Advanced Sport & Injury Clinic

WELCOME

Today's Date: _____

About You

Last Name:
First Name: MI:
Age: Date of Birth:
SSN: Gender: M / F
Home Address:
Email Address:
Home Phone:
Cell Phone:
Employer Name & Address:
Employer Phone:
Occupation:

Status:	Minor	Single	Married	Divorced

Reason For Visit

The reason for this visit is a result of:	Work	Sports	Auto	Trauma	Chronic

Other:

Please Explain:

Please describe pain & its location:

Date condition began?

Is this condition getting worse?	Yes	No	Constant	Comes & Goes

How would you describe the type of pain (circle all that apply):

Sharp / Dull / Diffuse / Achy / Burning / Shooting / Stiff / Numb/ Tingly / Other _____

Is this condition interfering with (circle all that apply):	Work	Sleep	Daily Routine

Have you had this or similar conditions in the past? Y / N
If yes, please explain:

Have you been treated by a Medical Physician for this condition? Y / N If yes, where:

Have you treated with a Chiropractor before? Y / N

Responsible for Account

Please check the proper box below to indicate how you would like us to file your bills:

☐ Personal Insurance	Insurance Name:
☐ Attorney	Attorney Name:
☐ Third Party (party at fault) ☐ PIP (personal car insurance)	Insurance Company:
☐ Work Comp	Work Comp Carrier:

☐ I am a cash patient

In Event of Emergency

Whom should we contact?
Relation:
Home Phone: Cell Phone:
Who is your Medical Doctor?
Medical Doctors Phone:

How did you hear about us

Friend? Name:
Attorney? Name:
Online? Site Name:

Note: We will limit e-mail correspondence to established patients who are adults 18 years or older, or the legal representative or established patients. We will use e-mail to communicate with you only about non-sensitive and non-urgent issues such as routine follow-up questions, appointment scheduling or billing questions. We will not disclose your emails to researchers or others unless allowed by state or federal. Please refer to our Notice of Privacy Practices for information as to the permitted use of your health information and your rights regarding privacy matters.

Health History

Please list ALL medications you are currently taking (Prescriptions & Over-The-Counter):

NAME	HOW OFTEN DO YOU TAKE?	CLINICAL REASON

Please ✓ if you have ever had any of the following:

	GENERAL				BONE / JOINT		
	Cancer		Night Sweats		Back Pain		Fractures
	Hepatitis		Weight Loss		Gout		Rheumatoid Arthritis
	Diabetes		Fatigue		Joint Pain		Osteoarthritis
	Thyroid Disease		Anxiety / Panic Attacks		Muscle Cramps		Osteoporosis
	Hemophilia Fever		Depression				
	EYES/EARS/HEAD		ABDOMEN		URINARY TRACT		BREAST
	Migraine Headaches		Peptic Ulcers		Kidney Failure		Mastectomy
	Glaucoma		Heartburn		Kidney Stones		Lump
	Cataracts		Hernia		Recent Infections		Biopsy
	Blindness		GERD		Recurrent Bladder Infections		Fibrocystic Disease
	Wear Contact Lenses		Frequent Nausea		Recurrent Kidney Infections		
	Partial plate/dentures		Frequent Vomiting		Dialysis		
	HEART		LUNGS		NEUROLOGICAL		
	Heart Attack		Shortness of breath		History of dizziness		Paralysis
	Chest Pain / Angina		Asthma		Alzheimer's		Numbness / Tingling
	Heart Failure		Recurrent Bronchitis		Head Injury		Weakness in arms/legs
	Heart Murmur		Emphysema		Memory Loss		Seizure
	Palpitations		Pulmonary Embolism		Blackout Spells		Epilepsy
	Pacemaker		Tuberculosis		Stroke		
	High Blood Pressure		Pneumonia				
	Other:						
	List Allergies:						

List previous surgeries / treatment with dates:

List any past serious accidents with dates:

Lifestyle Questions:

Do you exercise	☐ Never ☐ Rare ☐ Occasional ☐ Weekly ☐ Several times per week ☐ Daily Type of Exercise:
How much are you on your feet	☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%
Use of Alcohol	☐ Rare ☐ Occasional ☐ Moderate ☐ Daily ☐ Never ☐ No longer
Use of Tobacco	☐ Yes, ____Packs/day ☐ Quit /How long ago_____ ☐ Never
Do you use Recreation drugs	☐ Never ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily ☐ Quit/How long ago _____ Type:

For Women:

Taking birth control	Y / N
Are you pregnant	If yes, how far along?
Nursing	Y / N

Advanced Sport & Injury Clinic

4801 Spring Valley Road, Suite 80 • Dallas, Texas 75244 •972-488-9686

PERSONAL INJURY CLAIM FILING

Please Note

All existing insurance information is required to keep on file. Your health insurance will be used if coverage is not available through your preferred / primary method of filing your claims.
Thank you!

