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/Guardian Signature **Date:**

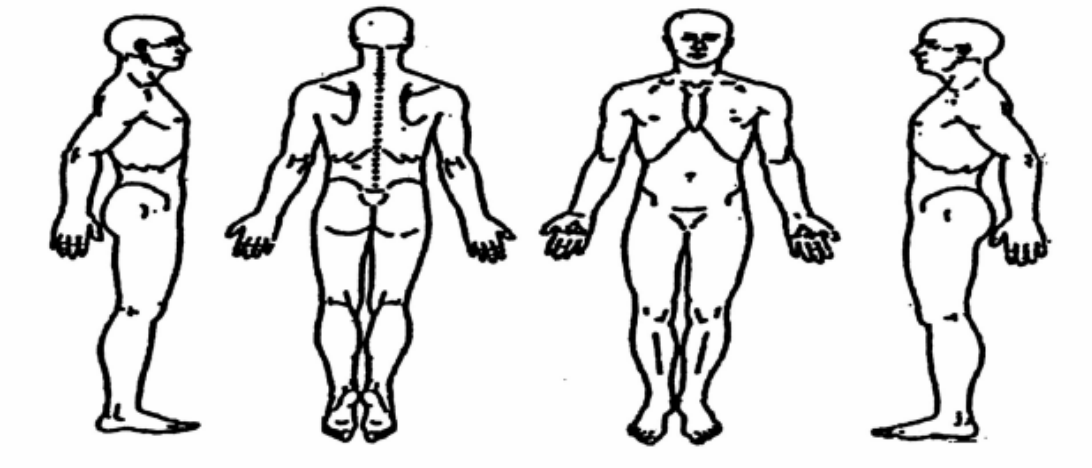
817-348-8488
501 Carroll St. #612 | Ft. Worth, TX 76107

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

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

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



3. How often do you experience your symptoms?

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

4. How would you describe the type of pain?

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

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. 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*)

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

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

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

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

9. Who else have you seen for your problem?

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

10. Have you had labs done recently (within last 6 months)? □ Yes □ No

If "Yes", when?_____

11. How long have you had this problem? _____

12. How do you think your problem began?

_____

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501 Carroll St. #612 | Ft. Worth, TX 76107

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

14. 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**

15. What aggravates your problem?

_____

16. What alleviates your problem?

_____

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

_____

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

19. 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	□	□	Kidney Disorders	□	□	**Gastric reflux**
□	□	Neck Pain	□	□	Bladder Infection	□	□	**Irritable Bowel**
□	□	Upper Back Pain	□	□	Painful Urination			**Syndrome/IBS**
□	□	Mid-Back Pain	□	□	Loss of Bladder Control	□	□	**Neuropathy**
□	□	Low Back Pain	□	□	Abnormal Weight Loss	□	□	**Weakness**
□	□	Shoulder Pain	□	□	**Abnormal Weight Gain**	□	□	**Fibromyalgia**
□	□	Elbow/Upper Arm	□	□	Loss of Appetite	□	□	**Gout**
□	□	Wrist Pain	□	□	**Abdominal Pain**	□	□	**Sleep apnea**
□	□	Hand Pain	□	□	**Ulcer**	□	□	**Snoring**
□	□	Hip Pain	□	□	Hepatitis	□	□	**Shortness of breath**
□	□	Upper Leg Pain	□	□	**Gall Bladder Disorder**	□	□	**Palpitations**
□	□	Knee Pain	□	□	Liver	□	□	**Heart arrhythmia**
□	□	Ankle/Foot Pain	□	□	**General Fatigue**	□	□	**Anxiety**
□	□	Jaw Pain	□	□	Muscular Incoordination	□	□	**Sexual dysfunction**
□	□	Joint Pain/Stiffness	□	□	Visual Disturbances	□	□	**Itching**
□	□	Arthritis	□	□	**Dizziness**	□	□	**Psoriasis**
□	□	Rheum. Arthritis	□	□	**Diabetes**			
□	□	Cancer	□	□	**Excessive Thirst**	**For Males Only**		
□	□	Tumor	□	□	**Frequent Urination**	□	□	**Prostate**
□	□	Asthma	□	□	Smoking/Tobacco Use	□	□	**Low – T**
□	□	**Chronic Sinusitis**	□	□	Drug/Alcohol Dependence	□	□	**ED**
□	□	**Other Breathing**	□	□	Allergies			
		Abnormalities	□	□	**Depression**	**For Females Only**		
□	□	**Dermatitis**	□	□	Systemic Lupus	□	□	Birth Control Pills
□	□	**Rash**	□	□	Epilepsy	□	□	**Hot flashes**
□	□	Eczema	□	□	HIV/AIDS	□	□	**Polycystic ovarian**
□	□	**High Blood Pressure**	□	□	**Anemia**	**disease**		
□	□	**Heart Attack**	□	□	**Vitamin D Deficiency**	□	□	**Infertility**
□	□	**Chest Pains**	□	□	**Metabolic syndrome**	□	□	**Painful periods**
□	□	**Stroke**			**pre-diabetic**	□	□	Hormonal Replacement
□	□	**Angina**	□	□	**Bariatric surgery**	□	□	Pregnancy
□	□	Kidney Stones						

