



PATIENT INFO

Name: (LAST) (MI) (FIRST)
Address: (STREET) (CITY) (STATE)
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)
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 _____

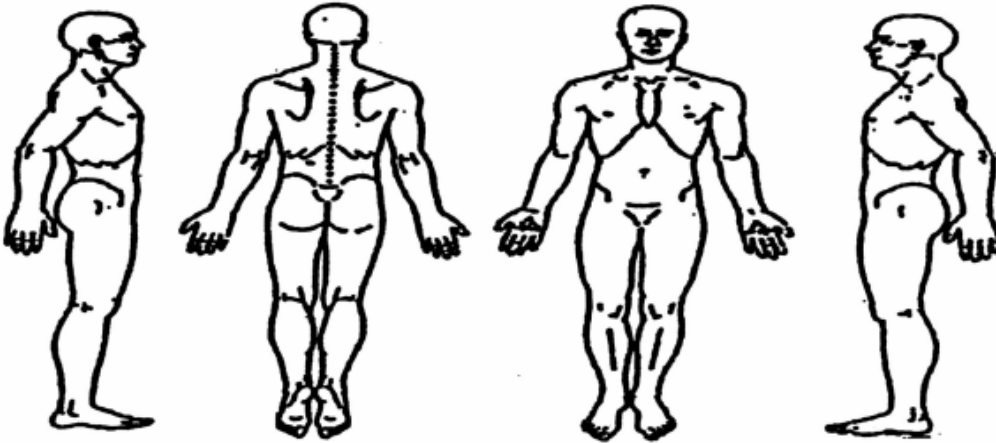
PATIENT INTAKE FORM

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?

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Numb |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Tingly |
| <input type="checkbox"/> Diffuse | <input type="checkbox"/> Sharp with motion |
| <input type="checkbox"/> Achy | <input type="checkbox"/> Shooting with motion |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing with motion |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff | <input type="checkbox"/> Other: _____ |

5. How often do you experience your symptoms?

- | | |
|---|---|
| <input type="checkbox"/> Constantly (76-100% of the time) | <input type="checkbox"/> Occasionally (26-50% of the time) |
| <input type="checkbox"/> Frequently (51-75% of the time) | <input type="checkbox"/> 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?

- | | | |
|--|---|---|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER physician | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> No one |

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 1/2 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: _____

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

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

29. What activities do you do outside of work?

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: _____



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 _____

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 12/31/2017 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 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 insurance payments made to 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. If you have any questions regarding this exciting amendment to our office, please ask me.

Sincerely,
