The Tri Doc

930 South Bell Blvd. Suite 103 · Cedar Park, Texas 78613 · 512-257-2225 Office · 512-257-3688 Fax · www.thetridoc.com

Welcome to The Tri Doc

We welcome you to our clinic and look forward to helping you with any health issues you have. We will happily address any questions or concerns you may have. At The Tri Doc we are committed to helping patients recover from injuries, resolve health concerns, and enjoy an active, healthy lifestyle. This commitment includes the possibility of referring out for diagnostic testing or to other practitioners if necessary to help you obtain optimal results.

Chiropractic care and rehab are most effective when you are committed to your health and follow the recommended treatment plan. Frequency and consistency are key. It is a process not a quick fix, but can have long lasting benefits.

We maintain a busy schedule and we really strive to stay on time. We respect your time and ask that you respect ours. Whenever possible, please keep your scheduled appointments and be punctual so that you and fellow patients do not have to wait. If you need to cancel or reschedule an appointment please allow 24 hour notice so we can open that appointment time for someone else who needs it. Failure to provide 24 hour notice will result in a $50 fee. Appointments may be canceled or changed through our online scheduling system or by calling the office. Please do not email regarding appointment changes.

Whenever possible, we recommend that you schedule your appointments in advance, but if an urgent issue arises and you need a same-day appointment we will do our best to accommodate you. If you are using the online scheduling system and can't find an appointment that works for you, please call us. We will try to find something to fit your schedule.

We love kids and your children are always welcome to join you in our clinic. For their safety and the well-being of all patients please supervise your children while they are here. Do not allow them to touch any of the fitness or treatment equipment.

Please do not use your cell phones in the treatment rooms. Please finish your calls prior to coming into the clinic.

We will file insurance claims for you as a courtesy, but this is not a guarantee of payment. We want you to be able to enjoy the benefits of chiropractic care and are happy to work with you by offering several financial options. Please note that all unsettled accounts over 90 days past due will be sent to our collection agency unless acceptable payment arrangements have been made.

The majority of our patients come to us through referrals. We appreciate you passing on our information to your friends and family and/or posting a review of our clinic online. We understand that you have many options when it comes to your healthcare and we thank you for choosing The Tri Doc.

Patient Signature _____ Date _____

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New Patient Information and History

Date: _____ How did you learn about our office? _____

Name: _____ Date of birth: ____ / ____ /_____

Address:_____ City/State/Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____

SSN:_____-_____-_____ TXDL:_____

Person responsible for payment:_____ Relationship to patient:_____

Responsible party's date of birth: ____ / ____ /_____ Responsible party's SSN:_____-____-_____

Emergency Contact: Name: _____ Relationship: _____

Phone: _____

I authorize doctors and/or staff to provide medical treatment to my minor son/daughter.

Parent's Printed Name:_____ Parent's Signature _____

Primary Care Physician:_____ Phone:_____

May we share information with your primary care physician in regards to your case? YES or NO

Have you been to a chiropractor before? _____

If so, what were you treated for and when? _____

Have you been treated for other health conditions within the past year? If yes, please explain. _____

_____

Do you have any concerns about your visit today? _____

What is your primary reason for coming in today? _____

When did your problem begin? _____

Have you been treated for this condition in the past? _____ If yes, who was your provider? _____

If yes, what was your previous treatment? _____

Is there anything that makes this condition better? _____

Is there anything that makes this condition worse? _____

On a scale of 0-10, how would you rate your pain? (0=no pain to 10=unbearable pain) _____

Describe how your pain feels: _____

Describe where your primary pain is: _____

Is there a time of day when the condition is worse? _____

Do you have pain anywhere else? _____ If yes, where? _____

What is your primary goal of treatment? _____

The Tri Doc

Patient Name: _____ Today's Date: _____

Do you have any races/events coming up that we should know about? _____

If so, what and when? _____

Have you had any other injuries? _____ If yes, explain: _____

_____

Have you ever been hospitalized? _____ If yes, when and for what? _____

List medications you are currently taking: _____

_____

List vitamins and supplements you are currently taking: _____

_____

Are you taking blood thinners? YES or NO Do you have a pacemaker? YES or NO

Are you immunocompromised? YES or NO

Men: When was your last prostate exam? _____

Women: Are you pregnant? YES or NO When was your last menstrual cycle? _____

*If you have had a breast augmentation, please inform your doctor during the exam so that you can discuss alternative adjustment options.

Are you Married? _____ Do you have children? _____

Do you use tobacco products or vape? _____ If yes, how much? _____

Do you drink alcohol? _____ If yes, how much? _____

Do you use recreational drugs? _____

What is your Occupation? _____ Do you sit a lot? _____ Do you stand a lot? _____

Do you exercise? _____ If yes, what do you do and how often? _____

Do you eat a healthy diet? _____ What did you eat for your last meal? _____

Cancellation and Late Arrival Policy

24 hour notice is required for any appointment changes or cancellations. Failure to contact the office at least 24 hours prior to your appointment for any changes or cancellations will result in a $50 missed appointment fee. Consideration will be given in the cases of true emergencies. If we have availability to reschedule you for another time within the same day, the $50 fee will be waived. Appointments may be cancelled or changed through our online scheduling system or by calling the office. Please do not email the office regarding appointment changes.

