Park Place Health Solutions

PATIENT INFO

Name: (LAST) (MI) (FIRST)

Address: (STREET) (CITY) (STATE) (ZIP)

Home Phone: Work Phone: Cell Phone:

Email Address:

DOB: / / Soc. Sec # : -

Driver's License #: State:

Marital Status: S M W Spouse's Name:

Your Employer: Occupation:

Employer Address: (STREET) (CITY) (STATE) (ZIP)

Referred By: Primary Care Physician:

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name:

Member #: Group #:

Insurer's Name (If Different From Patient): Relationship to Patient:

Insurer's DOB: / / Insurer's Soc. Sec #: - -

Insurer's Employer:

Person responsible for account:

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

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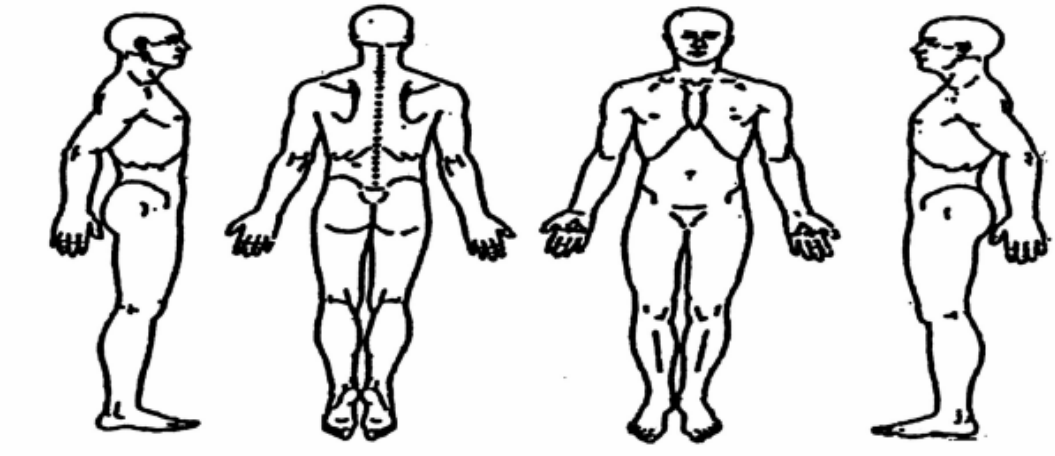
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Today's problem will be filed as: □ Insurance/ Self Pay □ Auto Accident □ Workman's Compensation

2. Chief Complaint/Reason for the visit: _____

3. Indicate on the drawings below where you have pain/symptoms



4. How would you describe the type of pain?

□ Sharp
□ Dull
□ Diffuse
□ Achy
□ Burning
□ Shooting
□ Stiff
□ Numb
□ Tingly
□ Sharp with motion
□ Shooting with motion
□ Stabbing with motion
□ Electric like with motion
□ Other:_____

5. How often do you experience your symptoms?

□ Constantly (76-100% of the time)
□ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time)
□ Intermittently (1-25% of the time)

6. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

8. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

9. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

10. Who else have you seen for your problem?

□ Chiropractor
□ ER physician
□ Massage Therapist
□ Neurologist
□ Orthopedist
□ Physical Therapist
□ Primary Care Physician
□ Other: _____
□ No one

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11. Have you had labs done recently (within last 6 months)? □ Yes □ No
If "Yes", when and where? _____

12. How long have you had this problem? _____

13. How do you think your problem began? _____

14. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

15. Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than ½ the days	Nearly every day
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**

16. What aggravates your problem?
_____

17. What alleviates your problem?
_____

18. What concerns you the most about your problem; what does it prevent you from doing?
_____

19. What is your: Height_____ **Weight** _____ **Date of Birth** _____

Occupation_____

20. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

21. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

22. Indicate if you have any immediate family members with any of the following (Please indicate the relationship to you):
□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Multiple Sclerosis (MS)
□ Heart Problems □ Cancer (see add. Forms) □ ALS □ Other: _____

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23. For each of the conditions listed below, place a check in the "Past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "Present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid-Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependence
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	HIV/AIDS
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	Multiple Sclerosis (MS)
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite	**For Females Only**		
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheum. Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Dermatitis/Eczema/Rash						
□	□	Other: _____						

24. List all prescription medications you are currently taking:

_____

_____

_____

25. List all of the over-the-counter medications you are currently taking:

_____

_____

_____

26. List all Allergies (medications, food, seasonal, etc.) you may have:

_____

_____

_____

27. List all surgical procedures you have had:

_____

_____

_____

28. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

29. What activities do you do outside of work?

_____

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30. Have you ever been hospitalized? □ Yes □ No
If Yes, why? _____

31. Have you had any past injuries or trauma, such as car accidents (ever?), falls, sports injuries, etc.?
□ Yes □ No
If "Yes", please provide details:
_____
_____

32. Is there anything else you wish to let us know about you visit today? □ Yes □ No

If "Yes", please provide details:
_____
_____

Patient Signature_____ **Date:** _____

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Insurance Verification Disclosure/Agreement

As a courtesy, Park Family Healthcare & Reclaim Physicians Medical will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Office Manager _____ Date _____

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Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the physician's hands or with the use of a machine. Frequently, adjustments create a "popping" or "clicking" sound/sensation in the areas being treated.

