Kristen Deligans, DC

3409 Post Oak Crossing
Sherman, TX 75092
PH: 903-892-9590
Fax: 903-893-4449

Name_____ Social Security# _____
Address_____City_____State_____Zip_____
E-Mail Address _____ Phone_____ Marital: M S W D
Age _____ Birth Date_____ Sex: F M How Many Children? _____
Occupation: _____Employer:_____
Emergency Contact _____Phone _____
How were you referred to our office? _____
Medical Doctor (PCP)_____ Phone _____
May we have your permission to update your medical doctor regarding your care at this office? Y N
Past Chiropractic Care? Y / N When? _____

INSURANCE:

Primary Insurance_____ Name of Policy Holder_____
ID# _____ Group # _____
Date of Birth of Policy Holder_____ Employer of Policy Holder_____

Secondary Insurance _____ Name of Policy Holder _____
ID# _____ Group # _____
Date of Birth of Policy Holder_____ Employer of Policy Holder _____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment _____
Date symptoms appeared or accident happened_____
Is this related to: Auto Accident _____ Work_____ Other _____
Have you ever had the same or a similar condition? Yes/ No If Yes, explain_____
How frequent is the condition? Constant_____ Daily _____ Intermittent _____ Night Only _____
How long does it last? All Day _____ Few Hours _____ Minutes _____
Are there any other conditions or symptoms that may be related to your major symptom? Yes / No
If yes, describe _____
Describe the pain: Sharp ___ Dull___ Numbness ___ Tingling ___ Aching ___ Burning ___Stabbing ____
What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___ Lifting ___ Twisting ____
Are there other related health problems? Yes / No If yes, explain_____
WOMEN ONLY: Are you pregnant or any possibility you may be pregnant? Yes/ No

I hereby verify that all the above information is true and correct.

_____

Patient/Responsible Party Signature Date

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PAST MEDICAL HISTORY: Have you ever been diagnosed as having or suffered from?

___Fractured or Broken Bones	___Osteoarthritis	___Eating Disorder
___Circulatory Problems	___Epilepsy	___Alcoholism
___Rheumatoid Arthritis	___Pace Maker	___Drug Addiction
___Seizures/Convulsions	___Strokes	___HIV Positive
___A Congenital Disease	___Cancer	___Gall Bladder
___Depression	___Diabetes	___Tuberculosis
___Kidney Disease	___Liver Disease	___Mental Illness
___High/Low Blood Pressure	___Excessive bleeding	___Ruptures
___Heart Disease	___Asthma	

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? If yes, explain_____

_____

Have you been treated for any health condition by a physician this year? If yes, explain_____

_____

What medications or drugs are you taking? _____

_____

_____

Do you have allergies of any kind? Y/N if yes, describe_____

_____

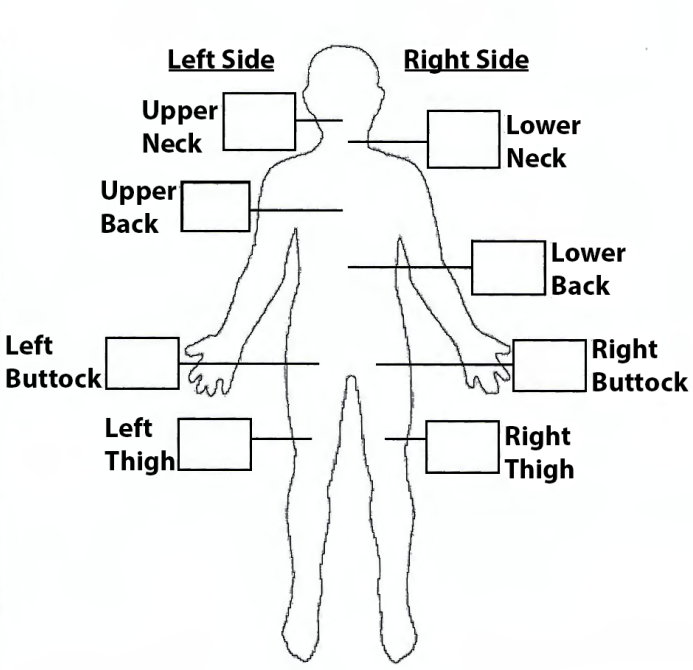
FAMILY HISTORY:	Diabetes	Heart	Kidney	Cancer	Other
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Brother, # of____	_____	_____	_____	_____	_____
Sister, # of ____	_____	_____	_____	_____	_____

PAIN LEVEL: (Circle) **NO PAIN** 1 2 3 4 5 6 7 8 9 10 **INTENSE PAIN**

PLEASE MARK AREA WITH PAIN SCALE

Pain Scale

0- No Pain
1- Very Mild
2- Mild
3- Tolerable
4- Moderate
5- Intense
6- Very Intense
7- Severe
8- Very Severe
9- Extreme
10- Worst Pain Possible



HABITS:

Smoking Packs/Day _____
Drinking Alcohol _____
Caffeine Cups/Day _____

Exercise:

Do you exercise? _____
How often? _____

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CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy on me (or on the patient name below, for whom I am legally responsible) by Dr. Kristen Deligans.

