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 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: _____

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

Massage Cancellation Policy

***This form is OPTIONAL, BUT we do require this form if you ask to schedule massages in our office.**

When you schedule a massage, it is your responsibility to make your scheduled time. We send out a courtesy appointment reminder the day before your appt, but it is your responsibility to reschedule, or attend your appointment in a timely manner. If you are not receiving appointment reminders, please inform the front desk (this will not waive your cancellation fee if you miss your scheduled massage appt).

Effective 09/15/2021. We ask that you contact our office 24 hours or more in advance before your scheduled time if you are needing to reschedule / cancel your massage appointment. If you cancel or no show the same day of your appointment, our cancellation fees are listed below, and we charge your card on file that same day that was cancelled or missed with one courtesy call to inform you. If your card is declined, we will cancel all future massages until a new card is provided.

30 minute massage cancellation fee = $20
60 minute massage cancellation fee = $40
90 minute massage cancellation fee = $60

Please provide your debit/credit card information below for us to have on file for massage cancellation fees ONLY, unless otherwise specified.

_____ _____ _____
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 require the Massage Cancellation Form to be filled out and signed in order to schedule massages in our office)

MASSAGE PRICES

$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)

***ADD CUPPING to your massage for an additional $15**

_____ _____

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

_____

Patient Signature