Amended 06/03/2021

Maximum Wellness Chiropractic, LLC
Drs. Tony & Leslie Maxwell
180 Joe Wimberley Blvd., Suite 202
Wimberley, TX 78676
PH: 512-842-3046 | Fax: 877-640-5603

PATIENT INFORMATION

Patient Name_____Social Security Number_____Today's Date_____

Address_____City_____State_____Zip_____

Birth Date_____/_____/_____Age_____ Sex □ Male □ Female Preferred Contact Method □ Phone □ Text □ Email

Email_____Preferred Phone_____Cell Phone Carrier_____

□ Single □ Married/Partnered □ Separated □ Divorced □ Widowed Are you active Military or Veteran? □Yes □No

Occupation_____Employer/School_____Employer Phone_____

Emergency Contact_____Relationship_____Phone_____

Emergency Contact_____Relationship_____Phone_____

Whom may we thank for referring you?_____□ Insurance Co. □ Website/Facebook □ Other

INSURANCE INFORMATION

Insurance Company_____Insurance Phone Number_____

Group Number_____ID Number_____Is the patient covered by additional service? □ Yes □ No

Subscribers Name_____ Relationship to Patient □ Self □Spouse □Child □Other

Birth Date_____/_____/_____Primary Physician_____ Permission to send PCP notes □ Yes □ No

PRESENT COMPLAINT

Reason for Visit _____

WHEN did your symptoms appear?_____/_____/_____HOW did your symptoms appear? □gradual □sudden □ overtime

What makes it BETTER?_____What makes it WORSE?_____

Have you had similar symptoms before? □ Yes □ No If so, When?_____

What treatments have you received for your current condition? □ Surgery/Injection □ Physical Therapy □ Chiropractic

□ Medication □X-ray/MRI □ Other □ None Diagnostic tests performed_____

Name and approximate date of other providers that have treated you for this condition:

Name(s)_____Date_____

Name(s) _____Date_____

FAMILY HISTORY	Back	Heart	Stroke	Cancer	Diabetes	High BP	Arthritis	High Chol	Osteoporosis	Thyroid
Mother:	□	□	□	□	□	□	□	□	□	□
Father:	□	□	□	□	□	□	□	□	□	□
# of Sisters	□	□	□	□	□	□	□	□	□	□
# of Brothers	□	□	□	□	□	□	□	□	□	□

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HEALTH HISTORY
Please check the following that you have had:

□ ADD/ADHD	□ Chicken Pox	□ Gout	□ Kidney Stones	□ Prostate Problem
□ Alcohol/Drug Addiction	□ Colitis	□ Headaches	□ Liver Disease	□ Reflux/Ulcers
□ Anemia	□ Collagen Disease	□ Hearing Loss	□ Lung Disease	□ Rheumatic Fever
□ Arrhythmia	□ Depression/Anxiety	□ Heart Disease/Attack	□ Mental Disorder	□ Scoliosis
□ Arthritis	□ Diabetes	□ Heart Murmur	□ Migraines	□Seizures/Epilepsy
□ Asthma	□ Dizziness/Vertigo	□ Hemorrhoids	□ Miscarriage	□ Sexual Disorder
□ Blood Clots	□ Eating Disorder	□ Hepatitis	□ Multiple Sclerosis	□ Sinus Trouble
□ Blood Transfusions	□ Emphysema	□ High Blood Pressure	□ Night Sweats	□ Stroke
□ Bowel Problems	□ Fibromyalgia	□ High Cholesterol	□ Osteoporosis	□ Suicidal thoughts
□ Broken Bones	□ Gallbladder disease	□ HIV/AIDS	□ Paralysis	□ Thyroid Disease
□ Cancer	□ Genital Herpes	□ Joint/Back Pain	□ Pneumonia	□ Tumors
□ Cataracts	□ Glaucoma	□ Kidney Infection	□ Polio	□ Urine Discolored