Patient Information

Today's Date: _____

Last Name: First Name:

Date of Accident:

SSN:

Attorney Information:

Name:

Phone: Contact Name:

Party at Fault Insurance:

Insurance Carrier:

Adjuster Name: Claim #:

Phone: Fax:

Name of Party-at-fault:

Your Auto Insurance:

Insurance Carrier:

Adjuster Name: Claim #:

Phone: Fax:

Your Health Insurance:

Insurance Carrier:

Policy Number: Group Number:

Phone: Fax:

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Name: _____ **Today's Date:** _____

Patient Acknowledgement Form

ALL PATIENTS	
Initial: _____	I understand all out-of-pocket fees are due at time of visit
Initial: _____	A 24 hour cancelation notice is required. You will be charged a 50% fee if you fail to provide a 24 hour notice
Initial: _____	MASSAGE SERVICES: Once your massage is scheduled a timed-slot is blocked for you. If you should arrive late this will shorten your massage time. However, you will still owe for the time blocked as you requested when the appointment was scheduled.

INSURANCE PATIENTS ONLY	
Initial: _____	**Advanced Sport & Injury Clinic** allows 60 days for your insurance to pay on filed claims
Initial: _____	**Advanced Sport & Injury Clinic** will dispute Insurance denials up to 3 times. If a denial is not resolved after the third attempt, the claim becomes the patient's responsibility and payment arrangements must be made.
Initial: _____	The patient is responsible for understanding all insurance information pertaining to his/her benefits, including coverage, co-pays, max visits allowed, and non-covered services. In the event that you treat outside your allowed benefits you will be responsible for the charges
Initial: _____	In the event that a Doctor-recommended service, necessary service, or a patient-requested service is not covered by your insurance, an additional out-of-pocket cost will be required

Signature: _____ Date: _____

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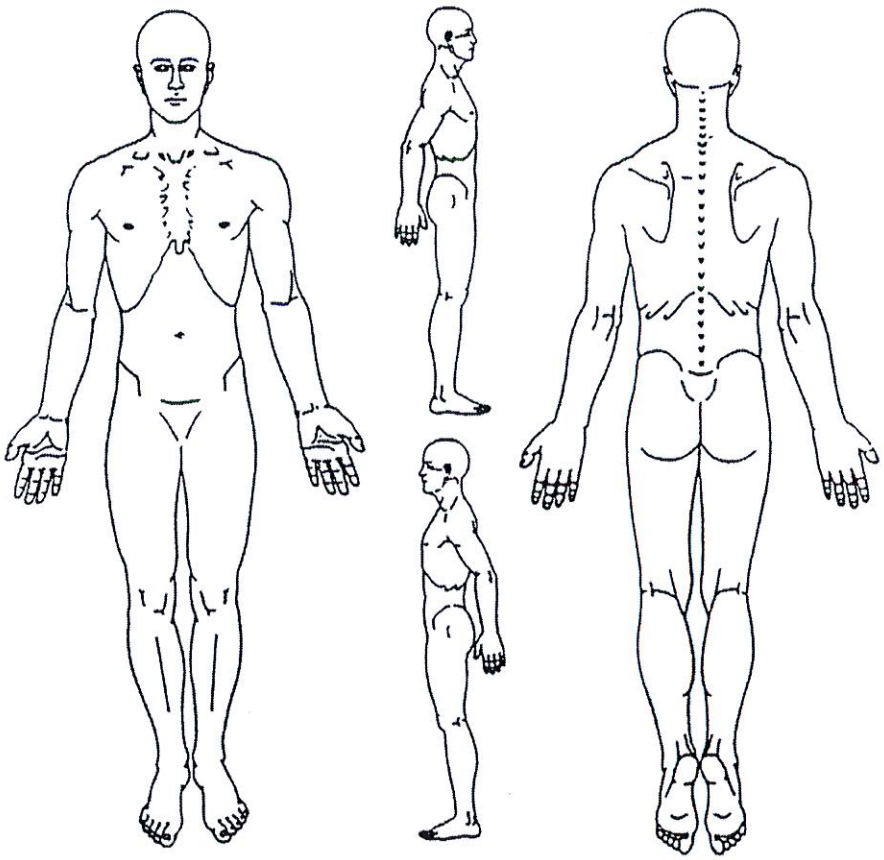
On the drawings below, please indicate where you are experiencing pain by drawing in the letter abbreviation(s) that most accurately reflects the type of discomfort that you have been experiencing.

