

# Campion Chiropractic Clinic

## Registro de Pacientes – ¡BIENVENIDOS!

Fecha de Hoy: \_\_\_\_\_

Lead Dr: S C

Nombre Completo: \_\_\_\_\_ Sexo:  Hombre  Mujer

Estado Civil:  S  C  D  W Nombre del Cónyuge: \_\_\_\_\_ # de Hijos: \_\_\_\_\_

Dirección: \_\_\_\_\_ Ciudad/Estado: \_\_\_\_\_ Código Postal: \_\_\_\_\_

Cumpleaños: \_\_\_\_\_ Edad: \_\_\_\_\_ # de la SS: \_\_\_\_\_

Empleador: \_\_\_\_\_ Profesión: \_\_\_\_\_

# de Celular: \_\_\_\_\_ # de Casa: \_\_\_\_\_ # de Trabajo: \_\_\_\_\_

Correo Electrónico: \_\_\_\_\_  Si no quieres boletines, tic aquí.

¿Como te gustaría que te recuerden?  # de Casa  # de Celular  Texto  Correo Electrónico

¿Como has oído hablar de nosotros? \_\_\_\_\_ Cual Dr.? \_\_\_\_\_

Contacto de Emergencia: \_\_\_\_\_ # de Teléfono: \_\_\_\_\_ Relación: \_\_\_\_\_

Doctor de Medicina: \_\_\_\_\_ Dirección: \_\_\_\_\_ # de Teléfono: \_\_\_\_\_

Principales Quejas: (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

¿Son sus quejas por un accidente?  de Coche  de Trabajo  Otra

¿Fecha del accidente? \_\_\_\_\_ Tienes un Abogado?  Si  No

# de Solicitud: \_\_\_\_\_ Nombre de tu Ajustador: \_\_\_\_\_ # de Teléfono: \_\_\_\_\_ # de Fax: \_\_\_\_\_

Dirección: \_\_\_\_\_ Ciudad/Estado: \_\_\_\_\_ Código Postal: \_\_\_\_\_

Compañía de Seguros: \_\_\_\_\_ # de Teléfono: \_\_\_\_\_

# de la Póliza: \_\_\_\_\_ # del Grupo: \_\_\_\_\_

Nombre de Asegurado: \_\_\_\_\_ # de la SS: \_\_\_\_\_ Cumpleaños: \_\_\_\_\_

Yo, \_\_\_\_\_, estoy de acuerdo en que, en última instancia, soy responsable del pago de los saldos por mi cuenta. Me ocupare de cualquier negociación con mi compañía de seguros, o con cualquier otra parte implicada, que pueda ser necesaria para liquidar mi cuenta. También estoy de acuerdo en pagar por cualquier tratamiento que se considere excedente y/o excluyendo la cobertura de mi compañía aérea.

