Dr Shane Cowan, D.C.
Phone: (214) 491-4944 Fax: (253) 830.1693
1824 W. Virginia St., McKinney, Texas 75069

WELCOME

New Patient Paperwork

About You	
Sex:	☐ Male ☐ Female
Legal First Name	
Middle Name	
Legal Last Name	
Nickname	
Address	
City, State, Zip	
Social Security #	
Date of Birth	
Email	
Home #:	
Cell #:	
Cell Phone Carrier	
(we need your cell phone carrier so our system can give you a reminder call)	
Preferred Contact:	☐ TEXT ☐ EMAIL
Are you a VETERAN?	☐ YES ☐ NO
Spouse / Emergency Contact	

Employment	
Employer:	
Occupation:	
Work #:	
Spouse Employer	

Do you have or experience any of the following?		
☐ Sinus Pain	☐ Fainting	☐ Intestinal Gas
☐ Hay fever	☐ Ringing in Ears	☐ Low Back Pain
☐ Numbness/Tingling	☐ Mid Back Pain	☐ Stress
☐ Muscle Spasms	☐ Fatigue	☐ Pins & Needles
☐ Thyroid Trouble	☐ Diabetes	☐ Pinched Nerve
☐ Slipped Disc	☐ Nervous Stomach	☐ Constipation
☐ Neck Pain	☐ Irregular Sleep	☐ Menstrual Irregularity
☐ Depression	☐ Arthritis	☐ Leg / Feet Pain
☐ Liver Trouble	☐ High Blood Pressure	
☐ Cold Hands	☐ Gallbladder Trouble	
☐ Headaches	☐ Dizziness	☐ Heart Trouble

Medical Questions	
Have you ever received Chiropractic care before?	☐ Yes ☐ No
Is it possible you are pregnant?	☐ Yes ☐ No

How did you hear about our clinic?	☐ Google ☐ Friend ☐ Nextdoor App ☐ Facebook ☐ Driveby
How did you hear about our clinic?	☐ Other _____
First and Last Name of Person who referred you?	

Are you here because of a auto accident?	☐ Yes ☐ No If yes, when was it?
If yes, do you have an attorney?	☐ Yes ☐ No

Are you here because of a work accident?	☐ Yes ☐ No If yes, when was it?
If yes, do you have an attorney?	☐ Yes ☐ No

What is your chief complaint?	
Known Allergies	
Previous Surgeries	
Current Medications:	

Patient Signature **Date**

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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 Shane Cowan, 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 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 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 21.55 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 Shane Cowan Enterprises, LLC, and send to 1824 W. Virginia St., McKinney, TX 75069.

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 Shane Cowan Enterprises, LLC, and to send any and all checks to 1824 W. Virginia St., McKinney, TX 75069.

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 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 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 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 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 the failure to do so may jeopardize my case.

Printed Patient Name: _____ **Date:** _____

Signature of Patient/Responsible Party: _____

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CONSENT FOR TREATMENT

Chiropractic is an art as well as a science. At McKinney Spine & Wellness, the doctor and staff will do everything necessary to ensure your experience here is a pleasant one. As part of your treatment, we want to make our patients aware of possible risks associated with a chiropractic adjustment. A chiropractic adjustment corrects vertebral subluxations. A subluxation is a misalignment of vertebral bones, which causes an abnormal alteration in the vertebral column. This abnormal alteration may result in a various amount of symptoms. A chiropractor corrects vertebral subluxations by employing various adjustment techniques. As with any health procedure, an amount of risk is associated with such procedures. In chiropractic such risks associated with an adjustment may include but are not limited to:

1. Stroke or stroke-like conditions.
2. Disc protrusion/rupture.
3. Muscle, ligament, or tendon sprain/strain.
4. Rib fracture or pathological fracture.
5. Burns related to the use of ultrasound or electrotherapy equipment.

Please be assured that the staff and doctors here at McKinney Spine & Wellness will do all necessary including examination, x-ray, and other diagnostic procedures, to ensure that your condition will not predispose you to the above mentioned conditions.

I, the undersigned, have read and understood the risks involved in the chiropractic adjustment and related chiropractic treatment

Printed Patient Name: _____ **Date:** _____

Signature of Patient: _____

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HIPAA

Regarding the Use & Disclosure of Protected Health Information

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures; I should refer to the Office's privacy notice entitled, Our Privacy Practices. I understand that I may review this privacy notice at any time prior to signing this form. I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy. I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing. I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

.

Printed Patient Name: _____ **Date:** _____

Signature of Patient: _____

Dr Shane Cowan
1824 W. Virginia St. McKinney, TX 75069
P: 214.491.4944 F: 253.830.1693

Massage Cancellation Policy

When you schedule a massage, it is your responsibility to make your scheduled time. We will make every attempt to remind you via phone the business day before your appointment.

Effective September 1, 2020: There will be a $20 fee for thirty-minute massages, $40 fee for hour massages, and $60 fee for hour and a half massages that are cancelled the same day of your massage appointment.

Please provide your debit/credit card information below for us to have on file.

