient History:

1. Where is your pain? _____
2. Does it travel to your arms, legs or head? _____ Yes No
3. When did the pain start? _____
4. What caused it? _____

5. On a scale from 0-10, with 0 being no pain and 10 being the worst pain imaginable, how bad was your pain when it first started? _____/10
6. How bad is it now? _____/10
7. Describe the pain (ie: sharp/burning/achy/tingle): _____
8. Is it constant or does it come and go? _____ Constant Comes / Goes
9. What makes it better? _____
10. What makes it worse? _____
11. Have you had this pain before? _____ Yes No

12. Have you ever been treated by a chiropractor before? _____ Yes No

13. Have you been treated by anyone else for this problem? _____ Yes No

14. Do you **OR** anyone in your immediate family have **ANY** heart problems? _____ Yes No

15. Have you **OR** anyone in your immediate family ever had a stroke? _____ Yes No

16. Have you **OR** anyone in your immediate family ever been diagnosed with any type of cancer? _____ Yes No

17. Are you taking any prescription medications for **ANY** condition? _____ Yes No

Signature: _____

Date: _____

INFORMED CONSENT WAIVER AND AUTHORIZATION TO TREAT

I, the undersigned, am hereby informed by Dr. Gregory W. Nelson that he is a licensed Doctor of Chiropractic in Texas.

I am aware and authorize that examination and x-rays, if deemed necessary, will be performed before any treatment is rendered. I am aware that treatment may include, but is not limited to, any one or more of the following: Skeletal and soft tissue manipulation; Mechanical intersegmental traction; Cryotherapy (Ice therapy), Heat therapy, Nutritional supplementation; Diagnostic x-ray; Rehabilitative exercise; Structural support/bracing; Electrical stimulation; Ultrasound.

I am fully aware that any type of treatment rendered to the human body may have adverse or undesired results. These may include, but are not limited to no improvement or worsening of the condition. I am aware that the possibility of experiencing any type of severe consequence through the care received in this office is present, although very slight.

I am aware that possible consequences of my condition remaining untreated include, but are not limited to, no improvement or worsening of my condition. I am aware that there are several treatment options available to me and have selected chiropractic treatment to attempt to alleviate my condition. I understand that treatment at this facility contains no guarantee of effectiveness and therefore place no liability on Dr. Gregory W. Nelson or Performance Sports Chiropractic, PC.

I agree to arbitrate any disagreement, controversy or claim which cannot be otherwise resolved to my satisfaction, arising out of or relating to any services provided by the staff of Performance Sports Chiropractic, P.C. or the Doctor(s) therein and to settle any dispute by arbitration in accordance with the rules of the American Arbitration Association, which provides dispute resolution services.

I have read and fully understand this agreement.

Signature: _____ Date: _____

Witness: _____ Date: _____

**ASSIGNMENT OF BENEFITS
AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR**

Patient: _____
Employer: _____
Claim / Group #: _____
SS #/ ID #: _____

I hereby assign benefits to Performance Sports Chiropractic, P.C. I instruct any insurance company to pay by check made out and mailed directly to:

**Performance Sports Chiropractic, P.C.
2828 Thousand Oaks
Suite 102
San Antonio, TX 78232**

If my current policy prohibits direct payment to the Doctor, I hereby instruct and direct you to make out the check to me and mail it as follows:

**Performance Sports Chiropractic, P.C.
2828 Thousand Oaks
Suite 102
San Antonio, TX 78232**

for the professional medical expenses benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for the professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment according to financial policy of the above assignee.

This agreement is irrevocable by the patient.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility. I agree that any insurance payment representing an amount in excess of the charges for treatment will be credited to my account, or forwarded to my address upon request in writing to the physician/facility named above.

A PHOTOCOPY OF THIS INSTRUMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. THIS AUTHORIZATION AND ASSIGNMENT TO THE DOCTOR LISTED ABOVE SHALL BE IRREVOCABLE FOR THE FULL EXTENT OF MY TREATMENT BY SAID DOCTOR AND UNTIL SUCH TIME THAT MY MEDICAL EXPENSES INCURRED HAVE BEEN PAID IN FULL.

Signature of claimant: _____ **Date:** _____

Witness: _____ **Date:** _____