PATIENT HISTORY

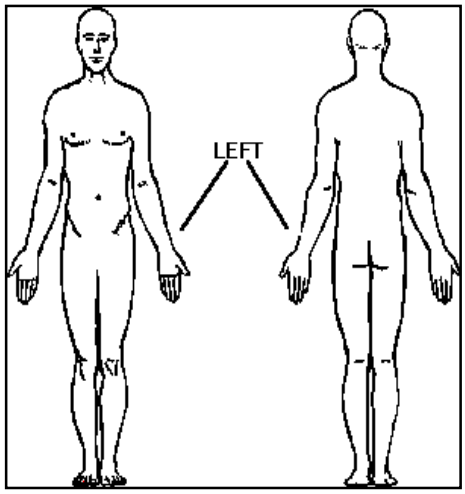
PERSONAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____ Sex: ____ SSN: _____
Address: _____ City: _____ State: ____ Zip: _____
Phones: Home: _____ Work: _____ Cell: _____ Email: _____
Occupation (include types of activity):_____
Race: ☐American Indian or Alaskan ☐Asian ☐Black or African American ☐Hawaiian or Pacific Islander ☐White ☐Other ☐Declined
Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic ☐Declined / Primary Language: _____
Do you have insurance?_____ Insurance Carrier:_____ Marital Status: ☐S ☐M ☐D ☐W ☐Sep
In Case of Emergency Contact: _____ Relationship: _____ Phone: _____
Whom may we thank for referring you? _____

PRIMARY REASON FOR VISIT

Describe what you are seeking our help on: _____
Is it due to an injury? ☐ Yes ☐ No, If Yes: ☐On Job ☐ Auto Accident. Date of Accident: _____ ☐ Other: _____
I am having: ☐ No Pain ☐ Mild pain ☐ Moderate pain ☐ Severe pain → PAIN LEVEL - ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
My pain feels: ☐ Dull ☐ Sharp / Knife-Like ☐ Aching ☐ Deep ☐ Surface
☐ Burning ☐ Pins & Needles ☐ Tingling ☐ Numbness ☐ Cramping

Mark areas of discomfort:



My symptoms started: When:_____ ☐ Immediately ☐ Gradually
My symptoms are: ☐ Getting worse ☐ Constant ☐ Getting better ☐ Comes and goes
During a 24 hour day, how often is it noticeable? _____
When during the day is it ...WORSE?_____...BETTER? _____
I've had this problem before and the last time was: _____
My pain radiates (SHOOTS) to: _____
My pain/radiation increases with: ☐ Coughing ☐ Sneezing ☐ Bowel Movement
My pain / symptom(s) **improve(s)** with:
☐ Rest ☐ Lying ☐ Sitting ☐ Standing ☐ Walking ☐ Heat ☐ Ice
☐ Nothing Other:_____
My pain / symptom(s) **worsen(s)** with:
☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Twisting ☐ Walking
☐ Kneeling ☐ Lying ☐ Pushing ☐ Pulling ☐ Climbing ☐ Gripping
☐ Reaching above shoulder level ☐Nothing ☐ Other _____
In general, my pain / symptom is worse when ☐ moving about ☐ not moving
My pain / symptom is interfering with: ☐ Work ☐ Sleep ☐ Daily Routine
What other doctors have you seen for this condition? Give type of treatment and dates: _____
Cont: _____
What do you think the problem is? _____
What do you want the Doctor to do for you? _____
What else about this condition would you like the doctor to know? _____

HEALTH HISTORY

Circle any condition you are currently experiencing or have experienced in the past: Mark "C" for current and "P" for past.