Firma del Paciente: \_\_\_\_\_ Fecha: \_\_\_\_\_

Firma de la Guardia: \_\_\_\_\_ Fecha: \_\_\_\_\_

Testigo: \_\_\_\_\_ Fecha: \_\_\_\_\_

Solicitud de Tratamiento

1. ¿Dónde tienes dolor o preocupación? (Selecciona todos los que se te aplican)
- |                                          |                                         |                                  |                                         |                                        |                                       |
|------------------------------------------|-----------------------------------------|----------------------------------|-----------------------------------------|----------------------------------------|---------------------------------------|
| <input type="checkbox"/> Dolor de Cabeza | <input type="checkbox"/> Mandíbula/Boca | <input type="checkbox"/> Cuello  | <input type="checkbox"/> Espalda Arriba | <input type="checkbox"/> Espalda Media | <input type="checkbox"/> Espalda Baja |
| <input type="checkbox"/> Hombro          | <input type="checkbox"/> Brazo          | <input type="checkbox"/> Codo    | <input type="checkbox"/> Antebrazo      | <input type="checkbox"/> Muñeca        | <input type="checkbox"/> Mano         |
| <input type="checkbox"/> Cadera          | <input type="checkbox"/> Muslo/Pierna   | <input type="checkbox"/> Rodilla | <input type="checkbox"/> Pierna Baja    | <input type="checkbox"/> Tobillo       | <input type="checkbox"/> Pie          |
| <input type="checkbox"/> Otros: _____    |                                         |                                  |                                         |                                        |                                       |
2. ¿Qué área es tu principal preocupación hoy? \_\_\_\_\_
3. ¿Qué crees que causo este problema? \_\_\_\_\_
4. ¿Qué tan grave es su preocupación por lo peor? (Numero 0 = Sin Síntomas. Numero 10 = Los peores síntomas.)
- 0    1    2    3    4    5    6    7    8    9    10
5. ¿Qué se siente? (Selecciona todos los que se te aplican)
- |                                       |                                          |                                        |                                         |                                   |                                    |
|---------------------------------------|------------------------------------------|----------------------------------------|-----------------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Quemadura    | <input type="checkbox"/> Atrapado        | <input type="checkbox"/> Dolorido      | <input type="checkbox"/> Insensible     | <input type="checkbox"/> Pellizco | <input type="checkbox"/> Hormigueo |
| <input type="checkbox"/> Dolor Agudo  | <input type="checkbox"/> Dolor Corriente | <input type="checkbox"/> Dolor picando | <input type="checkbox"/> Dolor Punzante | <input type="checkbox"/> Tensión  |                                    |
| <input type="checkbox"/> Otros: _____ |                                          |                                        |                                         |                                   |                                    |
6. ¿Con qué frecuencia lo sientes?
- 75% - 100% del día    51% - 75% del día    26% - 50% del día    1%-25% del día
7. ¿Cuáles son tus metas para venir aquí? (Selecciona todos los que se te aplican)
- |                                                    |                                                       |                                                              |
|----------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Inviértete libre de dolor | <input type="checkbox"/> Una explicación de mi estado | <input type="checkbox"/> Aprende a cuidar esto por mi cuenta |
| <input type="checkbox"/> Reducir los síntomas      | <input type="checkbox"/> Reanudar la actividad normal | <input type="checkbox"/> Otro: _____                         |
8. ¿Cuál de las siguientes te hace sentir dolor? ¿Cuáles son difíciles? (Selecciona todos los que se te aplican)
- |                                                    |                                                         |                                             |                                                    |
|----------------------------------------------------|---------------------------------------------------------|---------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Entrar/salir de la cama   | <input type="checkbox"/> Moviendo en cama               | <input type="checkbox"/> Utilizando el baño | <input type="checkbox"/> Bañera/Ducha              |
| <input type="checkbox"/> Vistiéndose               | <input type="checkbox"/> Cocinando                      | <input type="checkbox"/> Masticación        | <input type="checkbox"/> Levantándose de una silla |
| <input type="checkbox"/> Movimiento general        | <input type="checkbox"/> Limpiando                      | <input type="checkbox"/> Tareas del hogar   | <input type="checkbox"/> Cuidar niños/padres       |
