Dr. Jason Owens, DC
CedarParkFamilyChiropractic.com

cedar park family chiropractic + sports therapy

1130 Cottonwood Creek Trl, Ste. C-2
Cedar Park, TX (512) 823-0333

Sports Therapy Application – Tell Us About You

Name: _____ Date of Visit: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____

Date of Birth: _____ Age: _____ Gender: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Referred by: _____

Occupation: _____ Employer: _____

Spouse's Name / Contact Person: _____ Phone: _____

History for THIS Injury ONLY

Injury is on the: ☐ Right Side ☐ Left Side ☐ Both Sides

Describe Your Injury: _____

Purpose of your visit: _____

How did your injury happen?

☐ Gradual/Over Time ☐ Traumatic/All of a Sudden
☐ Don't Know ☐ Chronic

How long ago did it happen?

☐ Less than 14 days ☐ 2 weeks to 12 weeks
☐ 12 weeks to 1 year ☐ More than 1 year

Please circle your pain: (0=No Pain, 10=Worst Pain Ever)

1 2 3 4 5 6 7 8 9 10

Please rate your level of pain and/or dysfunction:

☐ None ☐ Very Little ☐ Moderate ☐ Significant ☐ Extreme Pain

When does your injury cause you pain?

☐ Constantly ☐ On and Off

What time of day does your injury cause you pain?

☐ Morning ☐ Afternoon ☐ Night

What best describes your pain?

☐ Ache ☐ Burning ☐ Dull ☐ Numbness ☐ Radiating ☐ Sharp
☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Tingling

What makes your pain worse?

☐ Standing ☐ Sitting ☐ Rest ☐ Activity

☐ Other: _____

What best relieves your pain?

☐ Medication ☐ Heat ☐ Cold/Ice ☐ Rest ☐ Activity ☐ Nothing

Any Sleep Disturbances?

☐ Falling Asleep ☐ Finding a Comfortable Position ☐ Awakened by Pain

Prior Treatment for THIS Injury:

Have you Had Surgery? ☐ Yes ☐ No When: _____

Have You Seen a Specialist? ☐ Yes ☐ No Who: _____

Were You Hospitalized? ☐ Yes ☐ No When: _____

Were You Advised to Have Surgery? ☐ Yes ☐ No

Any P.T. or Chiropractic Care? ☐ Yes ☐ No # of Visits: ___

With Who: _____

Medications:

Taking Meds for THIS Injury? ☐ Yes ☐ No

List all other Medications you are taking:

☐ Pain ☐ Steroids ☐ Diabetic ☐ Antidepressant ☐ Allergy
☐ Muscle Relaxers ☐ Blood Thinners ☐ Cholesterol
☐ Anti-inflammatory ☐ Cardiac ☐ Hypertension ☐ GI Tract

☐ Others: _____

Diagnostic Tests:

Any Diagnostic Imaging for THIS Injury? ☐ Yes ☐ No

☐ MRI ☐ CT Scan ☐ Bone Scan ☐ X-Ray ☐ EMG ☐ EEG
☐ Nerve Conduction (NCV) ☐ Bone Density Scan

Findings: _____

Prior to Treatment:

Is there anything else we should know about THIS condition prior to treatment? _____

_____

Overall Medical History

Medical Conditions:

- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ Shortness of Breath
- ☐ Prostate
- ☐ Birth Defects
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Kidney Stones
- ☐ Hypoglycemia
- ☐ Hernia
- ☐ Rheumatic Fever
- ☐ Heart Attack
- ☐ Thyroid Disease
- ☐ Hepatitis
- ☐ Gall Bladder Disease
- ☐ Bronchitis
- ☐ Anemia
- ☐ Lung Disease
- ☐ Stroke
- ☐ AIDS/HIV+
- ☐ Bone or Joint Disease
- ☐ Gout
- ☐ Meningitis
- ☐ Sinus Infection
- ☐ Migraine Headaches
- ☐ Recurrent Headaches
- ☐ Multiple Sclerosis
- ☐ Irregular Heartbeat
- ☐ Pancreatitis
- ☐ Seriously Depressed
- ☐ Unexplained Weight Loss
- ☐ High Blood Pressure
- ☐ Venereal Disease
- ☐ Colon Infection
- ☐ Cancer
- ☐ Asthma
- ☐ Heart Disease
- ☐ Heart Trouble
- ☐ Diabetes
- ☐ Fibromyalgia