□Other Health History_____

Females: Are you currently pregnant? □ Yes □ No Due date, if applicable: _____

Exercise: □ None □ Daily □ Light □ Moderate □ Heavy Habits: □ Drink Alcohol □ Smoke □ Tobacco

Please list any INJURIES or SURGERIES you have had to date:

Date	Description
_____	_____
_____	_____
_____	_____
_____	_____

ACCIDENT INFORMATION (Leave blank if non-applicable) Type of Accident □ Auto Collision□ On the job injury □ Other

Date of Accident_____/_____/_____Time of Accident_____:_____AM/PM

City_____State_____Where were you in the vehicle? □Driver □Passenger □Front □Back

Make of vehicle you were in _____ Year of vehicle _____ Other vehicle make _____

Did air bags deploy? □ Yes □ No Were you wearing a seat belt? □ Yes □ No Was a police report filed? □ Yes □ No

Did you hit any part of your body during the collision? □ Yes □ No Please explain: _____

Were you seen at ER or Urgent Care? □ Yes □ No Have you lost any days from work? □ Yes □ No How many days? ____

Name of Insurance Company involved_____

Address_____Phone Number_____

Claim Number_____Adjuster Name_____

Legal Representation □ Yes □ No Attorney's Name & Phone Number_____

_____

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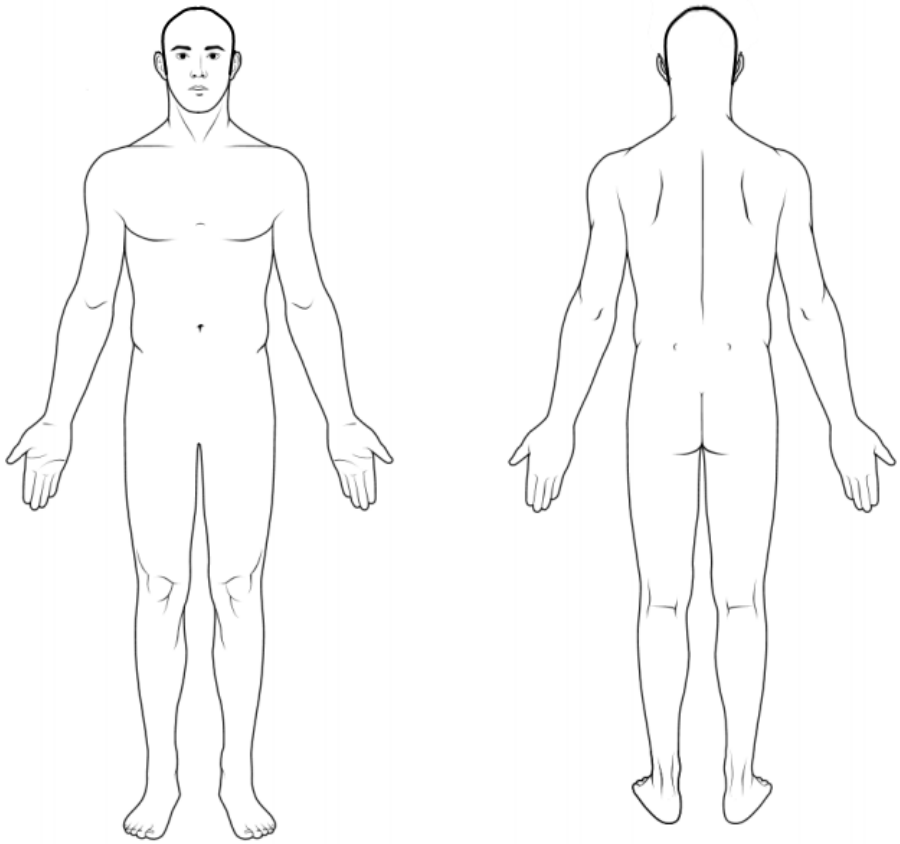
MEDICATIONS
Please list current medications, supplements, or nutraceuticals.

