VILLAGE CHIROPRACTIC AND medical massage Rx INSURANCE COVERED

HIGHLAND VILLAGE	FLOWER MOUND	FRISCO
PHONE (972) 317-3146| FAX (972) 317- 4417 2430 Justin Rd Ste B, Highland Village, TX 75077	PHONE (972) 460-4420 | FAX (972) 874-8439 2616 Long Prairie Rd, Flower Mound TX 75022	PHONE (972) 460-4420| FAX (469)294-0115 4235 Preston Rd Ste 300 Frisco, TX 75034

PATIENT INFORMATION

Full Name:

Full Address:

Home Phone: Work Phone: Cell Phone:

Preferred Form of Contact: ☐ Text ☐ Phone Call ☐ None

Email Address:

DOB: / / Soc. Sec #: - -

Driver's License #: State:

Marital Status: SINGLE MARRIED WIDOWED Spouse's Name:

Your Employer: Occupation:

Primary Care Physician and Phone Number:

How did you hear about the office?

INSURANCE INFORMATION

Insurance Type: Health Insurance Cash Pay Auto Insurance

Insurance Name:

Member #: Group #:

Insurer's Name (If Different From Patient): Relationship to Patient:

Insurer's DOB: / / Insurer's Soc. Sec # : - -

Insurer's Employer:

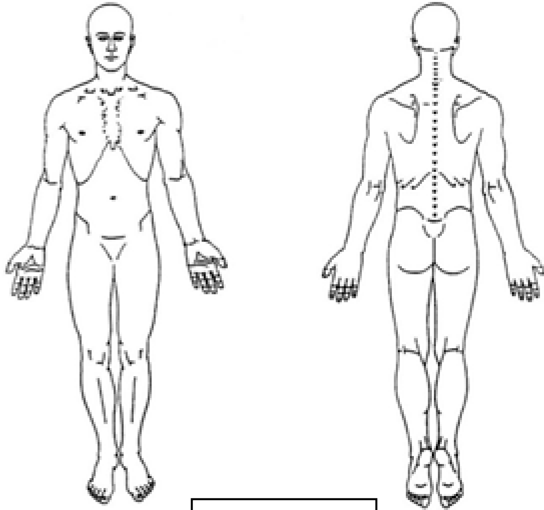
Person responsible for account:

Patient Name (Printed) ______________________________ Date ____________

Patient Signature ______________________________

Parent/Guardian Signature ______________________________

Patient Name: ___________________________________



Circle on body areas of complaint.

1. What are your current complaints:

____

____

2. Describe your symptoms:

☐ Sharp ☐ Prickling ☐ Shooting with Motion
☐ Dull ☐ Itchy ☐ Stabbing with Motion
☐ Diffused ☐ Numbness ☐ Electric with Motion
☐ Achy ☐ Tingling
☐ Burning ☐ Throbbing
☐ Shooting ☐ Stabbing
☐ Stiffness ☐ Sharp with Motion

3. How long has the pain been going on? ___________

____

4. How often do you experience symptoms:

☐ Constant 76-100%
☐ Frequently 51-75%
☐ Occasionally 26-50%
☐ Intermittently 0-25%

5. Are your symptoms getting:

☐ Worse
☐ Same
☐ Better

6. The past **week** my pain has been a (0-10): ________

7. How did your problem begin?

____

8. Has your pain interfered with any of the following normal activities of daily living? (aggravating factors)

☐ Standing ☐ Sitting
☐ Activity ☐ Lifting
☐ Laying ☐ Work
☐ Travel ☐ Driving
☐ Prolonged Standing ☐ Stooping/Bending
☐ Exercise ☐ Golfing
☐ Movement ☐ Reaching Overhead
☐ Running ☐ Stress
☐ Twisting ☐ Weather Changes
☐ Computer ☐ Working Out
☐ Walking ☐ OTHER: __________

9. What alleviates your symptoms: __________________

10. Review of Systems – Mark all that apply

☐ Fatigue ☐ Lower Back Pain
☐ Weight Loss ☐ Muscle Aches
☐ Weight Gain ☐ Dizziness
☐ Blurry Vision ☐ Headache
☐ Sore Throat ☐ Easy Bleeding
☐ Nasal Congestion ☐ Easy Bruising
☐ Chest Pain ☐ Seasonal Allergies
☐ Cough ☐ Anxiety
☐ Abdominal Pain ☐ Depression
☐ Neck Pain ☐ Sleep Disturbances
☐ Mid back Pain ☐ Other: ____________