N	T	A	P	B	S
Numbness	Tingling	Dull Ache	Sharp Pain	Burning	Stiffness



Please Estimate Your Plain Level

(Circle the number accordingly)

Ex: Low Back	0 = No Pain	0 1 2 3 ④ 5 6 7 8 9 10	10 = Intolerable
Body area: _____	0 = No Pain	0 1 2 3 4 5 6 7 8 9 10	10 = Intolerable
Body area: _____	0 = No Pain	0 1 2 3 4 5 6 7 8 9 10	10 = Intolerable
Body area: _____	0 = No Pain	0 1 2 3 4 5 6 7 8 9 10	10 = Intolerable
Body area: _____	0 = No Pain	0 1 2 3 4 5 6 7 8 9 10	10 = Intolerable

Name: _____ Date: _____

ADVANCED SPORT & INJURY CLINIC
4801 Spring Valley road • Dallas, Texas 75244 •972-488-9686

LETTER OF PROTECTION AGREEMENT

Advanced Sport & Injury Clinic is happy to accept Letters of Protection for those patients with personal injury claims handled by attorneys.

I, _____, understand that Advanced Sport & Injury Clinic will accept my Letter of Protection with my permission to file charges with any personal Injury I may have. I understand that without an actual Letter of Protection from my attorney on file with Advanced Sport & Injury Clinic I am fully responsible for the payment of all charges at the time of service. If at any time Advanced Sport & Injury Clinic is informed by my attorney that the case has been dropped, I am completely responsible for all charges including those already incurred.

Signature of Provider / Representative | Date:

Advanced Sport & Injury Clinic

4801 Spring Valley road • Dallas, Texas 75244 •972-488-9686

Acknowledgment of receipt of Notice of Privacy Practice

Pf-2000

Advanced Sport & Injury Clinic reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the notices of Privacy Practices for Advanced Spine & Sports Medicine*.

Patient's Name (print): _____

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

Representative of patient Signature: _____

(Required if the patient is a minor or an adult who is unable to sign this form)

Documentation of Attempts to Obtain Acknowledgement of Receipt of Notice of Privacy Practice

PF - 2100

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgment of receipt of the Notice Privacy Practices on _____. The acknowledgement was not obtained because:

	The Patient was undergoing emergency treatment
	The patient declined to sign the acknowledgment
	Other:

Name of patient (print): _____

Name of Staff Member: _____ **Date:** _____

Advanced Sport & Injury Clinic

4801 Spring Valley road Suite 80 • Dallas, Texas 75244 • PH: 972-488-9686 • FAX: 972-241-1936

Assignment of Benefits: Assignment 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 Jason M Jodoin, DC, a lien and assignment of any and 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 of 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 adjuster 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 exist 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 owed 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 **Advanced Sport & Injury Clinic**, and to send any and all checks to 4801 Spring Valley Road, Suite 80 Dallas, TX 75244.

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 full all services rendered, payable directly to **Advanced Sport & Injury Clinic**, and to send any and all checks to 4801 Spring Valley Road, Suite 80 Dallas, TX 75244.

STATUTE OF LIMITATIONS: I waive my right 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 name 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 to 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.

Printed Name of Patient and/or Responsible Parties

Signature of Patient and/or Responsible Parties | Date:

Advanced Sport & Injury Clinic
Dr. Jason Jodoin D.C.

The Nature of Chiropractic Treatment offered at Advanced Sport & Injury Clinic

Chiropractic treatment consist of evaluation, diagnosing and treating the conditions warranted through the means of using hands, mechanical instruments, various modalities as well as the use and instruction of exercise and/or stretching. When manipulations are performed, you may feel joint movement and you may hear joints "click" or other sounds. Some patients will feel some soreness and/or stiffness following the first few days after treatment. These are normal and not a cause for concern.

