Dr. Shane Cowan, D.C.
Phone: (214) 491-4944 Fax: (214) 491-4945
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
Marital Status	☐ Single ☐ Married
Spouse Name & #	

Employment	
Employer:	
Occupation:	
Work #:	

Do you have or experience any of the following?		
☐ Headaches	☐ Dizziness	☐ Heart Trouble
☐ 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	

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?	
Friend/Family Member name who referred you?	

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

Are you here because of a work accident?	☐ Yes ☐ No
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 PROCEEDS, LIEN, AND AUTHORIZATION

Assignment of Benefits

I herby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers") which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries or illnesses past present or future (conditions) to pay directly and exclusively in the name of Shane Cowan Enterprises, LLC DBA McKinney Spine & Wellness such sums as may be owing to McKinney Spine & Wellness and Dr. Shane Cowan for charges incurred by me which relate, directly or indirectly, to my condition (charges) , with such payments to be made exclusively in the name of McKinney Spine & Wellness. In the event a payer should issue payment in my name I grant permission to McKinney Spine & Wellness to sign my name to the check so that payment for services can be made. I further grant a lien to McKinney Spine & Wellness and Dr. Shane Cowan with respect to my charges. This lien shall apply to all payers and the full extent permitted by law. For the purposes of this assignment, lien, and authorization (herein, "Agreement"), "benefits" shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no fault coverage, uninsured and underinsured motorist coverage, third party liability distributions, disability benefits, workers compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein. In the event that I retain one or more attorneys to represent me in this matter, I direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letters of protection cannot be revoked or modified without the express written consent of this office. I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this assignment. I further authorize and direct all payers to release to this office any information regarding any coverage or benefits which I may have including, but not limited to , the amount of coverage, the amount paid thus far, and the amount of an outstanding claims. I hereby direct this office to file a copy of this assignment, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payee, which are presented to this office for payment of any account relating to me, my spouse, or any of my dependents.

I understand that I remain personally responsible for the total amounts due to McKinney Spine & Wellness for said services, unless otherwise negotiated in writing beforehand. If I discontinue treatment against the medical opinion/advice of my treating doctor, the balance of charges for services rendered will be due and payable immediately unless otherwise discussed with payer. If the office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse McKinney Spine & Wellness for the costs of such collection efforts, including but not limited to, all court costs and attorney fees. This assignment shall not be modified or revoked without mutual written consent of McKinney Spine & Wellness and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this assignment.

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.

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

Signature of Patient: _____

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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: _____

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 October 13, 2017: There will be a $20 fee for thirty-minute massages, $35 fee for hour massages, and $52.50 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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Phone: (214) 491-4944 Fax (214)491-4945 McKinneySpine@Gmail.com
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*******You may Fax or Email Records above***

Medical Release of Records

Print Patient Name: _____

Requesting Records From:

Fax: _____-_____-_____
Clinic Name: _____
Dr. Name: _____
Phone: _____-_____-_____

_____
Patient Signature

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 **214.491.4945**

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

Best Regards,

Shane Cowan