

New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name | Last Name | Date | Email*

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address | City | State | Zip

Telephone (Work) | (home) | Referred By

Age | Birth Date | Social Security # | Number of Children

Occupation | Employer

Marital Status | Spouse's Name | Spouse's Occupation

Spouse's Employer | Spouse's Health Status

Emergency Contact | Phone

Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe:

Date of Injury | Date symptoms appeared

Have you ever had same condition? ○ No ○ Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care? ○ No ○ Yes

If yes, please describe

Insurance Information

Name of party responsible for payment | Phone

Do you have health insurance? ○ No ○ Yes Name of company

*** If an auto accident, please provide:**

Insurance Company Name | Contact Person

Phone: | Claim #

Signatures

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

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Medical History

Have you been treated for any conditions in the last year? ○ No ○ Yes

If yes, please describe

Date of last physical exam | Is there a chance that you are pregnant? ○ No ○ Yes

Have you had X-rays taken? ○ No ○ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)I

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	○	○	
Been hospitalized?	○	○	
Been in an auto accident?	○	○	
Had Sprains/Strains?	○	○	
Been struck unconscious?	○	○	
Had surgery?	○	○	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	○ No	○ Yes
Do your symptoms interfere with daily life?	○ No	○ Yes
Does pain wake you up at night?	○ No	○ Yes
Are your symptoms worse during certain times of the day?	○ No	○ Yes
Do changes in weather affect your symptoms?	○ No	○ Yes
Do you wear orthotics?	○ No	○ Yes
Do you take vitamin supplements?	○ No	○ Yes

What activities aggravate your symptoms?

Habits	None	Light	Moderate	Heavy
Alcohol	○	○	○	○
Coffee	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○
Appetite	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○
Salty Foods	○	○	○	○
Sugary Foods	○	○	○	○
Artificial Sweeteners	○	○	○	○

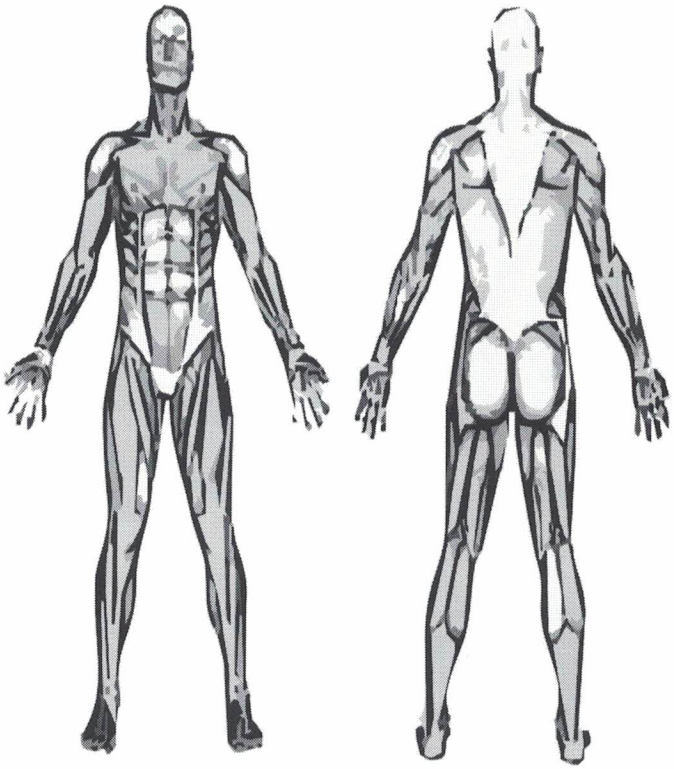
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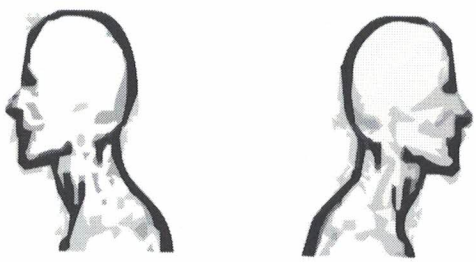
Have you ever suffered from:

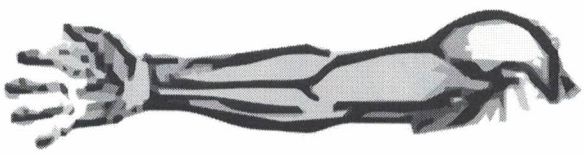
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing







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— Dr. Bryan Stanton —

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 **worst possible pain**

---

1 – What is your pain RIGHT NOW?

No pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst possible pain**

2 – What is your TYPICAL or AVERAGE pain?

No pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst possible pain**

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst possible pain**

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst possible pain**

OTHER COMMENTS:

_____

_____

_____

_____ _____

Patient's Signature Examiner's Signature

Twisted Spine & Joint
— Dr. Bryan Stanton —

Twisted Spine & Joint
9300 John Hickman Pkwy #601
Frisco, Texas 75035-5897

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name:**_____

Email address: _____ @_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease				

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

Section 7: Notice of Privacy Practices
Twisted Spine & Joint

Effective April 24, 2003
Updated: HITECH September 1, 2013

To our patients. This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your health information. Twisted Spine & Joint is required by law to maintain the confidentiality of your health information. Twisted Spine & Joint realizes that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances:

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the group health plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Twisted Spine & Joint must obtain your authorization to disclose psychotherapy notes, marketing disclosures and sale of PHI. Twisted Spine & Joint must notify you in case of a breach of unsecured PHI.

Uses and Disclosures for Payment – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your health insurance coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such

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individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the best service available. Examples of these outside persons and organizations might include vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about your health and health-related products we have available to you.

Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization.

- We may use or disclose your PHI for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.

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- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as described above, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard.

Your rights regarding your health information:

1. Right to Request Restrictions: Right to Request Restrictions: You have the right to request disclosure restrictions of PHI to a health plan with respect to healthcare for which you have paid out of pocket in full where not elsewhere restricted by law.

2. Twisted Spine & Joint is required by law to provide to you a notification of all demonstrated breaches of your PHI.

3. Communications. You can request that Twisted Spine & Joint communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that Twisted Spine & Joint contact you at home, rather than work. Twisted Spine & Joint will accommodate reasonable requests.

4. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that Twisted Spine & Joint restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. Twisted Spine & Joint is not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

5. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our Privacy Official: Jancy Stanton.

6. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Privacy Official: Jancy Stanton. You must provide us with a reason that supports your request for the amendment.

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7. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our Privacy Official: Jancy Stanton.
8. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Regional Office for Civil Rights, US Department of Health and Human Services. Regional Office information may be found online at **http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html** or ask the Privacy Official for the information. To file a complaint with our practice, contact our Privacy Official: Jancy Stanton. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
9. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

In accordance with the standards of implementation specifications of 45 C.F.R. § 164.524, Provider may grant an individual access to inspect and obtain a copy of protected health information about the individual in a designated record set.

Twisted Spine & Joint 's policy:

1. The designated record set that is subject to access by an individual is as follows:
   a. Medical Records
   b. Billing Records
   c. List of all those requesting copies of designated record set
2. The titles of the persons or offices responsible for receiving and processing requests for access by individuals are as follows:
   Privacy Official: Jancy Stanton

Twisted Spine & Joint also uses protected health information for the following reasons: (you may opt out of this authorization). Special initial authorization is required and attached.

Marketing; internal referral board, testimonials, pictures on bulletin board, sending newsletters or information unrelated to healthcare and other marketing materials.

If you have any questions regarding this notice or our health information privacy policies, please contact:
Jancy Stanton
You can reach the Privacy Official at:
Twisted Spine & Joint 9300 John Hickman Pkwy #601
Frisco, TX 75035
Phone number: 469-678-0023
Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

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Twisted Spine & Joint
— Dr. Bryan Stanton —

Section 8: Notice of Privacy Practices Acknowledgement
Initial Uses Authorization Form
Twisted Spine & Joint

Effective: 04/08/2013

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Twisted Spine & Joint. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Jancy Stanton.

Our clinic has open adjusting/treatment areas. Please initial that you acknowledge the doctor will be adjusting you and may discuss your condition and chiropractic care regimen in this joint treatment area. If you have any questions, wish to be adjusted, or discuss your condition in private you have the option to schedule a time with the doctor in the private consultation/adjusting room. _____ (please initial)

Twisted Spine & Joint also uses protected health information for the following reasons: (you may opt out of this authorization). Special initial authorization is required and attached. Marketing; internal referral board, testimonials, pictures on bulletin board, or information unrelated to healthcare and other marketing materials. _____ (please initial)

If you have any questions regarding this notice or our health information privacy policies, please contact:
Jancy Stanton
You can reach the Privacy Official at: Twisted Spine & Joint, 9300 John Hickman Pkwy #601, Frisco, Texas 75035, 469-678-0023
Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Your Email address: _____(you may receive PHI through email)

Print Patient Name: _____

Signature Patient/Personal Representative: _____

Relationship of Personal Representative: _____

Date of Signature: _____

==========

Staff complete only if NO signature is obtained, If it is not possible to obtain the patient's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

□ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices

□ Other: _____

Staff Signature: _____date: _____

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Twisted Spine & Joint
— Dr. Bryan Stanton —

INFORMED CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination test, diagnostic radiograph(s), and physical therapy techniques on me (or on the patient named below which I am legally responsible for) which are recommended by the licensed doctor of chiropractic providing services for, employed by, or associated with Twisted Spine and Joint Center, PLLC.