I have had an opportunity to discuss with Dr. Kristen Deligans the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and 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 judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, 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 conditions for which I seek treatment.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

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Verification of insurance Benefits

Our office will verify your insurance benefits with your insurance company and then notify you. If you feel your benefits are not in accordance with your insurance policy please contact your insurance company **IMMEDIATELY**! Our office staff will give you the toll free number and the insurance company representative that verified your benefits. **OUR OFFICE STAFF WILL DO EVERYTHING WE CAN TO MAKE SURE YOUR BENEFITS ARE VERIFIED CORRECTLY.**

However, please be advised regardless of what benefits have been verified, once the "Explanation of Benefits" (EOB) is received from your insurance company your benefits could be paid at a rate different than what was verified to our office. If this occurs, any additional amount due will be BILLED TO YOU and any overpayment will be refunded to you. Our office will refund any amount after all the EOB's have been received from your insurance company and likewise will have been received from your insurance carrier.

I fully understand the above and am in agreement with KRISTEN M. DELIGANS, DC policy regarding insurance benefits. Furthermore, I agree to pay KRISTEN M. DELIGANS, DC any amount of my bill that is not PAID by my insurance company.

_____ _____

Patient Signature Date

Kristen Deligans, DC

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HIPPA COMPLIANCE PATIENT CONSENT FORM

Our notice of Privacy Practice provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your right under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notated at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement the HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payments, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

__Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

__The practice reserves the right to change the privacy policy as allowed by law.

__The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

__The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

__The Practice may condition receipt of treatment upon execution of this consent.

May we phone or e-mail to you to confirm appointments? YES NO

Phone # _____ E-Mail _____

May we leave a message on your answering machine at home/cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed: _____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date _____

Witness: _____ Date _____

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AUTHORIZATIONS, SCHEDULING AND PAYMENT POLICIES

Authorization for Treatment: I authorize Kristen M. Deligans DC to perform all aspects of chiropractic treatment as indicated by assessment. **(Initials)** _____

Authorization for Assignment of Benefits: I authorize any and all insurance payments to be paid directly to Kristen M. Deligans DC for services rendered on my behalf. **(Initials)** _____

Authorization for Release of Medical Information: I authorize the release of any and all medical or other pertinent information that would be necessary for Kristen M. Deligans DC to file any and all insurance claims. This would include any medical and/or other pertinent information pertaining to the attending physician or consulting physician or any hospital or clinic. I further authorize that any photocopy of this authorization is just as binding as the original. **(Initials)** _____

Scheduling: We ask that you be prompt in arriving for your scheduled appointments. We do our best to closely adhere to your appointment time and because we understand how valuable your time is as well. If you need to cancel an appointment, please call to reschedule. **Appointments must be cancelled at least 24 hours in advanced in order to avoid our $25.00 missed appointment fee. (Initials)_____.** Help us serve you and our other patients by keeping your schedule. You can call and leave a message on the recorder if needed. It is available 24 hours a day.

Payments: As a courtesy to you, we do offer a service to our patients by billing your insurance, but it is essential that the insurance information you provide us is accurate and up-to-date. Our office NEVER guarantees that your insurance will pay. We will make every attempt at the beginning of your treatment to receive verification of your policy benefits. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account. **(Initials)** _____.

Your insurance is a contract between you, and/or your employers and the insurance company. We are NOT a party in that contract. While we have an agreement with the health plan to provide services, any questions regarding coverage must be resolved by you with the insurance company. **(Initials) _____**

If you do not have insurance, have not met your insurance deductible or have copays, full payment is due at the time of service. We accept cash, credit and debit cards, and checks. Checks returned by the bank, will be charges $25.00 for processing fee. **(Initials)** _____

As the responsible party, you are signing that you have read and understand the Authorizations, Scheduling, and Payment Policies.

_____

Patient/Responsible Party Signature Date