PATIENT INFORMATION

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)

Primary Care Physician: Primary Care Physician Phone: - -

How did you find us? (*please make selection below)*

- ☐ Physician (name:_____)
- ☐ Health/Wellness Facility (name:_____)
- ☐ Insurance Listing/Search Results
- ☐ Internet Search Engine (please circle the best option): Bing Google Yahoo Yelp
- ☐ Attorney/Law Firm (name:_____)
- ☐ Preferred Employer/HR Department (company name:_____)
- ☐ Family Member/Friend Recommendation (name:_____)
- ☐ Other:_____

INSURANCE INFORMATION

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

Insurance Name: Person responsible for account:

Member #: Group #:

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

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

Insurer's Employer:

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:**

_____ _____

PHONE 972.393.8067
Core Physical Medicine & 1rst Health
3400 Long Prairie Road, Suite 100, Flower Mound, Texas 75022 • 546 E. Sandy Lake Road, Suite 110, Coppell, TX 75019
825 W. Royal Lane, Suite 240, Irving, Texas 75039 • 601 S. Main St., Suite 260, Keller, Texas 76248

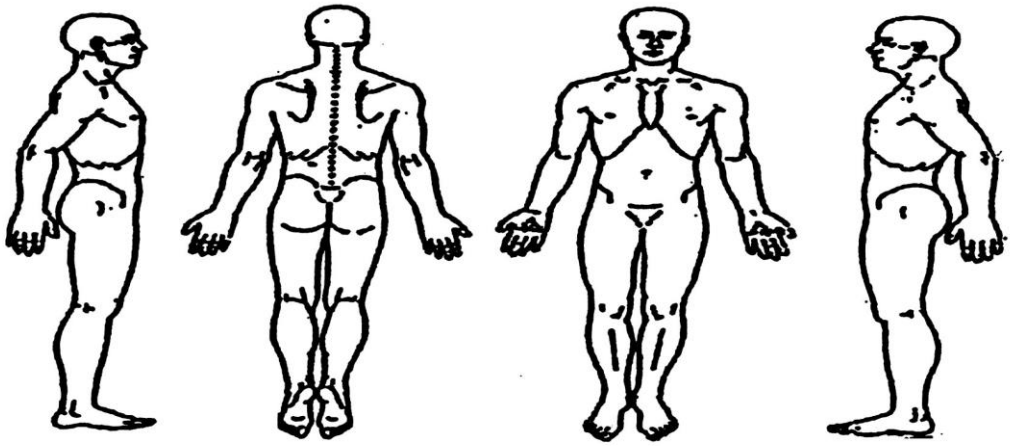
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

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

2. What is your primary area of concern/ pain? _____

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 long have you had this problem? _____

6. How do you think your problem began? _____

7. 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)

8. On a scale from 0-10 (10 being the worst), how would you rate your pain?

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

9. What aggravates your problem? _____

10. What alleviates your problem? _____

11. How are your symptoms changing with time?

□ Getting worse □ Staying the same □ Getting better

12. What is your: **Height** _____ **Weight** _____ **Date of Birth** _____

Occupation _____

13. How would you rate your overall health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

14. Rate your level of exercise activity:
□ Stenuous □ Moderate □ Light □ None

15. Indicate if you suffer from or have immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

16. For the conditions listed below, please check the "past" column if you have had the condition in the past; If you presently have a condition listed below, please check 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	□	□ Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Lower Leg Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Knee Pain	□	□ Loss of Appetite	**Females Only**	
□	□ Ankle/Foot Pain	□	□ Abdominal Pain	**Past**	**Present**
□	□ Jaw Pain	□	□ Ulcer	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Hepatitis	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Liver/Gall Bladder Disorder	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ General Fatigue		
□	□ Cancer	□	□ Muscular Incoordination		
□	□ Tumor	□	□ Visual Disturbances		
□	□ Asthma	□	□ Dizziness		
□	□ Chronic Sinusitis				

17. List all prescription and over-the-counter medications you are currently taking:

_____

_____

_____

18. List all nutritional supplements you are currently taking:

_____

_____

19. List all surgical procedures you have undergone:

_____

_____

20. What activities do you do at work?

Sit	□ Most of the day	□ Half of the day	□ A little of the day
Stand	□ Most of the day	□ Half of the day	□ A little of the day
Computer Work	□ Most of the day	□ Half of the day	□ A little of the day
On the Phone	□ Most of the day	□ Half of the day	□ A little of the day
Drive	□ Most of the day	□ Half of the day	□ A little of the day
Other Activities	□ Perform manual labor	□ Read a lot	□ Travel frequently

21. What activities do you enjoy outside of work?

_____

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

If yes, why?