_____ _____ _____
Credit Card Number Exp. Date CVV

_____ _____
Billing Address Billing Zip-Code

_____ _____
Printed Patient Name Patient Signature

_____
Date

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*******Please Fax Records as soon as possible to 253-830-1693***

Medical Release of Records

Patient Full Legal Name: _____

Patient Address: _____

Patient Date of Birth: _____

☐ Attached DL to this Fax

_____

Patient Signature

Requesting Records From:

Fax #: _____ Phone #: _____

Date(s) of Service: _____

Clinic Name: _____

Dr. Name: _____

To Whom It May Concern,

We are writing your office to obtain the all medical records pertaining to the above listed patient. It is imperative that we receive these in a timely manner so the doctor can review records before a treatment plan is created for the patient.

Please email this letter back with the medical notes to our office at MckinneySpine@Gmail.com. Or fax to **253.830.1693**

Should there be any questions, please do not hesitate to contact our office at 214.491.4944

Best Regards,
Dr. Shane Cowan, D.C.

McKinney Spine & Wellness

$40 New Patient Special

Included in this package:

First Initial Visit:

- *Consultation with Dr.Cowan*
- *X-rays (if needed)*
- *Brief Review of X-ray*
- *Therapy*

Second Visit:

- Report of Exam/ X-ray Findings
- Adjustment with Dr.Cowan

If you are interested in massages the price is as follows:

(we have to have the massage cancellation signed in order to schedule massages),

$65 for 30 minute massage (includes Therapy and adjustment in our office)

$85 for 60 minute massage (includes Therapy and adjustment in our office)

$110 for 90 minute massage (includes Therapy and adjustment in our office)

The massage therapist will do cupping for additional $15

LYMPHATIC MASSAGES

$80 for 30 minute Lymphatic Massage (includes Therapy and adjustment in our office)

$100 for 60 minute Lymphatic Massage (includes Therapy and adjustment in our office)

$125 for 90 minute Lymphatic Massage (includes Therapy and adjustment in our office)

If you want cupping, just tell the massage therapist, it is INCLUDED with Lymphatic Massage

_____ _____

Print Patient Name (First and Last) **Date**

_____

Patient Signature

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WORK RELATED ACCIDENT

Date & Time of Accident: _____ □ a.m. □ p.m.

Was your accident directly related to your work? □ Yes □ No

Give the address where the accident occurred (if different than your employers address:

_____

Was anyone else present during your accident..... □ Yes □ No

Did you report your accident to your employer.....□ Yes □ No

What recommendations did your employer make to you after your accident? _____

_____

_____

Has this type of accident happened to you before?□ Yes □ No

To the best of your knowledge, has this accident occurred in your workplace before?..... □ Yes □ No

Is your job physically stressful? ..... □ Yes □ No
Is your job mentally stressful?.. ..... □ Yes □ No
Is your workplace noisy?..... ..... □ Yes □ No
Have you changed job in the last year? ..... □ Yes □ No

In your words please describe the events that occurred just before and during your accident...

_____

_____

_____

_____

_____

RECOVERY

How many hours are in your normal work day? _____

Please indicate your daily job duties and any activities which you are occasionally asked to perform.

□ Standing	□ Driving	□ Operating Equipment
□ Sitting	□ Twisting	□ Work with arms above head
□ Walking	□ Crawling	□ Typing
□ Lifting	□ Bending	□ Stooping

AFTER INJURY

Did accident render you unconscious? □ Yes □ No
If yes, for how long? _____
Please describe how you felt immediately after the accident:

_____

_____

Have you gone to a Hospital or seen any other Doctor?
□ Yes □ No
When did you go?
□ Just after accident □ next day □ 2+ days
How did you get there?
□ Ambulance □ Private Transportation
Name of Hospital and/or Attending Doctor:

_____

Describe treatment you received: _____

_____

Were X-rays taken?..... □ Yes □ No
Was medication prescribed? .....□ Yes □ No
Have you been able to work since this injury?.. □ Yes □ No
Are your work activities restricted as a result of this injury?
□ Yes □ No

Indicate the symptoms that are a result of this accident:

□ Dizziness	□ Difficulty sleeping	□ Jaw Problems
□ Memory loss	□ Arms/Shoulder Pain	□ Irritability
□ Headaches	□ Numb Hands/Fingers	□ Fatigue
□ Blurred vision	□ Tension	□ Chest Pain
□ Buzzing in ear	□ Shortness of Breath	□ Neck Pain
□ Ears Ringing	□ Neck Stiff	□ Upset Stomach
□ Nausea	□ Lower Back Pain	□ Back Stiffness
□ Back Pain	□ Leg Pain	□ Numb Feet/Toes

Please list daily activities that have become painful / difficult since your accident: _____

_____

_____

_____

_____

Print Patient Name

_____

Patient Signature

_____

Date

Patient Name _____ **Date of Accident:** _____

SS #: _____-_____-_____

WORK COMP ATTORNEY

Attorney Office / Name : _____

Phone: _____ Fax: _____

Address: _____

□ **No Attorney**

HEALTH INSURANCE? (Circle) YES or NO

Insurance Name: _____

ID: _____ Group#: _____

EMPLOYER INFO

Employer : _____ HR Contact : _____

Phone: _____ **Fax :** _____

WORK COMP INFO:

Claim #: _____ Date of Accident _____

Employer Insurance Company: _____

Ins Phone _____ Ins Fax _____

Have you treated anywhere with this claim? □ NO □ YES

If YES, list All places you have treated at: _____

_____

Case Manager / Adjuster Name: _____ Phone _____

Email: _____ Fax _____

Revised: September 13, 2021