Please arrive promptly for your appointments so we can keep doctors and patients on time. Please allow yourself time to change clothes, if necessary, prior to your appointment time. Please call the office if you are running late for your appointment. We will always do our best to accommodate you, but if you arrive 15 minutes or more after your scheduled time we may need to reschedule you for another day or time.

I understand the above stated Cancellation and Late Arrival Policy. _____ patients initials

The Tri Doc
Review of Systems

Patient Name: _____ Today's Date: _____

Please check the signs and/or symptoms related to the following body systems you now have or have experienced in the past.

CONSTITUTIONAL
- ☐ Deny All
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

EYES
- ☐ Deny All
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

CARDIOVASCULAR
- ☐ Deny All
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

RESPIRATORY
- ☐ Deny All
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

MUSCULOSKELETAL
- ☐ Deny All
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

INTEGUMENTARY
- ☐ Deny All
- ☐ Breast Lumps / Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ History of Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

GASTROINTESTINAL
- ☐ Deny All
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

GENITOURINARY
- ☐ Deny All
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy / Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

ENMT
- ☐ Deny All
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ TMJ Problems
- ☐ Ulcers

NEUROLOGICAL
- ☐ Deny All
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

PSYCHIATRIC
- ☐ Deny All
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

ENDOCRINE
- ☐ Deny All
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

HEMATOLOGIC / LYMPHATIC
- ☐ Deny All
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

ALLERGIC / IMMUNOLOGIC
- ☐ Deny All
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

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Possible Non-Covered Services Declaration

While the vast majority of services performed at The Tri Doc are covered by insurance, there are certain cutting edge treatments and products that some insurance policies do not recognize and therefore do not cover.

The following services and/or supplies may or may not be considered eligible for insurance benefits by your health insurance, even when deemed medically necessary by your provider.

If you choose to receive these treatments or purchase these products you may be responsible for the full cost.

- Kinesiology Taping $15
- Low Level Laser Therapy $15
- Decompression Therapy $25
- Functional Dry Needling $25
- Acupuncture: $60
- Foam rollers/Trigger Point products: $8 - $100
- Therabands: $5 - $15
- Vitamins/Supplements $10-$60

I understand that my health insurance coverage has certain restrictions and limitations and may not pay for the above services and/or supplies. By choosing to obtain the services and/or supplies, I hereby consent and agree to be financially responsible for any and all related charges, if they are not covered by insurance.

Printed Name of Patient:_____

Signature of Patient or Authorized Representative: _____ Date: _____

The Tri Doc

Patient Name: _____ Today's Date: _____

Please read the following carefully:

I have answered the information to the best of my ability. I have not purposely omitted information or represented false information about myself. If I become aware of new information, I will notify the doctor or staff immediately.
I understand that insurance billing is a service provided as a courtesy and that I am financially responsible to The Tri Doc and/or its affiliated entities for any charges not covered by health insurance benefits. It is my responsibility to notify The Tri Doc of any changes in my health insurance coverage. In some cases exact insurance benefits cannot be determined until the insurance company processes the claim. I am responsible for the entire bill or the balance of the bill as determined by The Tri Doc and/or my health insurance carrier if any part of the submitted claims are denied for payment. Account balances that remain unpaid for more than 90 days will be forwarded to a collection agency.

With my signature I hereby authorize direct remittance of payment of all insurance benefits, including Medicare if applicable, to The Tri Doc for all covered medical services and supplies provided to me during the course of treatment.

Signature of Patient or Authorized Representative: _____ Date: _____

Functional Dry Needling and Acupuncture

Functional dry needling (FDN) and acupuncture are among our many available treatment options. Both procedures involve inserting a tiny monofilament needle through the skin. Needling can be very effective in treating a variety of musculoskeletal issues, but as with any treatment, there are risks of possible complications. The most serious risk with needling is accidental puncture of a lung (pneumothorax). If this were to occur, it would likely require a chest x-ray and no further treatment. Other risks include bleeding, bruising, infection, and nerve injury. These side effects are rare, but should be considered.
If your doctor determines that FDN and/or acupuncture are viable treatment options for your condition, he/she will discuss the details of the procedures, the probability of success, and the risk of side effects prior to treatment.

With my signature, I hereby consent to the performance of functional dry needling and/or acupuncture. I also consent to any measures necessary to correct complications which may result.

Signature of Patient or Authorized Representative: _____ Date: _____

Use and Disclosure of Protected Health Information

The Tri Doc may use my protected health information and may disclose such information to others for the purpose of treatment, determining insurance benefits, obtaining payment, or supporting the day-to-day healthcare operations of this office. You should review the attached Notice of Patient Privacy Policy for a more complete description of how your protected health information may be used or disclosed.

I have received the **Notice of Patient Privacy Policy**. _____ patients initials

Notice of Treatment in Open or Common Areas

Open/common areas are used for some treatments and therapies. Private areas are always available to discuss your health information upon request.

Appointment Reminders

Appointment confirmations and reminders will be automatically sent via secure, encrypted email. In addition, patients have the option of receiving reminders via text message. Text messages are not encrypted and therefore should not be considered a secure form of communication. Appointment reminders contain the patient's name and details about the scheduled appointment, but not personal health information.

With my signature I hereby acknowledge the privacy practices of this office and consent to the use and disclosure of my health information as outlined in the Notice of Patient Privacy Policy.

Signature of Patient or Authorized Representative: _____ Date: _____