Fainting	Blackouts	Seizures	Memory Problems	Tremors	Balance Difficulty
Chest Pains	Rapid Heartbeat	Irregular Heartbeat	Difficulty Breathing	Cold Hands / Feet	Swelling Ankles/Leg
Vertigo / Dizziness	Hearing Loss	Ringing in Ears	Changing Voice	Difficulty Swallowin	Loss of Smell
Nausea / Vomiting	Diarrhea	Constipation	Rectal Bleeding	Bowel Incontinence	Liver / Gallbladder
Producing Cough	Asthma	Wheezing	Tuberculosis	Emphysema	Pneumonia / Pleurisy
Skin Rash	Skin Ulcers	Dry Skin	Itchy Skin	Bug Bites	Hair / Nail Changes
Eye Pain	Blurry Vision	Double Vision	Spots in Vision	Dry Eyes	Excessive Tearing
Weak Urine Flow	Frequent Urination	Bladder Incontinence	Dribble	Sexual Dysfunction	Urinary Urgency
Excessive Fever	Airborne Allergies	Food Allergies	Weight Gain / Loss	Hypoglycemia	Hyperglycemia
Legs Cramps	Muscle Pain	Joint Pain	Muscle Spasms	Weakness	Muscle Twitching
Night Sweats	Excessive Thirst	Excessive Hunger	Heat/Cold Intolerance	Currently Pregnant	
Anemia	Easy Bruising				

HEALTH HISTORY (Continued)

Check all conditions you currently experience or conditions you have been previously diagnosed with:

☐ Blow to Skull	☐ Osteoporosis	☐ Spinal Cord Injury	☐ Arthritis	☐ Arteriosclerosis	☐ Mental Disorder
☐ Heart Attack	☐ Bursitis	☐ Varicose Veins	☐ High Blood Pressure	☐ Low Blood Pressure	☐ Small Pox
☐ Diabetes	☐ Brucellosis	☐ Alcoholism	☐ Typhoid Fever	☐ Ulcers	☐ Whooping Cough
☐ Stroke	☐ Hepatitis	☐ Polio	☐ Epilepsy	☐ Venereal Infection	☐ Eczema
☐ Diphtheria	☐ Appendicitis	☐ Goiter	☐ Malaria	☐ Rheumatic Fever	☐ Cancer _____
☐ Measles	☐ Scarlet Fever	☐ Influenza	☐ Multiple Sclerosis	☐ Mumps	☐ Connective Tissue Disorder
☐ Autoimmune	☐ HIV	☐ Other: _____			

MEDICAL AND SURGICAL HISTORY

List all surgeries (Type, approximate date): _____

Cont: _____

List any accidents you have been in: _____

List all broken bones (& approx. date): _____

List all joints dislocated (& approx. date): _____

Have you been knocked unconscious? _____ When? _____ For how long? _____

Have you had X-rays, MRIs or CTs taken before? _____ When? _____ By whom? _____

Why?_____

Have you received chiropractic care before?_____ When? _____

MEDICATIONS AND ALLERGIES

List all medications *(prescribed and over-the-counter) you are currently taking, including birth control medications:*

_____ _____ _____

_____ _____ _____

_____ _____ _____

List known allergies: _____

FAMILY HISTORY

I have _____ older sibling(s) and _____ younger sibling(s). I have _____ living children, ages _____

List major health conditions of blood relatives (i.e. grandparents, parents, siblings, children, aunts, uncles):

Family Member	Health Problem(s)	Age of Death (if applicable)
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Do you now use / do	***No***	***Yes***	***Explain:***
Alcohol	☐	☐	How many drinks per day? _____
Drugs (recreational)	☐	☐	Type _____
Tobacco	☐	☐	How Long have you smoked? _____ Date you quit smoking _____
Coffee	☐	☐	How many cups per day? _____
Soft drinks	☐	☐	How many drinks per day? _____ ☐ Regular ☐ Sugar Free
Exercise	☐	☐	How many times per week? _____ ☐ Mild ☐ Moderate ☐ Severe Intensity
Sleep soundly all night	☐	☐	How many hours per night? _____

Stress Work: ☐ Hi ☐ Med ☐ Lo Home: ☐ Hi ☐ Med ☐ Lo

Describe appetite ☐ Normal ☐ Poor ☐ Always Hungry

Dominant hand: ☐ Left ☐ Right ☐ Either

OTHER CONCERNS

List any other conditions that you are interested in having the doctor check:

1. _____
2. _____

AUTHORIZATION

I understand incorrect information, including omissions, on this document may lead to an incorrect diagnosis and treatment plan. I hereby authorize the doctor to conduct an examination regarding my complaints. I understand that this case is not accepted by the doctor until the doctor has decided it is appropriate for chiropractic care and until the patient/guardian has consented to treatment.