OFFICE USE ONLY:

HR: _____________ BP: __________/__________

OXG: ____________ TEMP: ____________

TX Phase (Circle one)

TX1 – Acute/Symptomatic **TX2** – Rehab/Repair

TX3 – Stability/Strength **TX4** – Restorative/Extended

TX FREQ: ________________________________

NOTES: ______________________________________

____

____

PA/NP Signature: ____________________________

CHIRO Signature: ____________________________

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

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

13. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other: _____________
□ Massage Therapist □ Physical Therapist □ No one

14. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

15. Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than ½ the days	Nearly every day
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**

16. Females only: When was your last Menstrual period? ____________________________

17. What is your: Height___________ Weight _____________ Date of Birth _____________
Occupation____

18. Have you had labs done recently (within last 6 months)? □ Yes □ No
If "Yes", when?____

19. Have you ever been told you had diabetes or a problem with blood sugar? Yes/No

20. 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

□ □ Headaches
□ □ Neck Pain
□ □ Upper Back Pain
□ □ Mid-Back Pain
□ □ Low Back Pain
□ □ Shoulder Pain
□ □ Elbow/Upper Arm
□ □ Wrist Pain
□ □ Hand Pain
□ □ Hip Pain
□ □ Upper Leg Pain
□ □ Knee Pain
□ □ Ankle/Foot Pain
□ □ Jaw Pain
□ □ Joint Pain/Stiffness
□ □ Arthritis
□ □ Rheum. Arthritis
□ □ Cancer
□ □ Tumor
□ □ Asthma
□ □ **Chronic Sinusitis**
□ □ **Other Breathing Abnormalities**
□ □ **Dermatitis**
□ □ **Rash**
□ □ Eczema
□ □ **High Blood Pressure**
□ □ **Heart Attack**
□ □ **Chest Pains**
□ □ **Stroke**
□ □ **Angina**
□ □ Kidney Stones

□ □ Kidney Disorders
□ □ Bladder Infection
□ □ Painful Urination
□ □ Loss of Bladder Control
□ □ Abnormal Weight Loss
□ □ ***Abnormal Weight Gain***
□ □ Loss of Appetite
□ □ **Abdominal Pain**
□ □ **Ulcer**
□ □ Hepatitis
□ □ **Gall Bladder Disorder**
□ □ Liver
□ □ ***General Fatigue***
□ □ Muscular Incoordination
□ □ Visual Disturbances
□ □ **Dizziness**
□ □ **Diabetes**
□ □ **Excessive Thirst**
□ □ **Frequent Urination**
□ □ Smoking/Tobacco Use
□ □ Drug/Alcohol Dependence
□ □ Allergies
□ □ **Depression**
□ □ Systemic Lupus
□ □ Epilepsy
□ □ HIV/AIDS
□ □ **Anemia**
□ □ **Vitamin D Deficiency**
□ □ **Metabolic syndrome pre-diabetic**
□ □ **Bariatric surgery**
□ □ ***Sleep Disturbances***
□ □ ***Mood changes***

□ □ **Gastric reflux**
□ □ **Irritable Bowel – Syndrome/IBS**
□ □ **Neuropathy**
□ □ **Weakness**
□ □ **Fibromyalgia**
□ □ **Gout**
□ □ **Sleep apnea**
□ □ **Snoring**
□ □ **Shortness of breath**
□ □ **Palpitations**
□ □ **Heart arrhythmia**
□ □ **Anxiety**
□ □ ***Sexual dysfunction***
□ □ **Itching**
□ □ **Psoriasis**
□ □ ***Hyperthyroid***
□ □ ***Hypothyroid***

For Males Only
□ □ **Prostate**
□ □ ***Low – T***
□ □ ***ED***

For Females Only
□ □ *Birth Control Pills*
□ □ ***Hot flashes***
□ □ ***Polycystic ovarian disease***
□ □ ***Infertility***
□ □ ***Painful periods***
□ □ **Hormonal Replacement**
□ □ Pregnancy