_____

23. Have you had past trauma such as car accidents (ever?), falls, sports injuries, etc? □ Yes □ No

If yes, what and when? _____

24. Is there anything else you wish to let the doctor know about your visit today? □ Yes □ No

If yes, what? _____

Patient Signature _____ **Date** _____

Colorectal cancer is one of the most common causes of cancer related deaths in the U.S. Most people can reduce their risk for colon cancer through early detection and prevention with a colonoscopy screening. Core Physical Medicine has partnered up with Victory Medical Center Plano to join in their fight against Colon Cancer.

We invite you to take part in their Colon Cancer Screening Program by filling out this quick questionnaire.

Have you ever had a colonoscopy?..... YES NO

If yes, when was your last colonoscopy? (Date or Year) _____

Do you have a family history of colon cancer or polyps? ……..... YES NO

Do you have a personal history of colon cancer? ……... YES NO

You have my permission to send this information to a board certified physician for review, and to contact me about a colonoscopy at Victory Medical Center Plano ……..…… YES NO

I hereby give my consent and authorize to Core Physical Medicine, to use and/or disclose the above information for the stated purpose; along with demographic and insurance information.

Patient Signature: _____ Date: _____
Patient Printed Name: _____

Core Physician: _____
Core Location: Coppell Flower Mound Keller Las Colinas

Insurance Verification Disclosure/Agreement

As a courtesy, Core Physical Medicine & 1rst Health will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. I will remember the information provided through the insurance verification is not a guarantee of coverage, and actual benefits are determined only when the claim is received. 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 _____

Informed Consent

Dear Patient:

The owners/employees of Core Physical Medicine and 1rst Health may have an ownership interest in facilities that patients are referred to for further treatment, including diagnostics and procedures. You as the patient have the right to go to any facility of your choice without any negative impact on your treatment at Core Physical Medicine. Please talk to our office manager or your treating doctor if you have any questions or if you would like to receive a list of alternative facilities.

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

I hereby assign any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and/or other legal entities ("payers"), which may elect or be obligated to pay, provide or distribute proceeds to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") to **pay directly in the name of 1rst Health**("office") such sums as may be owed said offices for charges incurred by me at the office relating to my condition)"charges"), with such payment to **be made in the name of 1rst Health.** For the purposes of this document (herein, "assignment"), "proceeds" shall include, but not be limited to, monies/proceeds from any settlement, judgment, or verdict, as well as any monies/proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

In the event that I retain one or more attorneys to represent me in this matter, I direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the express written consent of this office.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this assignment. I further authorize and direct all payers to release to office any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this office to file a copy of this assignment, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize 1rst Health to endorse/sign my name on any and all checks listing me as a payee, which are presented to this office for payment of any account relating to me, my spouse, or any of my dependents.

I understand that I remain personally responsible for the total amounts due 1rst Health for said services. If I discontinue treatment against the medical opinion/advice of my treating doctor, the balance of charges for services rendered will be due and payable immediately. If the office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **1rst Health** for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

This assignment shall not be modified or revoked without the mutual written consent of 1rst Health and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this assignment.

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:

Core Physical Medicine and/or 1rst Health

Expiration Date of Authorization

This authorization is effective through __12/2016__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 _Core Physical Medicine, 1rst Health, PA__ 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 **1RST Health, PA**, 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 **1RST Health, PA**. 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 **1RST Health, PA**. If you have any questions regarding this exciting amendment to our office, please ask me.

Sincerely,

Dr. Stephen Ward and Dr. Michael Schnappauf

PHONE 972.393.8067
Core Physical Medicine & 1rst Health
3400 Long Prairie Road, Suite 100, Flower Mound, Texas 75022 • 546 E. Sandy Lake Road, Suite 110, Coppell, TX 75019
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Release of Medical Records

I, _____, hereby authorize the release of my medical records

From:

_____

_____

_____

To:

Core Physical Medicine

□ Mail to:

□ Fax to:

_____
Print Name

_____
Signature

_____
Social Security Number

_____
Date of Birth

_____
Date