Patient's / Guardian's Signature: _____ Date: _____

Arlington Chiropractic Neurology Center
Informed Consent for Chiropractic Care

130 East Bardin Road, Suite 144
Arlington, Texas 76018-1030
Phone: (817) 419-6681
Fax: (817) 465-3580
E-mail: ChiroNeuro@Yahoo.com
www.ChiroNeurology.com

CHIROPRACTIC - Chiropractic health care seeks to restore health through natural means without the use of drugs or surgery. The human body possesses a natural ability to restore good health given an appropriate environment and removal of health impediments. Because the body is healing, time is required to make these changes.

DIAGNOSIS - Your diagnosis will be made after analyzing information you gave in your intake forms and your examination findings. Please be as thorough as possible in your paperwork and consultation with the Doctor as this allows a more accurate diagnosis, treatment and avoid unnecessary risks. The doctor may utilize video, consult with outside practitioners, or use other means to allow the best possible treatment of your condition.

TREATMENT - Your treatment will consist of a combination of in-office adjustments and therapies plus home exercises or activities. Treatment results will be highly dependent on your commitment to showing up for scheduled appointments and to doing the home exercises and activities. If you have any questions about a therapy please discuss your concern with the doctor or staff. Ultimately your body's health is in your hands and your recovery is dependent on your dedication and compliance to the treatment.

RISKS AND LIMITATIONS - I understand and I am informed that, in the practice of chiropractic there are some risks associated with examination and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts known, is in my best interest. I further acknowledge that no guarantees or assurances are been made to me concerning the results intended from the treatment.

RELEASE OF MEDICAL INFORMATION - I authorized Arlington Chiropractic Neurology Center and/or "office" to furnish information to insurance carriers, Medicare, Medicaid, TDI-WCD, insurance adjuster's, physicians, attorneys, and other related entities concerning the illness or medical treatment of myself or person for which I am guardian via phone, fax, email, internet or in writing, in order to provide medical care, communicate regarding my condition, determine benefits, and request payment.

HIPAA - Our office is HIPAA compliant and your privacy rights are fully outlined in the front desk HIPAA manual, website, and/or by asking our privacy officer. You may receive correspondence via phone, text, fax, email, or postal mail concerning your diagnosis, test results, treatments, appointments, birthdays, and/or other private information unless you inform the clinic of your decision to op-out of such correspondence.

CONSENT - I hereby request and consent to the treatment with chiropractic adjustments and adjunctive procedures, including various modes of therapies, diagnostic imaging and/or laboratory testing, on me (or the patient named below, for whom I am legally responsible) by Arlington Chiropractic Neurology Center and/or Michael Combs, DC, DACNB, FACFN, and/or other licensed Doctors or those working at the clinic or Office who now or in the future treat me while employed by, working or associated with, or serving as a backup for Michael Combs, DC.

I have read, understand and agree to the information set forth in this document. All my questions have been answered to my satisfaction. This document will remain in effect for 10 yrs or until revoked by the signing party.

I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment at this clinic.

_____
Patient Printed Name

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Arlington Chiropractic Neurology Center - Fee Schedule - Financial Policy

(Effective Date : 01/01/2023)

