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
Emergency Contact:	
Martial Status:	☐ Single ☐ Married ☐ Widowed ☐ Divorced
Spouse Name:	

Employment	
Employer:	
Occupation:	
Work #:	
Spouse Employer	

Do you have or experience any of the following?		
☐ Sinus Pain	☐ Fainting/Dizziness	☐ 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	☐ Heat Trouble
☐ Cold Hands	☐ Gallbladder Trouble	☐ Headaches

Questions	
Have you ever received Chiropractic care before?	☐ Yes ☐ No
Is it possible you are pregnant?	☐ Yes ☐ No
Are you a VETERAN?	☐ 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** _____

Dr. Shane Cowan, D.C.
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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: _____ **(OFFICE ONLY) Claim #:** _____

Signature of Patient/Responsible Party: _____ **Date:** _____

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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: _____

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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

$70 for 30 minute massage (includes Therapy and adjustment in our office)

$90 for 60 minute massage (includes Therapy and adjustment in our office)

$115 for 90 minute massage (includes Therapy and adjustment in our office)

***ADD CUPPING to your massage for an additional $20**

_____ _____

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

_____

Patient Signature

Patient Name _____ **DOB:** _____

PATIENT QUESTIONS

□ Yes □ No **Were you injured at work?**

If yes, what date? _____

□ Yes □ No **Were you in an accident? (auto, fall/slip, or any kind of accident).**

If yes, what date?_____

□ Yes □ No **Are you a Veteran?**

□ Yes □ No **Do you have health insurance?**

- **• If you have health insurance, but aren't sure if you want to use it - we are more than happy to verify your chiropractic benefits & compare them to our cash rate for you, so that you can get the best possible rate in our office.**

PRIMARY HEALTH INSURANCE

Insurance Company: _____ Provider Phone #: _____

ID/Member #:: _____ Group #: _____

□ Yes □ No **Are any family members patients in our office, so that we may update their ins info?**

SECONDARY INSURANCE

Insurance Company: _____ Provider Phone #: _____

ID/Member #:: _____ Group #: _____

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AUTO ACCIDENT

Date & Time of Accident: _____ □ a.m. □ p.m
City & State of Accident: _____
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
Did the airbag impact any part of your body?
If yes, 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/CT Scan 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?** _____

Time of Accident? _____ **A.M. / P.M.**

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: _____

APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	CLAIM NO.

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION AND/OR NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

YOUR NAME AND ADDRESS:

PHONE NUMBER: (H) (W) | DATE OF BIRTH: | SSN:

DATE, TIME AND PLACE OF ACCIDENT:

DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:

AT THE TIME OF THE ACCIDENT:

WERE YOU THE DRIVER OF OUR POLICYHOLDER'S CAR?	☐ YES	☐ NO
WERE YOU A PASSENGER IN OUR POLICYHOLDER'S CAR?	☐ YES	☐ NO
WERE YOU A PEDESTRIAN?	☐ YES	☐ NO
WERE YOU THE DRIVER OF A CAR OTHER THAN OUR POLICYHOLDER'S?	☐ YES	☐ NO

ARE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? ☐ YES ☐ NO IF YES, WHAT IS YOUR RELATIONSHIP?

AS A RESULT OF THIS ACCIDENT, WERE YOU INJURED? ☐ YES ☐ NO IF YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: DATE:

DESCRIBE YOUR INJURY:

DID A DOCTOR TREAT YOU? ☐ YES ☐ NO | DOCTOR'S NAME AND ADDRESS:

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN ☐ IN-PATIENT ☐ OUT-PATIENT | HOSPITAL'S NAME AND ADDRESS:

HAVE YOU EVER HAD THE SAME OR A SIMILAR CONDITION? ☐ YES ☐ NO IF YES, STATE WHEN AND DESCRIBE:

IS CONDITION SOLELY A RESULT OF THIS ACCIDENT? ☐ YES ☐ NO IF NO, EXPLAIN:

AMOUNT OF MEDICAL BILLS TO DATE:	WILL YOU HAVE MORE MEDICAL EXPENSES? ☐ YES ☐ NO	WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? ☐ YES ☐ NO
DID YOU LOSE WAGES AS A RESULT OF YOUR INJURY? ☐ YES ☐ NO	IF YES, AMOUNT LOST TO DATE:	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY?

DATE DISABILITY FROM WORK BEGAN: DATE YOU RETURNED TO WORK:

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, BENEFITS UNDER

ANY WORKER'S COMPENSATION LAW?	☐ YES	☐ NO	IF YES, AMOUNT (CHOOSE ONE):
EMPLOYMENT BY U.S GOVERNMENT?	☐ YES	☐ NO	PER WEEK _____
MILITARY SERVICE?	☐ YES	☐ NO	PER MONTH _____

SEE REVERSE SIDE

NAME AND ADDRESS OF YOUR PRESENT EMPLOYER WITH YOUR OCCUPATION AND DATES OF EMPLOYMENT:
AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO IF YES, EXPLAIN:

SIGNATURE_____ DATE_____

IMPORTANT - TO BE ELIGIBLE FOR BENEFITS:

1. COMPLETE AND SIGN THIS APPLICATION.
2. SIGN THE INCLUDED AUTHORIZATION.
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

Texas law requires the following to appear on this form.
"Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."