Other: ____

21. List all prescription medications you are currently taking:

____
____
____

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

____
____
____

23. List all Allergies (medications, food, seasonal, etc.) you may have:

____
____
____

24. List all surgical procedures you have had:

____
____
____

25. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

26. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

27. What activities do you do at work?

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

28. What activities do you do outside of work? ______________________________________

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

____

30. Have you ever been hospitalized? □ Yes □ No

If Yes, why? ____

31. Indicate if you have any immediate family members with any of the following (Please indicate the relationship to you):

□ Rheumatoid Arthritis □ Diabetes □ Lupus

□ Heart Problems □ Cancer (see add. Forms) □ ALS

□ Other: ____

32. Have you had any past injuries or trauma, such as car accidents (ever?), falls, sports injuries, etc.?

□ Yes □ No If "Yes", please provide details:

____
____

33. Is there anything else you wish to let us know about you visit today? □ Yes □ No

If "Yes", please provide details: ____

____

Patient Signature: _____________________________________ **Date:** ___________________

Informed Consent

Every type of health care is associated with some risk of a potential problem. This includes manual therapy and/or chiropractic care. We want you to be informed about potential problems associated with manual therapy and/or chiropractic health care before consenting to treatment.

Stroke: Stroke is the most serious problem associated with manual therapy and/or chiropractic care. Stroke means that a portion of the brain does not receive oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The chiropractic adjustment that is related to the vertebral artery stroke is called Extension-Rotation-Thrust Atlas Adjustment. We DO NOT use this type of adjustments on our patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractic would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disk Herniations: Disk herniation that create pressure on a spinal nerve, or the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustment, traction, etc. This includes both in the neck and back. Yet, occasionally, chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely, surgery may cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are o available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or mid-back. They extend from your back to your front chest area. Rarely, a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients who have weakened bones from conditions such as osteoporosis. Osteoporosis can be detected on your x-rays. We adjust all patients very carefully, and especially those with osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common in manual therapy and/or chiropractic care, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform your physician.

Other Problems: There may be other problems or complications that might arise from massage therapy treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Patient Name (Printed) ______________________________________ Date ________________

Patient Signature ____

Parent/Guardian Signature ____

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Assignment of Benefits

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 for deferred payment to VRx Medical, a lien and assignment against the proceeds of the patient's insurance settlement with all 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 adjustor for purposes of processing my claim for benefits and payment for 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 physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and 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 VRx Medical at 2430 Justin Rd, Suite B, Highland Village, Tx 75077.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/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 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 healthcare rendered by the physician/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 request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM 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. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my 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 physician/facility immediately. I understand the failure to do so may jeopardize my case.

Patient Name (Printed) ________________________________ Date ______________________

Patient Signature ____

Parent/Guardian Signature ____

HIPAA Disclosure

Standard Authorization of Use and Disclosure of Protected Health Information

The information covered by this authorization includes:

All Patient Medical Records

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

- VRx Medical, PLLC
- Village Chiropractic & Medical Massage Rx
- Medical Massage Rx
- Medical Massage Rx II

Personal Representatives and Emergency Contacts:

Name: ________________________________ Relationship: _______________________

Phone Number: ______________________________

Name: ________________________________ Relationship: _______________________

Phone Number: ______________________________

I hereby authorize the request and release of PHI held by VRx Medical to the above personal representative. By appointing the person named on this form as a personal representative, I understand that I am authorizing VRx Medical to give this person(s) access to PHI, the right to talk to VRx Medical about medical care, and the right to make decisions that will bind me.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize Village Chiropractic & Medical Massage Rx to use my protected information for the listed reasons.

Patient Name (Printed) _______________________________ Date _____________________

Patient Signature ____

Parent/Guardian Signature ____

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FINANCIAL POLICY

Please initial next to each section indicating your acknowledgement:

___________**REFERRALS:** If you have a managed care plan, an HMO, or similar plan that requires a referral, you will need a referral from your primary care physician to see our providers. If your insurance requires a referral that is generated through them, you must reach out to your primary care office for them to call your insurance. It is not our responsibility to generate a referral for ourselves. **If we have not received this referral prior to your arrival at our office, your appointment will either be rescheduled or you may be responsible for the entire bill. It is your responsibility to know if a referral is required and to obtain one.**

