Only $40 Out Of Pocket expense for first-day's Evaluation/Exam/Treatment

$40 paid before visit. Offer is for first day's services only.
If you're using insurance for treatments, clinic pays remaining balance due for copay, deductible, etc..
Not valid for Auto or Work-Comp Injury cases (which are much more complicated).

Download this page with the New Patient Forms and fill them out.

Call for an appointment

Bring the filled-out forms and $40 with you.

D.Loper Chiropractic
1911 N. Austin Ave, #405
Georgetown, TX 78628

Ph# / Txt# (512) 869-9811
Email: dloperdc@gmail.com
Web www.DavidLoperDC.com

D.Loper Chiropractic ~ DAVID W. LOPER, D.C ~ TX DC #5101 ~ www.DavidLoperDC.com
1911 N. Austin Ave #405, Georgetown, TX 78626 ~ ph# 512-869-9811 ~ fax# 512-366-9902 dloperdc@gmail.com

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment: The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may or may not cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment: As a part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological, muscle strength testing, postural analysis testing, ultrasound, hot/cold therapy, Electric muscle and nerve stimulation, radiographic studies, Neuro-Muscular (reflex) Re-Education, Rehabilitative Exercises myofascial therapy, massage.

The material risks inherent in chiropractic adjustment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

Patient's or Guardian's Signature: _____

Printed Name: _____ Date: _____

Dependent Patient's Name (if signed by Guardian): _____

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations (HIPPA)

I, understand that as part of my health care, Dr. David Loper, DC / A-SUN Chiropractic (herein referred to as "Provider") originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Provider is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Provider reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Provider change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of Provider's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept / decline the terms of this consent.

Patient's or Guardian's Signature: _____

Printed Name: _____ Date: _____

Dependent Patient's Name (if signed by Guardian): _____

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IRREVOCABLE ASSIGNMENT, SECURITY AGREEMENT AND AUTHORIZATION

I hereby authorize and direct you, (my insurance company, and/or my attorney and/or third-party liability insurance company), to pay directly to Dr. David Loper, DC, and/or. A-SUN Natural Health Center, LLP (the "Provider") such sums as may be due and owing the Provider for health care services rendered me by reason of accident or illness. Further, I authorize and direct you to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, Workers' Compensation benefits, or any other insurance benefits obligated to be paid to me or from any settlement or judgment on my behalf as may be necessary to adequately cover charges on services provided by the Provider.

I hereby grant the provider a security interest in any and all insurance benefits, and any and all proceeds of any settlement or judgment which may be payable to me as a result of the injuries or illness to cover expenses incurred from services I have been treated for by the Provider for said injury or illness.

If I am using health insurance (Indemnity, PPO, HMO, Medicare, etc.) to help cover charges for services and wish Provider to forgo collecting payment from me until they have responded in kind, I will abide to the terms in the contract I've signed with said insurance company. I will be responsible for deductable, co-insurance, co-pay, non-covered services and any amounts my insurance carrier deems is my responsibility and pay in full upon receipt of statement from the Provider.

In the event my insurance company becomes obligated to make payments for me for charges for services rendered by the Provider and refuses to make such payments upon demand by the Provider or me, I hereby assign and transfer to the Provider any and all causes of action that I may have against such insurance company, and authorize the Provider to prosecute said cause of action either in my name or in the Provider's name. Further, I authorize the Provider to compromise, settle or otherwise resolve such claim or cause of action for charges for services rendered by the Provider in such manner as the Provider shall determine in his sole discretion.

I hereby authorize the Provider to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection of insurance benefits or the proceeds of any settlement or judgment under this Assignment, Security Agreement and Authorization.

I hereby appoint the Provider as my attorney-in-fact and agent to endorse/sign my name on any and all checks issued by the insurance company to me as payment of any accounts due and payable to the Provider for health care services.

I understand that I remain personally responsible for the payment of all amounts due the Provider for health care services. I further understand and agree that this Assignment, Security Agreement and Authorization does not constitute consideration for the Provider to defer collection efforts for payment for health care services and the Provider may, at his option, demand immediate payment from me upon rendering such services.

I agree to pay the Provider for all costs of collection efforts, including court costs and attorneys fees if the Provider must take any action to collect an outstanding balance on my account.

General-Release: I authorize any doctor, hospital, employer, or other person, to whom a signed original or photocopy of this authorization is delivered, to furnish any information, copies of records, reports, and/or X-Rays which may be requested.

