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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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.

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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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AUTO ACCIDENT

Date & Time of Accident: _____ □ a.m. □ p.m.
Were you □ Driver □ Front Passenger □ Rear Passenger
Number of people in accident vehicle? _____
Did the police come to the accident site? □ Yes □ No
Was there a police report filed? □ Yes □ No
Was there any witnesses □ Yes □ No
Were you wearing your seatbelt? □ Yes □ No
Was this vehicle equipped with airbags? □ Yes □ No
If yes, did the inflate □ Yes □ No
What did your vehicle impact □Another vehicle □ other
If other, explain:_____
Did any part of your body strike anything in the vehicle?
□ Yes □ No
If yes, explain_____
Make & Model of the vehicle you were occupying:_____
What was the approx. speed of your vehicle? ____
Did the impact to your vehicle come from the:
□ Front □ Rear □ Right Side □Left side □Other
During impact, you were facing □ Right □ Left □ Forward
Were you: □ Aware □ Surprised by the Impact
If accident made impact with another vehicle……..
Make & Model of the other vehicle?_____

In your words please describe the 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

Insurance Verification Sheet

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

Was a Police Report Filed? **YES or NO** **State where accident occurred?** _____

ATTORNEY

Attorney Office / Name : _____

Phone: _____ Fax: _____

Address: _____

Do you have HEALTH INSURANCE? (Circle) YES or NO

Insurance Company: _____

ID / Member #: _____ Group #: _____

PATIENT'S AUTO INSURANCE

Claim #: _____ _____ Whose Auto Policy is this? _____

Insurance Company: _____ Policy #: _____

Adjuster Name: _____ Adjuster Phone #: _____

Adjuster Email: _____

Did you file an accident claim on this policy? **YES or NO**

Do you have (PIP) Personal Injury Protection? **YES or NO**

Do you have MedPay? **YES or NO** Do you have Uninsured Motorist Protection? **YES or NO**

OTHER PERSON AT FAULT - AUTO INSURANCE

Insurance Company: _____ Phone: _____

Policy #: _____ Claim #: _____

Adjuster Name: _____ Phone: _____

Adjuster Email: _____