In this office, we use trained assistants who may assist the physician with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. On the occasion when your physician is unavailable, your care may be handled by another physician or trained assistant.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The chiropractic adjustment that is related to the vertebral artery stroke is called Extension-Rotation-Thrust Atlas Adjustment. We DO NOT use this type of adjustments on our patients. Other type of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractic would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disk Herniations: Disk herniations that create pressure on a spinal nerve or the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustment, traction, etc. This includes both in the neck and back. Yet, occasionally, chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely, surgery may cause a disk problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment (or treatment) may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or mid-back. They extend from your back to your front chest area. Rarely, a chiropractic adjustment will crack a rib bone and this is referred to as a fracture. This occurs only on patients who have weakened bones from conditions such as osteoporosis. Osteoporosis can be detected on your x-rays. We adjust all patients very carefully, and especially with those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

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Physical Therapy Burns: Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform your physician.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always provide you with the best care and if results are not acceptable, we will refer you to another health care provider who we feel may assist your condition.

If you have any questions on the above information, please ask your physician. Once you have a full understanding, please sign and date below.

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Secondary Number: _____

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Witnessed By _____ Date _____

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Assignment of Benefits

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, grants and conveys for deferred payment to Reclaim Physicians Medical Group, a lien and assignment against the proceeds of the patient's insurance settlement with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Reclaim Physicians Medical Group, and to 913 S. Main St., Unit 212, Grapevine, TX 76051.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Functional Medicine of Irving, and to send any and all checks to 913 S. Main St., Unit 212, Grapevine, TX 76051

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

By my signature be it known that I have read and fully understand the above contract.

Patient Name (Printed) _____Date _____

Patient Signature _____

Parent/Guardian Signature _____

Office Manager_____Date _____

HIPAA Disclosure

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

All Patient Medical Records

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

Park Family Healthcare and/or Reclaim Physicians Medical

Expiration Date of Authorization

This authorization is effective through __12/31/2019_ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize __Office Manager__ to use my protected information for the listed reasons.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Office Manager _____ Date _____

Park Place Health Solutions

Dear Patient:

This office is part of Reclaim Physicians Medical Group, Inc., which is a multidisciplinary doctor group. We have done this for various reasons, with the most important one being that our facility can enjoy a more comprehensive approach to your health by utilizing an integrative health care model. All services received in this office, are medically billed under Dr. Mandy Thompson or Reclaim Physicians Group. As such, when you receive your explanation of benefits from your health insurance company, it will indicate the date of services and procedure codes and insurance payments made to Dr. Mandy Thompson, MD or Reclaim Physicians Medical Group, Inc. In addition, all credit and debit card processing will be done on our behalf and will show as a charge from Reclaim Physicians Medical Group, Inc.

Patient Signature_____ Date:_____

Staff Signature_____

Park Place Health Solutions

X-RAY CONSENT FORM

Patient Name _____ Date _____

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. In addition, they may be required in order to administer treatment. By signing below, I consent to having the diagnostic x-rays performed, which the doctor determines is clinically necessary.

Patients Signature _____ Date _____

CONSENT TO X-RAY A MINOR CHILD

I_____ authorize the performance of diagnostic x-ray examination of my child or ward which the above doctor or his associate may consider necessary or advisable in the course of examination and treatment.

Parent/Guardian Signature _____ Date _____

THIS PORTION FOR WOMEN ONLY:

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I am aware that the ten (10) days following the onset of a menstrual period are generally considered to be safe for x-ray exams. With those factors in mind, I am advising my doctor that:

I am pregnant. ○ Yes ○ No

I could be pregnant. ○ Yes ○ No

I am late with my menstrual period. ○ Yes ○ No

I am taking contraceptives. ○ Yes ○ No

I have had a tubal litigation. ○ Yes ○ No

I have had a hysterectomy. ○ Yes ○ No

I have irregular menstrual periods. ○ Yes ○ No My last menstrual period began on

_____

With full understanding of the above, and believing that I am currently not as risk, I wish to have an x-ray examination performed today if requested by the doctor.

Signature _____ Date: _____