Allergies:

- ☐ Seasonal: _____
- ☐ Food: _____
- ☐ Latex
- ☐ Other: _____

Lifestyle Activities:

- ☐ Hobbies: _____
- ☐ Sports: _____
- ☐ Other Physical Activities: _____

FOR WOMEN ONLY:

Number of _____ Pregnancies _____ Births _____Children

Please give any additional information on any difficult pregnancies, delivery complications, and/or menstrual problems: _____

PRACTICE MEMBER SIGNATURE

_____ _____

Signature (If Minor, Signature of Legal Guardian) **Date**

Do NOT Write Below. For Doctor Use ONLY.

_____

_____

_____

_____

_____

_____

_____

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Informed Consent for Sports Therapy Treatment

Doctors of chiropractic and physical therapists who use manual therapy techniques such as the manual therapy, myofascial release, active rehab exercises, kinesio-taping, cryotherapy (ice), and occasional spinal adjustments should advise patients that there are or may be risks associated with such treatment. In particular you should note the following risks or complications:

A. Manual Therapy, Myofascial Release:

a. **Explanation and Benefits:** Manual therapy and myofascial release involve a licensed health care provider's hands applying pressure on muscle tissue and manipulating joints. In particular, myofascial release involves the gentle sustained pressure into the myofascial connective tissue restrictions. The benefit of manual therapy and myofascial release is to restore normal tissue function, joint function, and aid in normal musculoskeletal biomechanics. Manual therapy and myofascial release have been shown to decrease patient reported pain levels, speed recovery, and restore range of motion.

b. **Risks:** The risks of manual therapy and myofascial release include localized discomfort, skin reddening, superficial tissue bruising, release of emboli (rare), symptoms shifting to different body areas, post treatment soreness, or an increase in pain.

c. **Alternatives:** The alternatives to manual therapy and myofascial release include: prescribed and over-the- counter medication, joint or soft tissue injections performed by a physician, and rest.

B. Active Rehabilitation Exercises:

a. **Explanation and Benefits:** Active rehabilitation exercises are designed and prescribed for the sole purpo se of facilitating appropriate mobility or stability within the musculoskeletal system. Such rehabilitation exercises include, but are not limited to, functional movements, stretches, self-myofascial release, and open and closed chain exercises.

b. **Risks:** The risks of active rehabilitation exercises include aggravation of a present condition, blood pressure changes, and increased heart rate.

c. **Alternatives:** The alternatives to active rehabilitation exercises include: prescribed and over-the-counter medication, joint or soft tissue injections performed by a physician, and rest.

C. Kinesio-Taping:

a. **Explanation and Benefits:** Kinesio-taping is the specialized taping of areas of the body. Kinesio-taping may aid normal muscle movement and provide stability by mimicking the effects of bracing.

b. **Risks:** The risks of kinesio-taping include skin reactions, itching, allergic reactions, hyper pigmentation (discoloration), and blistering.

c. **Alternatives:** The alternatives to kinesio-taping include: icing, bracing, athletic taping, and ace bandaging.

D. Cyrotherapy (ice):

a. **Explanation and Benefits:** Cryotherapy is the exposure to subzero temperatures to decrease inflammation. Cryotherapy can aid in decreasing muscle soreness, stiffness, swelling and bruising.

b. **Risks:** The risks of cryotherapy include skin reactions, itching, allergic reactions, burning, hyper pigmentation (discoloration), and blistering.

c. **Alternatives:** Alternatives to cryotherapy include: prescribed and over-the-counter medication, joint or soft tissue injections performed by a physician, and rest.