Patient's or Guardian's Signature: _____

Printed Name: _____ Date: _____

Dependent Patient's Name (if signed by Guardian): _____

Patient Information CASE#_____ Form Revised 11/03/2021

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Patient NAME: _____
Your Address: _____ City, Zip: _____
Physical Address (if other than mailing address): _____
Sub-Division Name or RRoute #: _____
Home Phone: _____, Birth Date: _____, Age ___, Sex: M ___, F___
Cell Phone# _____, e-mail: _____
Social Security #: _____, Drivers Lisc. #: _____
_____ Married, _____ Single, _____ Widowed, _____ Divorced, _____ Separated
Employer: _____
Address: _____ City: _____ ZIP: _____
Business Ph#: _____ Type of Work: _____
Spouse Name: _____ Spouses Employer: _____
City: _____ Business Ph#: _____ Cell Ph#: _____
How did you find me? _____
Including yourself, who is responsible for your bill? : Only Myself ___, Spouse ___, Parent ___, Medicare ___ Personal Health Insurance ___, My Auto Insurance ___, Other's Auto Insurance ___, Lawyer___, Medicaid ___, Workers Comp Covers It All ___, Insurance is in My name_____ or in Other's Name ____, Relationship _____, their Name & birth date _____
Name & ph# of Nearest Relative/Friend not living with you _____
Emergency contact, name, ph# & relationship: _____
_____
Your Current Medical Doctor's name and location: _____
_____
Prior Chiropractor's name, town, phone, and approximate last visit date: _____
_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, not the doctor. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment of all bills incurred by me at this office, regardless of outcomes of reimbursement issues with third party payers (insurance). I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and any amount paid directly to the Doctor's Office will be credited to my account on receipt and I will owe the balance. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable. I hereby appoint the Provider as my attorney-in-fact and agent to endorse/sign my name on any and all checks issued by the insurance company to me as payment of any accounts due and payable to the Provider for health care services. I agree to pay the Provider for all costs of collection efforts, including court costs and attorneys fees, if the Provider must take any action to collect an outstanding balance on my account. I authorize / assign payment directly to A-SUN Natural Health Center by my insurance carrier / attorney / work-comp. carrier / or other third party settlements to cover charges for health-care services I receive here. I hereby authorize the Doctor to treat my condition, as he or she deems appropriate through use of manipulation and other therapeutic modalities. X-rays ordered from here will remain the property of this office, being on file where they may be seen at any time while a patient of this office and forwarded to other health professionals at my request. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis. I agree to a $30 missed appointment fee for time I scheduled and Dr. Loper reserved his time for but then I not show up without calling to cancel within 24 hours of appointment time

I authorize any doctor, employer, insurance or other person, to whom a signed original or photocopy of this authorization is delivered, to furnish any information, copies of records, reports, and/or x-rays which may be requested.

Signed, (guardian if Minor Patient) _____

Date:_____ Patient, (if minor) _____

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PAST MEDICAL HISTORY: Circle "C" if current problem and "P" if problem is from the past.

General
C P Allergy
C P Convulsions
C P Fainting
C P Fatigue
C P Headache
C P Sudden Weight Loss
C P High Blood Pressure

Vascular
C P Nausea/Vomiting
C P Dizziness
C P Numbness on one side of the face or body
C P Difficulty Walking
C P Difficulty Speaking
C P Fainting/Light Headed
C P Double Vision
C P Rapid Eye Movement
C P Neck or Head Pain

Muscle & Joint
C P Arthritis
C P Bursitis
C P Low Back Pain
C P Neck Pain/Stiffness
C P Shoulder Pain
C P Spinal Curvature
C P Mid back Pain

Pain or Numbness
C P Shoulders/Arms
C P Elbows/Hands
C P Hips/Legs
C P Ankles/Knees/Feet

Genito-Urinary
C P Bedwetting
C P Frequent Urination
C P Kidney Infection
C P Painful Urination
C P Prostate Trouble
C P Kidney Stones

Eyes, Ears Nose & Throat
C P Hearing Loss
C P Ear-ache
C P Failing Vision
C P Nosebleeds
C P Sinus Infections
C P Thyroid Problems

Skin Problems
C P Bruise Easily
C P Hives or Allergic Reaction
C P Skin Rash
C P Acne