Other:_____

20. List all prescription medications you are currently taking:

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

23. List all surgical procedures you have had:

_____
_____
_____

24. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

25. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

26. 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

27. What activities do you do outside of work?

_____

28. Have you ever been hospitalized? □ Yes □ No

If Yes, why? _____

29. Indicate if you have any immediate family members with any of the following (Please indicate the relationship to you):

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer (see add. Forms) □ ALS
□ Other: _____

30. Have you had any past injuries or trauma, such as car accidents (ever?), falls, sports injuries, etc.?

□ Yes □ No

If "Yes", please provide details:

_____
_____

31. 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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501 Carroll St. #612 | Ft. Worth, TX 76107

Insurance Verification Disclosure/Agreement

As a courtesy, Path to Wellness & 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 _____

817-348-8488
501 Carroll St. #612 | Ft. Worth, TX 76107

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.

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 _____

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:

Wellness Solutions & Reclaim Physicians Medical

Expiration Date of Authorization
This authorization is effective through 12/31/2017 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 of Wellness Solution to use my protected information for the listed reasons.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Office Manager _____ Date _____

Dear Patient:

This office has joined 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. This means the incorporation of Medical and Osteopathic physicians, who are directly involved in your healthcare, into our scope of various services. As such, certain services and diagnostics will be administered, when clinically warranted, and billed under the Reclaim Physicians Medical Group, Inc. 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 payments made to Reclaim Physicians Medical Group, Inc. If you have any questions regarding this exciting amendment to our office, please ask me.

Sincerely,

_____

Dr. Lauren Letz, DC
Dr. Andrea Roberts, DC
Dr. Ashley Salazar, DC
Dr. Meredith McKnight, DC

Medical Massage Policy Changes

Our facility is a medical massage clinic and has to be compliant with policies and guidelines of medical necessity. One stipulation is that treatment is directed by a Doctor. This will require our massage patients to see a chiropractor or the nurse practitioner at least once every 30 days to stay compliant. This applies to all patients regardless of being selfpay, insurance, MVA, etc. This can occur during your normally scheduled visits downstairs or at your convenience prior to a massage.

Massage Cancellation Policy

In order to better accommodate our growing number of patients in need of massage therapy, we encourage patients with an appointment who need to reschedule to give us as much advance notice as possible.

Less than a 24 hour notice is considered a no-show.

Beginning February 2017, we will be implementing a cancellation fee for no-show massage appointments. This is not something we do lightly and will only be used in extreme cases. We will always allow 3 grace cancellations or no-show appointments before we audit your account and make the decision to charge a $35 fee to the account. We do understand uncontrollable things in life do happen.

If we see that cancellations are a problem we reserve the right to ask for prepayment of massage or we may ask to put a credit card number on your account to charge a no-show fee if necessary.

Please remember to cancel or reschedule your massage appointment with at least 24 hours notice.