| <input type="checkbox"/> Cuidar mascotas           | <input type="checkbox"/> Trabajar Jardín                | <input type="checkbox"/> Usando Computadora | <input type="checkbox"/> Usando teléfono           |
| <input type="checkbox"/> Compras                   | <input type="checkbox"/> Asistiendo a eventos           | <input type="checkbox"/> Ejercicio          | <input type="checkbox"/> Jugando deporte           |
| <input type="checkbox"/> Entrar/Salir del vehículo | <input type="checkbox"/> Montar/Conducir en su vehículo |                                             |                                                    |
| <input type="checkbox"/> Otros: _____              |                                                         |                                             |                                                    |
9. ¿Qué te ayuda a sentir mejor?
- |                                         |                                                         |                                        |                                                 |
|-----------------------------------------|---------------------------------------------------------|----------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Acupuntura     | <input type="checkbox"/> Active Release Technique (ART) | <input type="checkbox"/> Quiropráctica | <input type="checkbox"/> Láser frío             |
| <input type="checkbox"/> Graston        | <input type="checkbox"/> Caliente                       | <input type="checkbox"/> Hielo         | <input type="checkbox"/> Acostada               |
| <input type="checkbox"/> Masaje         | <input type="checkbox"/> Descompresión/Inversión        | <input type="checkbox"/> NADA          | <input type="checkbox"/> Medicina para el dolor |
| <input type="checkbox"/> Terapia física | <input type="checkbox"/> Dormir/Descansar               | <input type="checkbox"/> Estirar       | <input type="checkbox"/> Otras terapias         |
| <input type="checkbox"/> Otros: _____   |                                                         |                                        |                                                 |
10. ¿Ha visto a alguien más por esta preocupación? \_\_\_\_\_ ¿Cuándo? \_\_\_\_\_
- ¿Qué recomendaron o que tratamientos realizaron? \_\_\_\_\_
11. ¿Tiene alguna de las siguientes condiciones médicas?
- |                                       |                                         |                                          |                                         |                                         |                                         |
|---------------------------------------|-----------------------------------------|------------------------------------------|-----------------------------------------|-----------------------------------------|-----------------------------------------|
| <input type="checkbox"/> SIDA/VIH     | <input type="checkbox"/> Cáncer         | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Nefropatía     | <input type="checkbox"/> Polio          | <input type="checkbox"/> ETS            |
| <input type="checkbox"/> Alcoholismo  | <input type="checkbox"/> Depresión      | <input type="checkbox"/> Cardiopatía     | <input type="checkbox"/> Enfe. Pulmonar | <input type="checkbox"/> Prob. Próstata | <input type="checkbox"/> Carrera        |
| <input type="checkbox"/> Anemia       | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> Lupus          | <input type="checkbox"/> Escoliosis     | <input type="checkbox"/> Enfe. Tiroides |
| <input type="checkbox"/> Artritis     | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Hipertensión    | <input type="checkbox"/> Enfe. Muscular | <input type="checkbox"/> Convulsiones   | <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> Asma         | <input type="checkbox"/> ERGE           | <input type="checkbox"/> Reemplazo Arti. | <input type="checkbox"/> Migrañas       | <input type="checkbox"/> Senos nublados | <input type="checkbox"/> Úlceras        |
| <input type="checkbox"/> Otros: _____ |                                         |                                          |                                         |                                         |                                         |
12. ¿Cuáles son tus hábitos de vida?
- |                                                       |                                                        |                                                           |
|-------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Tabaco _____ (# cigs/día)    | <input type="checkbox"/> Alcohol _____ (# bebidas/día) | <input type="checkbox"/> Drogas Recreativas               |
| <input type="checkbox"/> Cafeína _____ (#bebidas/día) | <input type="checkbox"/> Sueño _____ (# horas/noche)   | <input type="checkbox"/> Ejercicio _____ (# horas/semana) |