For Women Only
C P Cramps or Backache w/cycle
C P Excessive Menstrual Flow
C P Irregular Cycles
C P Lumps in Breast
C P Pain w/intercourse
C P Pelvic Inflammatory Disease

Gastrointestinal
C P Colon Problems
C P Constipation
C P Diarrhea
C P Gall Bladder
C P Hemorrhoids
C P Bulimia
C P Liver Problems
C P Strep Throat

Respiratory
C P Asthma
C P Chest Pain
C P Chronic Cough
C P Spitting up blood

Other
C P Stroke
C P Rheum.Fever
C P HIV/AIDS
C P Alcoholism
C P Diabetes
C P Cancer

List any prior accidents, injuries or falls with approximate dates: (even if it appears to be unrelated to this current problem i.e. car, recreational, school, sports, childhood, work): _____

_____

_____

LIST ANY OTHER CURRENT MEDICAL CONDITIONS AND PRIOR SURGERIES (with approx. dates): ____

_____

_____

Your Family History (some health problems are the result of familial tendencies)

Family Member	**Illnesses**	**Age or Age Died**	**Cause of Death**
Father:			
Mother:			
Brother(s):			
Sister(s):			

Signature: _____ **Date** _____

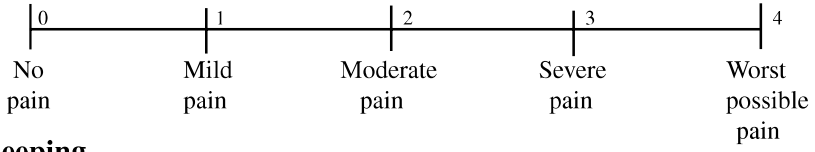
Print Name: _____

Functional Rating Index

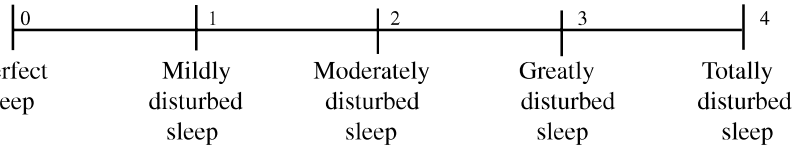
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

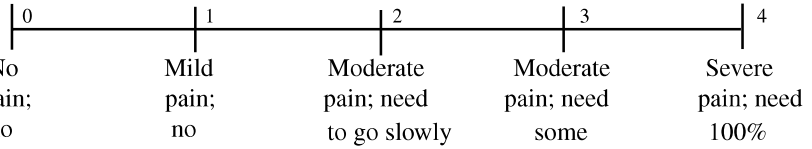
1. Pain Intensity



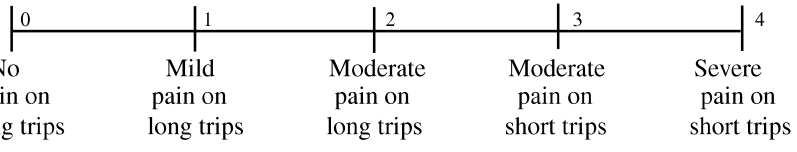
2. Sleeping



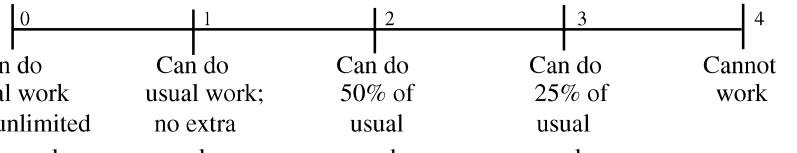
3. Personal Care (washing, dressing, etc.)



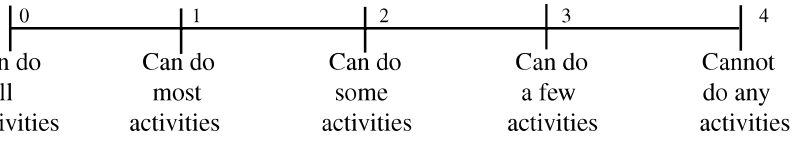
4. Travel (driving, etc.)