Name	Dosage	Frequency	Reason

PAIN DRAWING
Please tell us WHERE you hurt AND rate your pain from 1-10 with 1 being minimal and 10 being severe.
Check any of the following symptoms: □ Aching □ Burning □ Cramping □ Dull □ Numbing □ Sharp
□Shooting □Stabbing □Soreness □Throbbing □ Tight □ Tingling



OUR FINANCIAL POLICY AND HOW IT WORKS
Insurance coverage varies greatly. Everyone has different insurance that normally changes on a yearly basis; therefore, we cannot predict whether your policy will cover the services we provide in our office. As a courtesy to you, we will do an insurance verification and contact your insurance company to determine the amount and extent of coverage. Regardless of your coverage, we will suggest the chiropractic care we think you need.

OUR RESPONSIBILITIES:

- We will verify your insurance benefits.
- We will bill your insurance for you as a courtesy.
- We will provide guidance in getting your bill paid, if necessary.

YOUR RESPONSIBILITIES:

- Please know and understand your insurance coverage.
- Please pay your balance or deductible, co-payment or co-insurance at the time of check-in.
- Please read and keep your Explanation of Benefits statements from your insurance company.
- Please follow up promptly with claims that are not paid by your insurance company, or you will be billed directly for them.

I HAVE READ AND UNDERSTAND THE STATEMENTS ABOVE.

X_____ X_____
Patient or Responsible Party Signature Date

CONSENT FOR TREATMENT
All health care professionals are regulated by laws and boards. These health care professionals are required to give you, the patient, advance notice of any care risks, because health care is not an exact science. It is not reasonable to expect any doctor to foresee all risks and/or complications. Informed consent information regarding any risks such as paraplegia, quadriplegia, brain damage, stroke, disc injury, breaks, fracture, dislocations, drug reactions, death or loss of function of any organ or limb or disfiguring scars associated with physical care, drugs, surgery and/or treatment is an undesirable result, but it does not necessarily indicate an error in clinical judgement. No guarantee of cure or results has been made to you, the patient in the clinic. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgeries. The practice of chiropractic can include exams and diagnostic testing. In some cases, the utilization of specialized instrumentation, lab tests, radiological exams, nutritional advice, rehabilitation, physical therapy, etc.
There are special procedures unique to chiropractic: the chiropractic adjustment, chiropractic manipulative therapy, CMT. Adjustments are made by chiropractors to correct and/or reduce or stabilize vertebral or extremity aberrant motion. The goal of chiropractic health care is to reduce or stabilize the nerve interference, caused by the aberrant motion of the joint and surrounding tissue structures. Adjustments are usually performed by hand but may be performed by hand guided instruments. An adjustment is the application of a specific force applied to a segmental contact point, usually on a vertebra, to reduce or stabilize the joint and its surrounding environ. You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur seldom enough to contraindicate care but should be considered in your informed decision to receive chiropractic care. The risks may include musculoskeletal sprain/strain, disc injuries, dislocations, fractures, neurological deficits, Horner's Syndrome, vertebral artery syndrome, stroke, etc. The chances of this occurring are estimated by experts to be approximately only 1 per 400,000 treatments to 1 per 1 million treatments.

The purpose of Primary Care is to promote natural health. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the procedures. Sometimes the response is phenomenal. In most cases, there is gradual but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same specialized care. It depends on the patient's nervous system and body balance. Many medical failures find quick relief through this specialized health care science. The fact is that the Science of Acupuncture, Chi, Chiropractic, Osteopathy, and Physical Medicine may never be so exact as to provide definite answers to all problems; all make great studies in alleviating pain, controlling disease and balancing the body.

Please discuss any questions or problems with the Doctor(s) BEFORE signing this consent for treatment statement of policy.
I HAVE READ AND UNDERSTAND THE FOREGOING. I AGREE TO THE SPECIALIZED CARE AND I HAVE NO EXPECTATIONS OF ANY ABSOLUTE RESULTS.