I understand that, as with any health care procedure, there are certain complications which may arise with chiropractic treatment. Although the complications with chiropractic care are extremely rare, and mostly minor in nature, they have been recognized. Those complications include, but are not limited to: fractures, disc injuries, dislocation, muscle spasms and strains, headaches, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of cervical manipulation, while extremely rare and of questionable correlation, could be associated with injuries to the arteries in the neck leading to or contributing to serious complications. I do not expect the doctor to be able to anticipate all risk and complication and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known and are in my best interest. I have had an opportunity to discuss with the doctor and/or office personal of Twisted Spine and Joint, the nature, purpose, and risks of chiropractic adjustment and other recommended procedures and have had my questions answered to my satisfaction. I understand, as with any healthcare procedures results cannot be guaranteed.

I have read or had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risk involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Also, if applicable, by signing below I state to the best of my knowledge that I am not currently pregnant; if I am pregnant, or become pregnant during course of treatment, I will report this to the doctor as soon as possible. Having been informed of the risks, I hereby give my consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I will seek treatment at Twisted Spine and Joint Center.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_____
Printed Name of Patient

_____ _____
Signature of Patient or Representative (If minor) Date

_____ _____
Witness to Patient's Signature Date

9300 John Hickman Pkwy Ste 601
Frisco, Texas 75035-5897
ph. 469-678-0023

Financial Policies: Updated: 01/01/2025

I agree to assign insurance benefits to **Twisted Spine & Joint**. We bill insurance companies as a courtesy for our patients and make every effort to inform patients of network status, however, patients are responsible for confirming with their insurance carrier if they deem our providers as in or out-of-network. I understand that if my contractual agreement with my insurance provider requires me to pay a copayment, deductible, and/or coinsurance, I must do so at the time of service to receive treatment.

I acknowledge full financial responsibility for services rendered by **Twisted Spine & Joint** and authorize transfer of all unpaid amounts to me, which includes, but is not limited to: co-pays, deductibles, co-insurance, pre-existing clauses, excluded conditions and/or termination of coverage. I agree to pay all legal fees, including attorney and court fee, as well as collection costs, in the event of default payment of charges that are my financial responsibility. I further authorize and request all insurance payments be made directly to **Twisted Spine & Joint** and authorize said assignee to release all information necessary, including medical records, to secure payment.

Changes in Insurance Coverage:
If you have a change in insurance coverage, it is your responsibility to make sure we have all of the pertinent information on file, including effective dates. Any medical expenses not covered by your insurance plan will be billed to you.

Return Checks:
A service charge of **$30.00** will be added to all checks returned for non-sufficient funds. I agree to pay all legal fees, including attorney and court fees, as well as collection costs, in the event of default payment of charges that are my financial responsibility.

FMLA/Disability/Paperwork Policy:
Any FMLA, disability, or other paperwork requiring doctor review and completion is subject to a **$125.00** fee. Please allow 2 weeks for this paperwork to be completed.

Cancellation Policy:

We require one business day's notice (24 hours) for cancellation of all doctor visits. Monday appointments must be cancelled on the preceding Friday. It is the policy of **Twisted Spine & Joint** to bill a cancellation fee to a patient that does not show or cancel at least one business day (24 hours) in advance of an appointment. This is to ensure that our treatment team is using their time to treat patients that are in need of our services. A patient that arrives 20 minutes past the time of the appointment may be considered a "no-show" for the purposes of this policy. A fee of **$55.00** will be charged for no show/no call appointments.

I authorize **Twisted Spine & Joint** to contact me by automated SMS text message for appointment reminders. I understand that message/data rates may apply to messages sent by text under my cell phone plan. I may opt-out of receiving these communications at any time by calling **Twisted Spine & Joint**, or by responding **STOP** to the text message sent from **Twisted Spine & Joint**.

Please sign digitally by typing below indicating you have read, understand, and accept all policies.

Patient Name Patient Signature Date