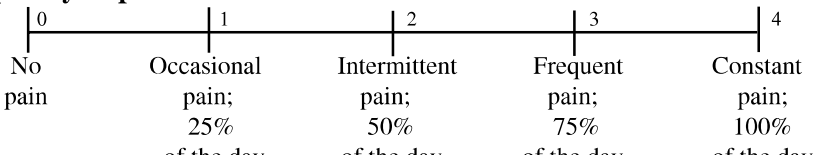
5. Work



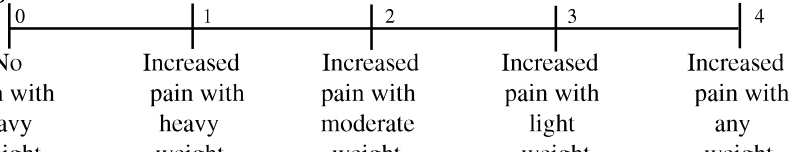
6. Recreation



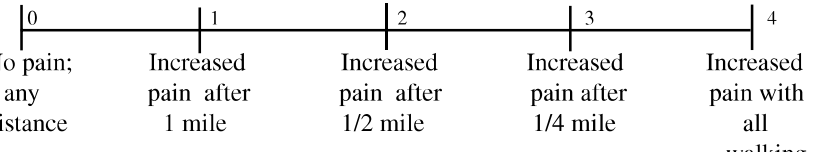
7. Frequency of pain



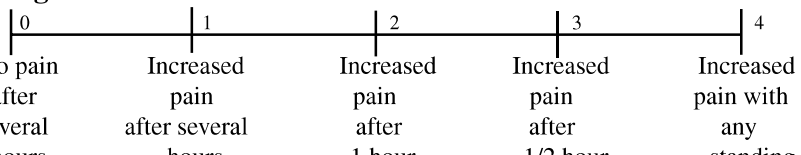
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

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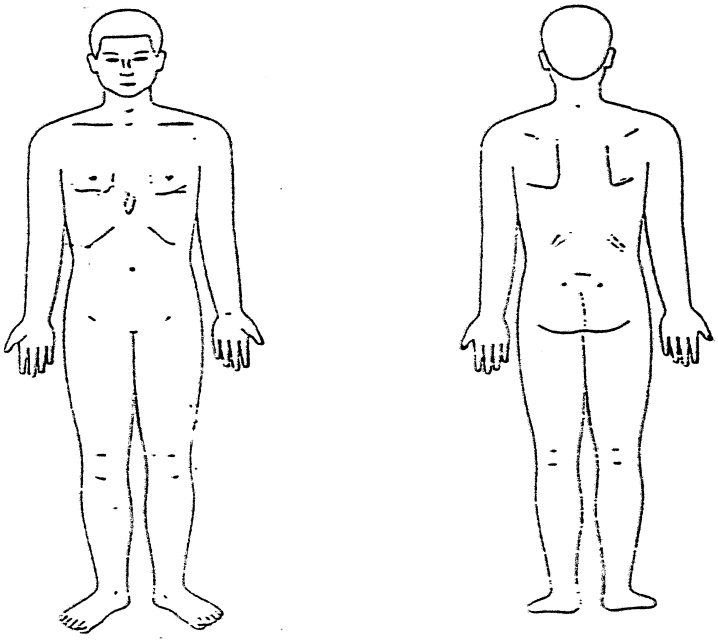
Patient Name: _____ Date: _____

Circle the areas *on your body that you have a problem.*
Include ALL affected areas.
Mark stress points and radiation.
Number each area
by order of importance

Mark them off to the side
with the symbol *from below.*
N *NUMBNESS*
P *PINS & NEEDLES*
B *BURNING*
S *STABBING*
A *ACHY*
C *CRAMPING*
T *TIGHT*

If more than one area,
Give more than one rating below



TODAY, *Grade your main problem's pain or discomfort level.*

None		*Slight*		*Mild*		*Moderate*		*Bad*		*Extreme*
0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

WORST Since this flair-up started, *Grade your main problem's pain or discomfort level.*

None		*Slight*		*Mild*		*Moderate*		*Bad*		*Extreme*
0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

WHEN DO YOU FEEL YOUR WORST? _____

_____

BEST Since this flair-up started, *Grade your main problem's pain or discomfort level.*

None		*Slight*		*Mild*		*Moderate*		*Bad*		*Extreme*
0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

WHEN DO YOU FEEL YOUR BEST? _____

_____

HOW AND WHEN did this latest Flair-up get started?_____

_____

_____

WHAT HAS BEEN DONE for this problem up to now? _____

_____

_____

Give the **PAST HISTORY** of your problem: _____

_____

_____