2845 Parkwood Blvd #200 Plano, TX 75093
Phone#: 972-781-2800

Date: _____

Patient Name _____ **Date of Birth**: _____ **Age:** _____

Address: _____ **City**: _____ **St**: _____ **Zip**: _____

E-Mail: _____ **Occupation:** _____

Home #: _____ **Cell #:** _____ **Work#:** _____

(Place star by best contact #)

How did you hear about us? _____

If under 18:

Parent/Guardian: _____ **Relationship**: _____

If different from above:

Address _____ **City**: _____ **St**: _____ **Zip**: _____

Email: _____ **Best phone# to contact:** _____

Patient Insurance Information

Insurance Provider: _____ **Member ID**: _____ **Group #** _____
Employer of Subscriber: _____
If the patient is the spouse or child of the primary subscriber please provide the following:

Subscriber Name: _____ **DOB**: _____ **Relationship to patient**: _____

Is this visit due to auto accident: _____ **Date of accident/injury**: _____ **Responsible party**: _____

Authorization To Release Information:

I hereby authorize the above-named agency to release any treatment information requested by attorneys, physicians, insurance companies, employers, health care providers, or any other entities concerned with the payment or charges for the treatment services of The Tx Room and hereby authorizes payment directly to The Tx Room for services rendered. I accept responsibility for payment of any charges not paid or accepted by my insurance.

Treatment Financial Policy:

By signing below I acknowledge that the treatment I am to receive is a fee for service treatment and all fees will be paid prior to each treatment session. I understand that if The Tx Room is not an in-network provider, I will be provided all the necessary forms for filing my insurance claims so that I may collect any reimbursement due to me from my insurance carrier.

Consent to Treatment:

By signing below I understand the treatment I will be receiving can include the following treatment methods and modalities: manual therapy, soft tissue & spinal manipulation, ice/heat, active rehab exercises & stretches, traction/decompression, kinesio-taping and LED laser therapy. I acknowledge that I have the right to let the doctor know of any reservations I have w/ any of the above treatment's that may be performed. I further understand that some of the above mentioned treatments may be painful at the time of service and may cause slight bruising and pt tenderness at sight of treatment. Knowing that I have a condition requiring health care, I voluntarily consent to treatment performed by Dr. McDougal, Dr. Bernard and Dr. Kemmerer or the Tx Room staff.

I have read and fully understand the above statements and authorize treatment to begin.

_____ _____

Signature of Patient (if minor, signature of legal guardian) **Date**

Patient Medical History

Current Injury/Reason for Visit: _____

_____

Rate your pain today: No pain 1 2 3 4 5 6 7 8 9 10

Date problem/symptoms began: _____ **Better/worse/same since date of onset:** _____

Have you had this or a similar problem before? Yes / No How was it resolved? _____

Have you seen primary care physician, orthopedic surgeon, or any other doctor prior to visit: Yes / No

What form of treatment/therapy have you had prior to visit? _____

Was there any success in resolving injury/problem? _____

Prior to treatment, is there anything we should know about your condition and/or past medical history that you think we may need to be aware of: _____

_____

Personal Medical History

Please check any of the following that apply. This is very important for us to know so if known please put year diagnosed as well.

__ Tuberculosis
__ Kidney Disease
__ Prostate
__ Birth Defects
__ Arthritis
__ Kidney Stones
__ Hernia/sports hernia
__ Epilepsy
__ Head or Spinal injuries
__ Thyroid Disease
__ Gall Bladder Disease
__ Gout
__ Meningitis
__ Migraine H/A's
__ Recurrent H/A's
__ Tension H/A's
__ Multiple Sclerosis
__ Irregular Heartbeat
__ Pancreatitis
__ Depression
__ Unexplained Weight Loss
__ High Blood Pressure
__ Lung Disease
__ Colon Infection
__ Hypo/Hyperglycemic
__ Bone or Joint Disease
__ Heart Trouble
__ Heart Disease
__ Stroke
__ Asthma
__ Heart Attack
__ Anemia
__ Cancer

Please list all medications that you are currently taking: _____

_____

List any and all surgeries if you have not already mentioned before now: _____

_____

Doctor Notes:

FINANCIAL POLICY

Payment

Payment is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include collection of any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. After you insurance has paid your claim, you will receive a statement for the remaining balance, if applicable. If you have any questions regarding your claim or insurance benefits, please contact customer service at your insurance company.

Insurance

We are participating providers with Blue Cross Blue Shield and United Healthcare networks only. The Tx Room does not accept Medicare, Medicaid, TriCare or CHAMPUS. Please remember that insurance is a contract between the patient and the insurance company, and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Your health plan may have a benefit structure that will determine your out of pocket costs. Insurance verifications are done over the internet and by telephone where information can also be conveyed verbally to our staff. We make every possible effort to obtain accurate benefits when appropriate; however, our information is only as good as that provided by the health plan representative or what has been updated online. For this reason, we urge you to review the health plan coverage information given to you by your employer or insurer to gain your own understanding of your insurance benefits.

Some policies do require a referral, if so these must be received by our office prior to your visit if you wish to use your insurance. If you do not wish to obtain a referral you may utilize our affordable cash rate.

Patient Billing

Responsibility for Payment: I understand that I, personally, am financially responsible to The Tx Room for charges not covered by the assignment of insurance benefits. Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

Assignment of Benefits: I hereby assign, transfer, and set over directly to The Tx Room, sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize The Tx Room to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to The Tx Room.

Returned checks will incur a $30.00 service charge. Stop payments constitute a breach of payment and are subject to the $30 service fee.

Cancellations/Missed Appointments: If you do not cancel your appointment at least 12 hours before your appointment, or if you no-show, we will assess you a $25 missed appointment fee.

I have read and understand the practice's financial policy and I agree to be bound by its terms.

Please print the name of the patient _____

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

Notice of Information Practices and Privacy Statement

How We Collect Information About You: The Tx Room and its employees and volunteers collect data through a variety of means including, but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, and rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between The Tx Room and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance,

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect data from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page (www.thetxroom.com) that simply records the number of visitors and no other data.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of The Tx Room. We reserve the right to use non-identifying information about our patients for fundraising and promotional purposes that are directly related to our mission.

Patients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without the patient's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

PATIENT NAME (OR GUARDIAN IF UNDER 18 YEARS OF AGE) _____

SIGNATURE _____

DATE _____