E. Cervical Spine Adjustments:

a. **Explanation and Benefits:** Cervical spine adjustments are the thrusts applied to the vertebra utilizing parts of the vertebra and contiguous structures as levers to directionally correct articular malpositions and improve or correct subluxation. The benefits of cervical spine adjustments include correction of vertebral subluxations, increased stability, and decreased pain.

b. **Risks:** The risks of cervical spine adjustments include, but are not limited to, pain and discomfort, fractures, strokes, dislocations, sprains, and injury to a vertebral artery. Vertebral artery injuries may cause strokes, sometimes with serious neurological impairment, and on rare occasion result in death. The possibility of such serious injuries resulting from cervical spinal adjustment is extremely remote.

In addition, the nature of your injury may require the doctor to perform treatment near or around sensitive areas (e.g., chest, groin, buttocks, etc.). The doctor will make every effort to safeguard your modesty and appropriately conceal the area.

The informed consent documents are used to communicate information about the proposed treatment along with disclosure of risks and alternative forms of treatment. The informed consent documents should not be considered all-inclusive in describing methods of care and all potential risks. Your doctor may provide you with additional or different information, which is based on the facts in your particular case and the current state of medical knowledge.

I understand that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment including, but not limited to the risks described above. Knowing that I have a condition requiring treatment, I voluntarily consent to treatment performed by the doctor (including spinal manipulation). Although the treatment is usually beneficial and seldom causes problems, I understand and have been informed of the potential risks. I have been informed about the methods used by the doctor, I have had the opportunity to ask questions and express concerns prior to treatment. I do not expect my doctor to be able to anticipate and explain all risks and complications of my treatment. Further, I wish to rely on the professional and clinical judgment of my doctor during the course of my treatment.

I have read and fully understand the above statements. I authorize Cedar Park Family Chiropractic personnel to administer treatment as deemed necessary. I intend this consent to apply to all my present and future care.

Minor Consent: *If applicable, I have the legal right to select and authorize healthcare services for the minor child named below, and I authorize a doctor to perform the treatment as outlined above to this minor.*

TO BE COMPLETED BY PATIENT OR PATIENT'S LEGAL REPRESENTATIVE:

Patient's Name: _____

Patient's Signature: _____

Name of Patient's Legal Representative (if applicable): _____

Signature of Patient's Legal Representative (if applicable): _____

Date Signed: _____/_____/_____ Patient's Date of Birth: _____/_____/_____

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Our Patient Attendance Policy Agreement

Cedar Park Family Chiropractic strives to provide each patient with the highest quality of care while attempting to accommodate your schedule. Therefore, we provide reserved time slots for each patient in order to minimize waiting times and assure continuity of your personal treatment. Appointments can be scheduled by phone, email, or in person at the office. We ask that all patients arrive 5 minutes before your scheduled time to empty your pockets and have time to make any updates to your patient file. Your consistent attendance of the planned treatment care plan is paramount to your health.

Cancellations, along with patient no-shows, decrease our ability to accommodate the scheduling needs of other patients. We ask for your full cooperation with the following policy:

- If you are unable to keep a scheduled appointment, we request that you notify our office *48 hours* in advance of your scheduled appointment time. If someone is not available to take your call, please leave a voicemail or email **Contact@CedarParkFamilyChiropractic.com**.
- All cancellations and no-shows will be documented in our records. If you accumulate *2 cancellations or no-shows*, a fine of $45.00 will be assessed on each cancellation or no-show thereafter.

We believe that this policy is necessary for the benefits of all patients, so that we can continue to provide the highest quality treatment and service to every patient.

All Cedar Park Family Chiropractic Staff and patients appreciate your cooperation with this policy.