___________**INSURANCE BENEFITS:** Please be aware that when a patient requires a visit to a health care provider, there are diagnostic tests or procedures that may be suggested for appropriate care that may be done by one of our providers. These procedures may be done during the normal course of the exam by specialized personnel. Although necessary as part of routine evaluations, insurance companies often categorize these as procedures. **Depending on your insurance policy provisions, these procedures may fall under a separate benefit other than your office co-pay, such as a deductible or coinsurance**. In most cases, exact insurance benefits cannot be determined until the insurance company receives and processes the claim. Therefore, any estimate for services will be considered an estimate only and any payment will be considered a partial-payment until such time that the insurance company processes your claim. Your insurance is a contract between you and your insurance carrier; payment for services is ultimately your responsibility. It is extremely important for you to know your coverage. Many of the diagnostic and therapeutic procedures performed in our office (such as those listed above and others) are considered additional costs by your insurance company. Your health care providers are not aware of what additional costs may be incurred and will not review that with you. As health care providers, our physicians may recommend a diagnostic or therapeutic procedure available only to specialist physicians in order to provide you with the best possible treatment. If you have concerns regarding the cost of any procedure, you may ask your provider to discuss the cost BEFORE the procedure is performed.

___________**WAIVER OF CONFIDENTIALITY:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment and the type of treatment received at our office may become a matter of public record or disclosed to third parties.

___________ **MOTOR VEHICLE ACCIDENT:** Our offices only accept personal injury protection claims. As a courtesy to our patients, if you have a personal injury protection claim open and allow VRx Medical to be directly reimbursed we will accept liability insurance for any balance over what your personal injury pays to VRx Medical. VRx Medical does not accept LOP or LIAB only cases. If you have any further questions in regards to motor vehicle accidents please feel free to reach out to our MVA specialist.

___________ **TRANSFERRING OF RECORDS:** You will need to request in writing, and pay a copying fee of $25 PRIOR to sending copies of your records to another doctor or organization. You authorize us to include all relevant information, including your payment history and hereby indemnify and hold us harmless for any claims or damages resulting from our providing records pursuant to your request. If you request records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

___________ **FORMS FEE:** Please allow 5-7 business days to complete all forms that require a physician signature and medical review (i.e., Worker's Comp, FMLA, Short-term disability (STD), other extended leave of absence, etc.) The physician must take the time to fill out the forms and as such may charge for each record requested, a $30.00 Forms Fee. Each time a correction needs to be made to a form; another Forms Fee will be charged to the account. Additional medical records request will also have a $40.00 assigned fee.

___________ **MASSAGE NO SHOW/CANCELLATION COURTESY:** In order to better accommodate our growing number of patients, we are encouraging each patient to give as much notice as possible when you need to cancel or reschedule an appointment. Less than 24-hour's notice is considered a no-show. We allow 2 grace cancellations per year (no-shows) before we begin charging you this fee, as we understand life happens. As of January 1, 2021 we will charge patients a $25 fee on their 3rd no-show and every no-show after. If it becomes difficult for you to make your scheduled appointments and you reach 5 no shows we will help you by only allowing same day appointments to be scheduled.

___________ **PATIENT BALANCE POLICY:** After your insurance company processes your claims, we will promptly mail you a patient statement if deemed necessary. Payment in full is due upon receipt of this statement. If you have any questions or would like to dispute the balance, it is your responsibility to contact our billing office within 30 days. Accounts past 30 days will be considered past due and may be referred to outside resources for further management. If you are unable to pay the balance due in full, you must contact our RCM department to discuss arrangements.

___________ **SUPPLY & DURABLE MEDICAL EQUIPMENT RETURN:** Supplies may be returned within 30 days of purchase date. If you return a supply we will credit your account the amount you paid for future use within our offices. DME (Durable Medical Equipment) is billed to insurance and cannot be returned after the date it is issued. Please discuss any concerns with receiving durable medical equipment (DME) before signing off and leaving our offices.

Patient Name (Printed) ________________________________ Date ______________________

Patient Signature ____

Parent/Guardian Signature ____

Consent to Treat a Minor

I ____________________________________ (Parent/Guardian) hereby authorize VRx Medical, PLLC and

whomever they designate to administer manual therapy treatment, soft tissue therapy, examination and

evaluation as deemed necessary to my child (Child's Name) ____.

Additional Parent/Guardian Name: ____

Parent/Guardian Signature: ____ Date: ___________________

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