Thank you,
Path TO Wellness

_____ _____

Patient Printed Name Patient Signature

_____

Date

Informed Consent for Dry Needling of Trigger Points

Patient's Name: _____ Date:_____

Your chiropractor has recommended that you receive Dry Needling technique for the evaluation and or treatment of myofascial trigger points and tender points within your muscles, tendons or ligaments. Recent evidence has shown that trigger points are localized areas of hyperactive muscle or tissue that have numerous inflammatory and pain producing chemicals causing local tightness of the muscle. The tightness of the muscle is often accompanied by pain and dysfunction of the muscle, consequently irritating local nerve endings as well as decreasing normal movement of the nearby joints enough to limits normal functional activities.

Dry needling to trigger points has been shown to decrease or completely reduce the irritation and to reduce or completely eliminate the irritating chemicals in an active trigger point. This release can immediately improve range of motion, decrease pain and improve function. Patients often feel a significant improvement of their symptoms immediately after the treatment. Trigger point dry needling facilitates a hastened return to strengthening and exercises that result in a faster return to function. The dry needling procedure involves placing a very thin, single use disposable sterile solid tilament needle (not hollow) with sterile technique into a trigger point. The number of needles used during any individual visit and the number of visits you are given this treatment depends on many factors that differ from patient to patient. THIS IS NOT ACUPUNCTURE; THIS IS A DIFFERENT FORM FROM TRADITIONAL ACUPUNCTURE. Be assured that this procedure is very safe. Most patients do not feel the needle when it is placed and other than a focal muscle twitch or feeling of a subtle muscle cramp around the needle tip, there is little to no pain with this procedure. Because the needle being used is very thin, there is usually little to no bleeding with this procedure. Occasionally, however, complications may arise. Any procedure intended to help may have complications or side effects. While the chances of experiencing complications are unlikely, it is the practice of this clinic to inform our patients about them. Most of these complications are very minor and self-limiting and resolve rapidly.

Minor complications include:

- **Focal bruising at the needle insertion site.**
- **Minor soreness in the immediate area afterword.**
- **A small amount of bleeding at the needle insertion site that stops on its own within a few minutes.**
- **These minor complications generally resolve within a day or two after the treatment. More serious complications, while very rare, are possible and include:**
- **Fainting**
- **Persistent bleeding at the needle insertion site.**
- **Infection**
- **Puncture of the lung (only if the needle is being used near lung tissue)**

The possibility of complications may be increased if you have certain pre-existing problems. It is very important that you discuss with your physical therapist any problems that you have had, currently have, or might have, specifically:

_____ I have a fear of needles, have fainted, or fear I will faint when needles have been used for my diagnosis or care in the past.

_____ I have a bleeding disorder that causes my blood to clot slowly or not at all. Please specify: _____

_____ I have a history of a blood disorder that can be transmitted to another person. Please specify: _____

_____ I take blood thinners (anti-coagulation) medication. Please specify: _____

_____ I have taken pain relievers (e.g. aspirin, Tylenol, Ibuprofen, etc.) in the past 48 hours. Please specify: _____

I have read this Patient Information and Consent carefully, I understand this procedure is not acupuncture and I have had an opportunity to ask questions and obtain any desired clarification. I also understand that there is no guarantee or warranty for a specific cure or result. I understand the above statements regarding examination and treatment side effects. I give my permission and consent to the procedure or treatment. I understand that I can stop this procedure at any time. Patient

Signature:_____Date:_____

If patient is less than 18 years of age a parent or legal guardian must sign.

Name of Parent/Legal Guardian (Please print): _____

Signature: _____Date: _____

Consent to X-Ray

I hereby acknowledge that Dr. Lauren Letz and/or her staff at Path to Wellness Chiropractic has informed me of the advisability of, risk inherent in, and the probable consequences of not receiving X-Rays. She has also explained to me the reasons and need for such x-rays. I do hereby authorize Dr. Lauren Letz, a licensed Doctor of Chiropractic or an Associate Doctor, to perform all such x-rays as she deems pertinent to the diagnosis and management of my case.

Dated this _____ day of _____, 20__

_____
Patient Signature

_____
Witness

Pregnancy Waiver

To be completed by all females of childbearing age

I herby acknowledge that Dr. Lauren Letz and/or her staff at Path to Wellness Chiropractic has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated of my own volition that I am not pregnant nor am I attempting to get pregnant as of this date and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

Dated this _____ day of _____, 20__

_____
Printed name of Patient

_____
Signature of Patient or Authorized Representative

_____
Witness