OFFICE CANCELLATION FEE $45.00

Patient Acknowledgement/Signature (If Minor, Signature of Legal Guardian) **Date**

Our Financial Policy

We are committed to providing you with the best health care possible. We have established our financial policies to achieve this goal. You will be expected to pay for your health care at the time the service is rendered unless other arrangements are made in advance.

- **Health Insurance:** We will provide you with a statement or "Superbill" at your request, which contains all the information necessary for your insurance company to reimburse you.
- **Patient Payments:** All fees are payable at the time services are rendered.
- **Methods of Payment:** For your convenience, we accept Cash or Credit Cards (Visa, MasterCard, AMEX, Discover) for your initial visit. If a payment plan is chosen for future care, this is handled by auto collection through your card on file with our office. We do not accept checks for your initial first two visits. All checks returned as insufficient funds will incur a $45 returned check fee.

We make the payment process as simple and smooth as possible, so you will have an enjoyable visit in our office. I have read and understand the above policies.

Patient Acknowledgement/Signature (If Minor, Signature of Legal Guardian) **Date**

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HIPAA Privacy Notice Acknowledge

We are concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the uses and limitation of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I authorize my health care provider to use a telephone system and/or email to use my name, address and phone number, the name of my schedules treating chiropractor, and the time and place of my schedules appointment(s) for the limited purpose of contracting me to notify me of a pending appointment or other health related communications. I also authorize my health care provider to disclose to third parties who answer my phone limited protected health care information regarding pending appointments and to leave a reminder message on my voice mail system and/or answering machine.

I have read and agree to the above terms and HIPAA compliance statement.

I, _____ acknowledge that I have received a copy of Cedar Park Family Chiropractic's Notice of Privacy Practices for Protected Health Information.

Patient Acknowledgement/Signature (If Minor, Signature of Legal Guardian) **Date**

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Notice of Privacy for Protected Health Information (HIPAA)

This notice Describes how Chiropractic and Medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Use and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1. A CPFC staff member may have to disclose your health information, including all of your clinical records, to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health.

2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier or your employer, if they are potentially responsible for the payment of your services.

3. A CPFC staff member may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.

4. A CPFC staff member may need to use your name, address, phone number, and your clinical records to contact you to provide phone call, information about treatment alternatives, or other health related information that may be of interest to you. 164.520(b)(I)(iii)(A). If you are not at home to receive the appointment reminder, a message will be left on your machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

Permitted Uses and Disclosures Without Your Consent or Authorization

Under Federal Law, we are also permitted or required to disclose your health information without your consent or authorization in the following circumstances:

1. If we are providing health care services to you based on the orders of another health care provider.
2. If we provide health care services to you as an inmate.
3. If we provide health care services to you in an emergency.
4. If we are required by law to treat you and were unable to obtain your consent after attempting to do so.
5. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples and noted in the uses and disclosures section above, other use or disclosure of your health information will only be made with your written authorization.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive request to revoke your authorization 164.508(b)(5)(i).

2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at our office address, c/o Billing Department.

Your Right to Limit Uses or Disclosures

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know in writing to what individuals or organizations you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your Right to Inspect and Copy Your Health Information

You have the right to request that we give you an account of the disclosures we have made of your health information for the last six years before the date of your request.

The accounting will include all disclosures except these disclosures:

- Required for your treatment, to obtain payment for your services, or to run our practice
- Made to you or to individuals involved in your care
- Necessary to maintain a director of the individuals in our facility
- For national security or intelligence purposes, as required by law
- Made to correction officers or law enforcement officers, as required by law
- That were made prior to the effective date of the HIPPA privacy law

We will provide the first accounting within a 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request, we will tell you the amount of the fee, and you will have the opportunity to withdraw or modify your request.

Your Right to Obtain a Paper Copy of This Notice

If you have agreed to the privacy notices by email, you may request a paper copy of this notice at any time.

Our Duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement, we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms, the change will apply for all your health information in our files.

Re-Disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by federal privacy rules.

Your Right To Complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint, and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to Dr. Jason Owens, DC at our office address.