Informed Consent for Chiropractic

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named above, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed and that each individual responds differently to the treatment.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

Relative Contraindications: Adds significant risk of injury to the patient but does not rule out the use of dynamic trust. These conditions include: articular hypermobility, severe bone demineralization, benign bone tumors, bleeding disorders, anticoagulant therapy, progressive radiculopathy (meaning weakness, muscle loss, bowel/bladder symptoms).

Absolute Contraindications: Manipulation (including low force techniques) is absolutely contraindicated when the following are present: acute arthropathy, acute/unstable fractures, unstable dens, malignancy of the spine/involved region, infections of the spine, myelopathy, VBS in the cervical spine, arterial aneurysm in the area.

I understand and acknowledge that untreated conditions warranted for chiropractic care allows for adhesions, scar tissue, and other degenerative changes to occur. These changes can further reduce skeletal mobility and can cause chronic pain cycles. In addition, it is quite probable that the delaying or not following the recommendations of the doctor will complicate the condition and make future rehabilitation more difficult.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature _____ Date _____

Print Name: _____

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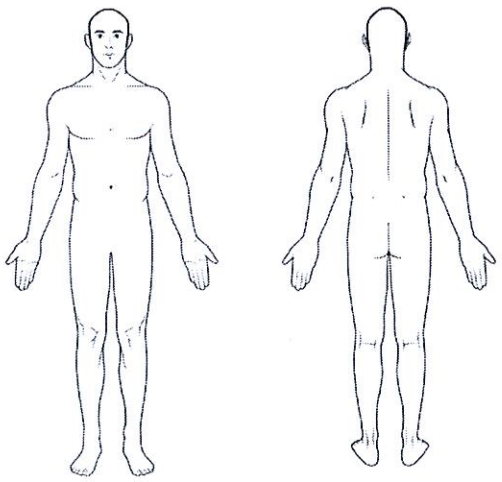
BP-lie	Eyes	X-rays Taken:		AP-L
Sit (R) (L)	Ears	LCN	AP-T	LAT-L
Stand	Nose	APLC	LAT-T	L5-S1 spot
Temp	Throat	APOM	Obliques	Obliques
Resp	Lungs	FLEX/EXT		
	Heart	Obliques	Other	

POSTURE:

NEUROLOGICAL	
Rhomberg	Smell (1)
Walk-Heel	Snel/Periph (II)
Walk-Toe	Card Planes/Pupils (III, IV, VI)
DTR – Biceps (C5)	Corn/Sens (V)
Brachio (C6)	Expres (VII)
Triceps (C7)	Audio (VIII)
Patellar (L4)	Gag (IX)
Achilles (S1)	Swallow (X)
Altar Move	SCM/Trap (XI)
Plantar Reflex (Bab)	Tongue (XII)

STANDING	LUMBAR SPINE
Flexion (90)	Bechterew (D)
Extend (30)	**SUPINE**
Rot (30)	Soto Hall (D)
Lat Flex (30)	Laseague (D/Sc)
Heel Walk (D4)	Braggard (D/Sc)
Toe Walk (D5)	WLR (D/Sc)
Neri's Bow (D/Sc)	Fajerstan (D)
Kemp	Sot/Las/Vas (D)
SITTING	Hoovers (M)
Patella (N-L4)	Babinski (N)
Burns Bench (M)	Fabere (Hip)
Valsalva (D)	Gaensien (SI)
	Lilac Comp (SI)

PRONE
Achilles
Menneis
Ely's
Leg Length
Palpate/Kin



CERVICAL SPINE	
KLEINS – VBAI	Adsons
ROM	Costo-Clav
Flex (45)	Abd-Ext
Ext (55)	STRENGTH
Rot (70)	Deltoid (C5)
Lat Flex (40)	Biceps (C6)
Swallow (ies)	Triceps (C7)
Shid Dep (NR)	Fing Flex (C8)
Max Comp (D/F)	Fing Abd (T1)
Distract (Mm/IVF)	Dynamometer
Soto Hall (Fx/D)	
Vaisalva (D)	

THORACIC SPINE
Vaisalva (D)
Soto Hall (Fx/D)
Palpate/Kin

Name: _____ Date: _____ DC: _____