MUJERES: ¿Esta embarazada?  Si  No  Incierto

ADVERTENCIA: Si usted está o podría estar embarazada y no notifica al médico, esto podría ser peligroso para usted o la salud de su bebé y este consultorio no será responsable. Consentimiento de rayos X - Firma del paciente: \_\_\_\_\_

# Campion Chiropractic Clinic

## Informed Consent for Chiropractic Treatment

**TO THE PATIENT:** You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by a licensed Doctor of Chiropractic working at this clinic or office or serving as a backup for the Doctors at this clinic.

I have had the opportunity to discuss my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- Broken bones
- Dislocations
- Sprains/strains
- Burns or frostbite (physical therapy)
- Worsening/aggravation of spinal conditions
- Increased symptoms and pain
- No improvement of symptoms or pain
- Infection (acupuncture)
- Punctured lung (acupuncture)
- Other \_\_\_\_\_

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death. The reported complication of artery dissection by chiropractic cervical adjustment is rare and has been reported in approximately 1 out of a million treatments. To put that risk into perspective, complications from aspirin are 1 in ten thousand, and birth control 1 in five thousand.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment. The doctor cannot be responsible for any pre-existing medically diagnosed conditions.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan, and I intend this consent to cover the entire course of treatment for my current condition(s).

### Unsworn Declaration of Notary

My name is \_\_\_\_\_ [first-middle-last], my date of birth is \_\_\_\_\_.

My address is \_\_\_\_\_, \_\_\_\_\_, Texas, \_\_\_\_\_ [zip], USA.

I declare under penalty of perjury that the foregoing is true and correct.

Executed in Brazos County, State of Texas, on the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Patient or Responsible Party: \_\_\_\_\_

Printed Name: \_\_\_\_\_

*To be completed by doctor or staff:*

\_\_\_\_\_  
witness to patient's signature

\_\_\_\_\_  
date

\_\_\_\_\_  
translated by

\_\_\_\_\_  
date

## USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

**Your Protected Health Information (herein "PHI")** will be used or disclosed to others for the purposes of your treatment, obtaining payment, or supporting the day-to-day health care operations of this office. Some of these include having your name on a sign-in sheet, posted on a referral board, and used on charts and records that may be seen by others while in this office. We may also use various means of contacting you including phone calls, emails, and mail-outs such as appointment cards, birthday cards, and newsletters. Our office may leave messages on your phone, voice recorder, send emails or text messages to you that may contain PHI. This office utilizes an open treatment and therapy areas where your PHI may be heard or seen by other patients. We also consider this protected PHI.

You must list any restrictions on the release of your PHI below. Campion Chiropractic reserves the right to accept or deny those listed below based on our PHI Notice information.

No restrictions

Restrictions: \_\_\_\_\_

**You should review the Notice of Privacy Practices** (herein "Notice") that was received by you (if requested) and posted on the wall in the reception area for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of any health information, including your demographic information, collected from you and created or received by this office.

**You may request a restriction on the use or disclosure of your PHI.** This office may or may not agree to restrict the use or disclosure of your PHI. If we agree to your request, the restriction will be binding with this office. Use or disclosure of PHI in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**You have the right to revoke this consent** which must be done in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. ***This office reserves the right to modify the privacy practices outlined in the Notice.***

**I have reviewed this Consent Form and the Notice (as posted or requested), and give my permission to be examined, treated, and receive any examinations and office procedures that the provider deems necessary. I also allow this office to use and disclose my PHI in accordance with that stipulated above and in the Notice.**

Patient's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Patient/Guardian's Name (printed) \_\_\_\_\_

If Guardian, please list relationship \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Reviewed with Patient: Dr. Init \_\_\_\_\_

Karen M. Campion, D.C., P.A.

## FINANCIAL POLICY

PATIENT NAME: \_\_\_\_\_

Karen M. Campion, D.C., P.A., dba Campion Chiropractic and Sports Injury Clinic, and her staff welcome you to our office and are here to serve your healthcare needs and appreciate the opportunity to do so. We have sincerely endeavored to keep your health care costs in this office as reasonable as possible so that you may feel financially, as well as physically comfortable while pursuing the ultimate health that chiropractic provides. In the interest of maintaining a good doctor-patient relationship and continuing the delivery of quality healthcare, it is our hope that you will take responsibility for your financial obligation to our practice/office. The following are general policies we have established for our patients, which we believe allow the flexibility that some patients need. We encourage you to discuss your account, and any payment arrangements that you desire, with our office personnel. Discussion of these issues early on in your treatment process will prevent most concerns or misunderstandings.