X_____ X_____
Patient or Responsible Party Signature Date

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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 assigns to the physician or facility named above 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 a payment of services rendered to me.

IRREOVCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive 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 costs, or other legally compensable amounts owned by an insurance company, in accordance with Article 21.55 of the Texas Insurance Code or other applicable insurance or state statue. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, whenever 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 name above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 60 days (electronic/paper) following your receipt of such bill for services to the extent such bills are payable under the terms of demand specifically conforms with Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court costs, and interest for judgement, upon violation.

PERSONAL INJURY PROTECTION (PIP): I agree to use my PIP and I agree to assignment of benefits and direct pay of all bills sent by Maximum Wellness Chiropractic to Maximum Wellness Chiropractic at the address shown on the HCFA forms.

THIRD PARTY LIABILITY: If my injuries are the result of negligence form a third party, then I instruct the liability carrier to cut a separate draft to pay in full all services rendered, payable directly to the physician/facility named above.

STATUTE OF LIMITATIONS: I waive my rights to claim any Statute of Limitations regarding claims for services rendered or to be rendered by the physicians/facility named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAVIER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this chiropractic 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.

RESPONSIBILITY: You, the patient, are ultimately responsible for payment of all charges incurred regardless of insurance or third party status.

A photocopy of this instrument shall serve as original.

I HAVE READ AND UNDERSTAND THE FOREGOING POLICIES AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY FULL SATISFACTION IN A WAY THAT I CAN UNDERSTAND.

X_____ X_____
Patient or Responsible Party Signature Date

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CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND/OR HEALTHCARE OPERATIONS

Through the use of this consent form, **Maximum Wellness Chiropractic, LLC** referred to as the "office" or this "office" is notifying you and you agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or healthcare operations.
2. If you do not consent to the above use and/or disclosure, Federal Rules do not require or oblige this office/practice to treat you in the absence of your consent.
3. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosures necessary to carry out treatment, payment and/or healthcare operations, is available for you to read and you are hereby encouraged to do so prior to signing this consent form.
4. The following appointment reminders may be used by this office: a.) a postcard mailed to you at the address provided by you; b.) telephoning your home and leaving a message on your answering machine or with the individual answering the phone; c.) email or SMS text
5. Missed appointments, without at least 24 hours notice, will result in a $25 fee.
6. This office reserves the right to change its privacy practice that are described in the above referenced notice, in accordance with applicable law, and make available to all patients any and all revised and current notices.
7. You have a right to request that this office restrict how protected health information is used and/or disclosed to carry out treatment, payment and/or healthcare operations.
8. This office is not required to agree to any restrictions on your health information that you have requested.
9. If this office agrees to a requested restriction, then the restriction will be binding on this office/practice.
10. This consent is valid for seven years. You have the right to revoke this consent, in writing, at any time for all *future* transactions with the understanding that any revocation will not apply to the extent that this office/practice has already taken action in reliance of previously signed consent.
11. Should you revoke this consent at any time, the office retains its right to refuse treatment based upon the revocation and the future lack of such consent.
12. You must sign and date all consents and authorizations requested to which you agree.

I HAVE READ AND UNDERSTAND THE FOREGOING NOTICE, AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY FULL SATISFACTION IN A WAY THAT I CAN UNDERSTAND.

X_____ X_____
Name of Patient/Individual Responsible (please print) Date Signed

X_____ _____
Patient or Responsible Party Signature Witness

VITALS: Height_____ Weight_____ lbs BP_____/_____ Pulse_____ Temp_____ ºF

Estimated CPTs--To be filled out by the provider:

□ 99201	□ 99202	□99203	□99211	□99212	□99213	□G0283/97032
□ 98940	□ 98941	□ 98942	□98943	□97110	□97140	□97012 □97035

Stage 1: Pain Relief_____

State 2: Stabilization Care _____

Stage 3: Wellness Care_____