New Patient Exams:			**Adjunctive Therapies:**			**Case Management:**		
Problem Focused	99201	$50.00	Heat Therapy; Cryotherapy	97010	$15.00	Case Management -Team <30 min	99361	$100.00
Expanded	99202	$100.00	Traction - Mechanical	97012	$25.00	Case Management -Team 60 min	99362	$200.00
Detailed	99203	$150.00	Electrical Muscle Stimulation	97014	$25.00	Case Management - Phone minimal	99371	$25.00
Comprehensive	99204	$200.00	Electrical Muscle Stim. - Manual	97032	$35.00	Case Management-Phone intermediate	99372	$40.00
Complex	99205	$250.00	Ultrasound	97035	$25.00	Case Management -Phone minimal	99373	$60.00
Established Patient Exams:			Therapeutic Activities	97110	$40.00	Court Appearance - 500.00 / hr		$500.00
Minimal	99211	$40.00	NeuroMuscular Reeducation	97112	$35.00	**Specialized Testing / Procedures:**		
Problem Focused	99212	$50.00	Gait Training	97116	$35.00	Spontaneous Nystagmus IR camera	92541	$75.00
Expanded	99213	$75.00	Massage	97124	$25.00	Positional Nystagmus Eval. IR camera	92542	$75.00
Detailed	99214	$100.00	Myofascial Release TPT	97140	$40.00	Caloric Evaluation per canal	92543	$50.00
Comprehensive	99215	$125.00	Therapeutic Activity One-on-one	97530	$50.00	Caloric Evaluation w/o Recording	92533	$25.00
Consultation:			Cognitive Skills Development	97532	$50.00	Optokinetic Evaluation IR camera	92544	$75.00
Problem Focused	99241	$75.00	Self care/Home management Training	97535	$50.00	Optokinetic Evaluation w/o Recording	92534	$25.00
Expanded	99242	$125.00	Community/Work Reintegration Training	97537	$50.00	Computerized Posturography	92458	$100.00
Detailed	99243	$175.00	Functional Capacity Evaluation per unit	97750	$50.00	Positional Posterior Canalithiasis	92700	$75.00
Comprehensive	99244	$225.00	**Adjustments:**			Rotary Chair	92546	$50.00
Complex	99245	$275.00	CMT 1 to 2 Regions	98940	$40.00	Tracking Evaluation IR camera	92545	$75.00
Phone Consultation:			CMT 3 to 4 Regions	98941	$50.00	Pulse Oximetry	94761	$10.00
Brief	99371	$25.00	CMT 5 Regions	98942	$60.00			
Intermediate	99372	$50.00	Extra-Spinal	98943	$40.00			
Extensive	99373	$75.00						

Miscellaneous:							
Nutritional Supplements	price varies	Other supplies	price varies		Records request - copies	99080	Varies
X-rays	price varies	MMI Determination - 1 area	99455	$450.00	Special Report - Short	99080	$50.00
Blood work	price varies	MMI Determination - 2 areas	99455	$650.00	Radiology Interpretation	76140	$75.00
Orthotics / Braces / Pillows	price varies	Missed Appointment		$25.00	Narrative	99199	$250.00
Electrodes/E-stim/TENS	price varies						

Definitions. In this Agreement, "Office" and "Clinic" shall refer to Arlington Chiropractic Neurology Center, Cizombs Inc, and/or Michael Combs, DC located at 130 E Bardin Road, Suite 144, Arlington, TX 76018.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that any partial payments received by the Office towards my Charges shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full upon demand, and shall not constitute an accord and satisfaction of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments. The Office does not bill massage (CPT 97124) to any commerical insurance carriers and is the responsibility of the patient. The Office reserves the right to charge $25.00 for missed or rescheduled appts without 24 hours notice.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). For example (without limiting this Agreement), I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I further understand that a Payer may require certain Charges to be pre-certified or pre-authorized. I understand that there may be other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I further agree that should the Office assist me in the verification process, I assume the risk that the Payer and/or the Office may in my opinion fail to accurately understand or communicate to me the Terms of Non-Coverage. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office responsible or liable in any of the foregoing instances.

Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize and direct the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any and all Payers including, without limit, my health benefit plan. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said Payers in writing, or (b) law expressly imposes on the Office to accept (collectively, "Mandatory Fee Reductions"). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are imposed on the Office by virtue of laws which regulate or restrict "balance billing," I hereby waive the application of such laws. In the event that no Mandatory Fee Reductions are actually imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase, "(by [Name of Office])," shall serve as a properly authorized endorsement. I further authorize the Office to apply any credit balances on my Charges 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.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms 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 the Office 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. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Agreement. I have reviewed the Office's "Assignment & Lien" form and further agree to the terms and definitions contained in the Assignment & Lien.

I have read, understood, and agree to the terms of this Agreement.

Patient's / Guardian's Signature: _____ **Date:** _____