1. **INSURANCE** – As a courtesy to our patients, we will verify your insurance at or before your first visit to our office. We will file claims on all visits and procedures performed in our office. Fees are based on the contracted insurance company's guidelines. Depending on your insurance carrier, these fees may vary. When we file a claim on your behalf, it is with the understanding that benefits will be assigned to Karen M Campion, D.C., PA (that is, the insurance company will pay Karen M Campion, D.C., PA directly). You are responsible for payment of all deductibles, co-insurance, co pays, and non-covered services. Please remember, insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and payment to your doctor rests with you.
2. **REFERRALS** - We gladly accept referrals from other doctor's offices. You are required to 1) know whether or not your insurance requires a referral and 2) obtain that referral before you are scheduled to see the doctor. Our office will be happy to assist you in determining the status of any one of our doctors on your insurance plan; however, this is not a guarantee of coverage. You should take the time to call your insurance company to ask specifically about the doctor you wish to see and your covered benefits. Referrals typically have an expiration date and a limited number of visits, so you should be careful to monitor the dates and visits. If your insurance company requires a valid referral for evaluation/treatment and you do not have one, you will be rescheduled for another day.
3. **NO INSURANCE** – Patients who do not have insurance are expected to pay for all services rendered on the day of treatment. We understand that individual situations may make it difficult to meet these financial expectations and we are happy to discuss payment arrangements as needed based on treatment recommendations.
4. **RETURNED CHECKS** – Your account will be charged a \$30 fee for each returned check. In addition, you will be asked to bring cash/money order to our office to cover the returned check amount and fees incurred.

5. PAST DUE ACCOUNTS – Patients who have not made an effort to make payment arrangements or have not expressed an interest in meeting their financial obligations to us may be turned over to a collection agency. Patients who have allowed their account to be turned over to an agency will be expected to satisfy their financial obligation to us, plus pay for any fees incurred from the agency. You will be expected to pay for any future services in advance, before being seen by our doctors.
  
6. NON-COVERED SERVICES – Medicare and certain insurance companies will only pay for services which they determine to be “reasonable and necessary”. If Medicare or another insurance company determines that your visit with our doctors/clinic is not “reasonable and necessary”, then they will deny payment for that service. Sometimes insurance companies will not cover an office visit/examination prior to procedure when the patient comes to the doctor with no symptoms and is requesting a screening procedure. Denial of payment by your insurance company does not mean that you do not need visit with the doctor/clinic beforehand.

Our doctors/clinic recommends a consultation and/or spinal screening prior to any treatment or procedures in order to evaluate the patient’s history and general health. The patient will then be informed about any examinations, physical therapy, acupuncture, spinal decompression, Graston, therapeutic exercises, and other diagnostic tests that may be needed in order to diagnose your condition and start treatment. We are required to inform you that your insurance company may not cover the consultation/office visit/examination/spinal manipulation/spinal decompression/acupuncture and/or physical therapy modalities and that you will be responsible for payment.

If for any reason, after a thorough consultation, examination and x-rays (if necessary), your problem is NOT a chiropractic case, or that we CANNOT help you, we will advise you of such and refer you to someone we think can help you.

*Patient Statement:*

*I have been informed of Karen M. Campion, D.C., P.A.’s financial policy and agree to its terms. I have been notified that Medicare and other insurance companies may deny payment for my initial office visit/examination or other procedures and treatments for the reasons stated above. If Medicare or my insurance company denies payment, I agree to be personally and fully responsible for payment.*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

# Campion Chiropractic Clinic

## PATIENT REQUEST FOR RECORDS

Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize the release of the following records, or copies of the following records, to be transferred from \_\_\_\_\_, and sent to:

Campion Chiropractic Clinic  
3120 Texas Avenue South  
College Station, TX 77845

Check all that apply below:

- Medical Records
- X-Ray Report / Films
- CT Report / Films.
- MRI Report/Films
- Labs
- Other: \_\_\_\_\_

I understand that this authorization is valid for no more than 1 year and may be cancelled anytime upon verbal or written request made directly to Campion Chiropractic Clinic.

Please FAX this form or drop off in person to protect your HIPAA information.

Patient / Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_