# Complete Chiropractic

**4645 Avon Ln #130B * Frisco, Texas 75033 * (469) 473-4005**

## Patient Information

Date_____

Name _____

First M. Last Preferred Name

Address _____

_____

City State Zip

Sex: ☐ M ☐ F Birthdate ___/___/___ Age_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS # _____

Occupation _____

Employer _____

Employer Address _____

City State Zip

Spouse _____

Occupation _____

Whom may we thank for referring you?

_____

_____

## Contact Information

Home Phone_____

Work Phone _____ Ext. _____

Cell Phone _____

E-mail _____

IN CASE OF AN EMERGENCY, CONTACT:

Name _____

Phone _____

## Patient Condition

Height _____ Weight _____

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse?

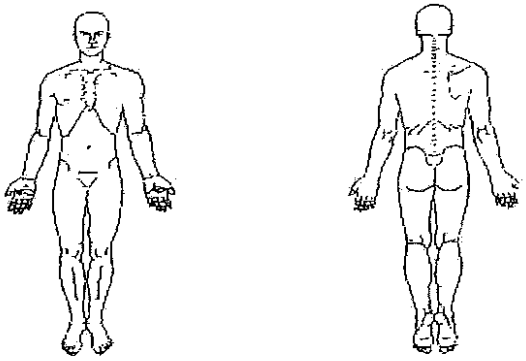
☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain on a scale from 1 to 10

0----------5----------10

(no pain) (severe pain)

Mark an X on the picture where you continue to have pain, numbness, or tingling



Type of Pain:

| | | | |
|---|---|---|---|
| ☐ Sharp | ☐ Dull | ☐ Throbbing | ☐ Numbness |
| ☐ Aching | ☐ Shooting | ☐ Burning | ☐ Tingling |
| ☐ Cramping | ☐ Stiffness | ☐ Swelling | ☐ Other |

How often do you have this pain (is it constant or does it come and go)?

_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

**Additional Comments (Please explain in detail your condition/pain):**

_____

_____

_____

_____

_____

_____

_____

_____

_____

## Health History

What treatment have you already received for your condition? □ Chiropractic Services □ Medications □ Surgery □ Physical Therapy □ None □ Other _____

Name and telephone number of other doctors (s) who have treated you for your condition_____

Date of Last: □ Chiropractic Adjustment _____ □ Medical Appointment _____ □ Massage _____

**Place a mark on "past," "present", or "never" to indicate if you have had any of the following:**

| Past | Present | Never | | Past | Present | Never | | Past | Present | Never | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| □ | □ | □ | AIDS/HIV | □ | □ | □ | Glaucoma | □ | □ | □ | Polio |
| □ | □ | □ | Abnormal Weight Gain | □ | □ | □ | Gout | □ | □ | □ | Poor Circulation |
| □ | □ | □ | Allergy Shots | □ | □ | □ | Heart Disease | □ | □ | □ | Prostate Problems |
| □ | □ | □ | Anemia | □ | □ | □ | Hepatitis | □ | □ | □ | Prosthesis |
| □ | □ | □ | Angina | □ | □ | □ | Hernia | □ | □ | □ | Rheumatoid Arthritis |
| □ | □ | □ | Anorexia | □ | □ | □ | Herniated Disc | □ | □ | □ | Ringing in Ears |
| □ | □ | □ | Appendicitis | □ | □ | □ | High Blood Pressure | □ | □ | □ | Sensitivity to Light |
| □ | □ | □ | Arthritis | □ | □ | □ | High Cholesterol | □ | □ | □ | Stroke |
| □ | □ | □ | Asthma | □ | □ | □ | Kidney Disease | □ | □ | □ | Thyroid Problems |
| □ | □ | □ | Bleeding Disorders | □ | □ | □ | Lazy Eye | □ | □ | □ | Tuberculosis |
| □ | □ | □ | Breast Lump | □ | □ | □ | Liver Disease | □ | □ | □ | Tumors/Growths |
| □ | □ | □ | Bronchitis | □ | □ | □ | Loss of Bladder Function | □ | □ | □ | Ulcers |
| □ | □ | □ | Bulimia | □ | □ | □ | Migraine Headaches | □ | □ | □ | Visual Disturbance |
| □ | □ | □ | Cancer | □ | □ | □ | Mononucleosis | **Females Only** | | | |
| □ | □ | □ | Chest Pains | □ | □ | □ | Multiple Sclerosis | □ | □ | □ | Birth Control |
| □ | □ | □ | Constipation or Diarrhea | □ | □ | □ | Muscle Spasms | □ | □ | □ | Painful Periods |
| □ | □ | □ | Diabetes | □ | □ | □ | Muscular Incoordination | □ | □ | □ | Hormonal Replacement |
| □ | □ | □ | Dizziness | □ | □ | □ | Osteoporosis | □ | □ | □ | Currently Pregnant |
| □ | □ | □ | Emphysema | □ | □ | □ | Pacemaker | □ | □ | □ | Trying to Become Pregnant |
| □ | □ | □ | Epilepsy | □ | □ | □ | Painful/Frequent Urination | □ | □ | □ | Miscarriage |
| □ | □ | □ | Excessive Thirst | □ | □ | □ | Parkinson's Disease | | | | |
| □ | □ | □ | Fractures | □ | □ | □ | Pinched Nerve | | | | |
| □ | □ | □ | General Fatigue | □ | □ | □ | Pneumonia | | | | |

**Please List All Surgeries and Major Injuries (fractures, motor vehicle accidents, etc.):**

_____

_____

_____

_____

| **Medications** | **Allergies** | **Vitamins** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**EXERCISE**
□ None
□ Moderate
□ Daily
□ Heavy

**WORK ACTIVITY**
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

**LIFESTYLE**
□ Smoking
□ Alcohol
□ Coffee/Caffeine
□ Water

Packs/Day_____
Drinks/Day_____
Cups/Day_____
Glasses/Day_____

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## Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants, and conveys, to Complete Chiropractic, a lien and assignment of any arid all claims, causes of action, and right to any proceeds and/or benefits, including any Personal injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred 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 the 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.SS 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: No** 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. S4Z.057 of the Terms Insurance Code, and Article 21. SS of the Texas Insurance Code, provides for attorney fees, an 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Complete Chiropractic and send them to 4645 Avon Ln #130 Frisco, TX 75033

**THIRD PARTY LIABILITY:** If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in frill all services rendered, payable directly to Complete Chiropractic, and to send any and all checks 4645 Avon Ln #130 Frisco, TX 75033

**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 the reasonable cost of collection. including attorney fees and court costs incurred.

**LIMITED POWER OF ATTORNEY:** I hereby grant to the physician/facility named above power to endorse my name upon any checks, or drafts. or other negotiable instrument representing a 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, Health Insurance, and UM/UIM claim on my behalf. 1 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, Health Insurance, and UM/UJM 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 me 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 that failure to do so may jeopardize my case.

**Signature of the Patient**: _____

**Date:** _____

COMPLETE
CHIROPRACTIC
*Dr. Sharyce Wise*

**Office Policy**
Effective October 3rd, 2022 Complete Chiropractic will require all patients to keep an active credit card on file with us to save their appointment or can pay in advance for their appointments. All credit card information will be safely secured in our system. Circumstances, when your card would be charged, include but are not limited to:

- Missed or canceled appointments without 24-hour notice

**Cancellation Policy:**
When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call Complete Chiropractic as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 24 hours in advance. The exception will be for major emergencies and the patient must provide a note to avoid the cancellation fee. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

A cancellation is considered late when the appointment is canceled less than 24 hours before the appointed time. A no-show is when a patient misses an appointment without canceling. In either case, we will charge the patient a $50.00 missed appointment fee.

You can get a refund for the $50 cancellation/missed appointment fee if you refer a patient and they come into our office to get treated.

**Please read through this form and sign below in agreement**

Print Name_____

Signature_____

Date_____

# Informed Consent Document

PATIENT NAME: _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

**The nature of the chiropractic adjustment.**

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

**Analysis / Examination / Treatment**

As a part of the analysis, examination, and treatment, you are consenting to the following procedures: **Patients should initial each procedure they are consenting to.**

_____Spinal manipulative therapy

_____Examination

_____Hot therapy

_____Electrical muscle stimulation

**The material risks inherent in chiropractic adjustment.**

As with any healthcare procedure, there are certain complications that may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

**The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the take of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a casual relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

**The availability and nature of other treatment options.**

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and painkillers
- Hospitalization
- Surgery

If you chose to use one of the above-noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

**The risks and dangers attendant to remaining untreated.**

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

## ----------CONSENT TO TREATMENT----------

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures. This includes examination tests, and physical therapy techniques, on me (or on the patient named below for which I am legally responsible), which are recommended by the doctor of Chiropractic who now, or in the future, renders treatment to me, while employed by, working for, associated with, or serving as backup for the doctor of Complete Chiropractic.

I have had an opportunity to discuss with the doctor and or with office personnel the nature, purpose, and risks of Chiropractic adjustments and their recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed

I have read the above explanation of Chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having had the opportunity to ask about the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

| _____ | _____ | _____ |
|---|---|---|
| Patient Name | Patient/Legal Guardian Signature | Date |

## ----------CONSENT TO TREATMENT (MINOR)----------

I hereby request and authorize **Sharyce Wise, D.C.** to perform diagnostic tests and render chiropractic adjustments and other treatment to my **minor son/daughter:** _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examinations at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW**

I have read [ ] or have read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Sharyce Wise and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

**Dated: _____**

**Patient's Signature _____**

**Print Name_____**

**Signature of Parent or Guardian (if a minor) _____**