curis FUNCTIONAL HEALTH

221 Regency Parkway, Suite 101 Mansfield, TX 76063 **Phone**: 817-453-0430 **Fax**: 817-453-0400

PATIENT INFORMATION

Date: ___________

Legal Name: ______________________________

Address: ______________________________

City: __________________ State: ______ Zip: ________

Mobile Ph: __________________ SS# ________________

Alt. Ph: ______________________________

Date of birth: ____/_____/_____ Age ______ Sex _______

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Email Address: ______________________________

Whom may we thank for referring you? ________________

EMPLOYMENT INFORMATION

Occupation: ______________________________

Employer: ______________________________

Address: ______________________________

Phone # ______________________________

EMERGENCY INFORMATION

Contact Name: ______________________________

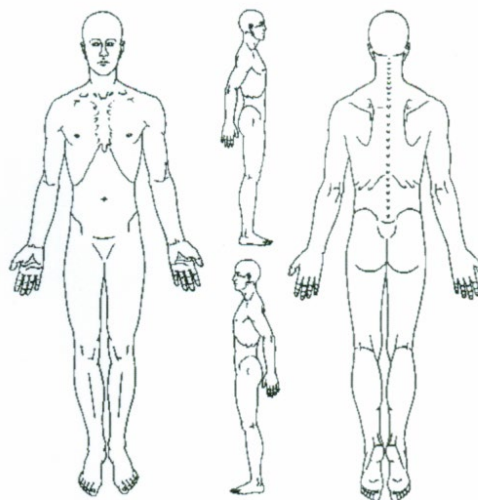
Relationship: _____________ Ph. # ________________

CURRENT HEALTH CONDITION

CHIEF COMPLAINT: ____

When did symptoms first appear? __________________________

Mark your areas of concern



Has this condition occurred before? ☐ Yes ☐ No

How often do you experience the symptoms?
☐ Constant 100% ☐ Frequent 75%
☐ Intermittent 50% ☐ Occasional 25%
☐ Rare 10%

What makes the symptoms worse? ________________________
What relieves the symptoms?___________________________

How would you describe the pain?
☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Numb
☐ Throbbing ☐ Radiating ☐ Deep ☐ Other

Rate the pain on a scale of 1-10 (10 being unbearable pain)
Right now 1---2---3---4---5---6---7---8---9---10
At its worst 1---2---3---4---5---6---7---8---9---10
Other Doctors seen for this condition ☐ Yes ☐ No
If so, please list the name(s) of physician(s) seen for this condition:

____

Type of treatment? ____________________________________ Results ________________________

Is this condition: ☐ Job related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other_________________________

Do you wear a shoe lift? ☐ Yes ☐ No

Do you suffer from any condition other than which you are now consulting us? ☐ Yes (explain) ☐ No

____

Are you in litigation for any accidents (Auto, Workmens Comp. Etc.) at this time? ☐ Yes ☐ No

Female Patient: Is there any possibility you are pregnant? ☐ Yes ☐ No

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD

☐ AIDS/HIV
☐ Anemia
☐ Arthritis
☐ Cancer
☐ Diabetes
☐ Epilepsy
☐ Gout
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Rheumatic Fever

CHECK ANY YOU HAVE HAD IN THE PAST 6 MONTHS

Musculoskeletal Code
☐ General Stiffness
☐ General Weakness
☐ Swollen Joints
☐ Spinal Curvature
☐ Neck Pain
☐ Arm Pain

General Code
☐ Fatigue/Weakness
☐ Allergies
☐ Headaches
☐ Loss of Sleep
☐ Weight Change
☐ Fever/Chills

C-V-R Code
☐ Chest Pain
☐ Short Breath
☐ Asthma
☐ Blood Pressure Problems
☐ Irregular Heartbeat
☐ Heart Problems

Genitourinary Code
☐ Bladder Trouble
☐Painful/Excessive Urine
☐ Discolored Urine

Nervous System Code
☐ Nervous
☐ Numbness
☐ Dizziness
☐ Forgetfulness
☐ Depression
☐ Cold/Tingling in extremities
☐ Stress
☐ Twitching
☐ Other Endocrine problems
☐ Change in sex characteristics
☐ Neck/Surgery/Irradiation
☐ Diabetes

Gastrointestinal Code
☐ Poor/Excessive Appetite
☐ Excessive Thirst
☐ Vomiting
☐ Nausea
☐ Diarrhea
☐ Constipation
☐ Liver Problems
☐ Gall Bladder Problems
☐ Abdominal Cramps
☐ Gas/Bloating/Belching
☐ Heartburn
☐ Black/Bloody/Stools

EENT Code
☐Vision Problems
☐ Dental Problems
☐ Sore Throat
☐ Ear Aches
☐ Hearing Difficulty
☐ Stuffed Nose
☐ Frequent Colds
☐ Nose Bleeds
☐ Sinus Trouble
☐ Hoarseness

Family History
The following members have the same or similar problem(s) as I do:
☐ Father
☐ Mother
☐ Brother
☐ Sister
☐ Other _______

For Women Only
☐ Pain b/w shoulders
☐ Low back pain
☐ Foot trouble
☐ Walking Problems
☐ Jaw Problems
☐ Heat & Cold Intolerance
☐ Thyroid Problems
☐ Height Change
☐ Sweats
☐ Bleeding/Bruising
☐ Lung Problems
☐ Varicose Veins
☐ Ankle Swelling
☐ Stroke
☐ Cramps
☐Irregular Cycle
☐ Painful Periods
☐ Pregnant (now)

OCCUPATIONAL INFORMATION

Job involves ☐ Sitting ☐ Standing How long? _______

☐ Bending ☐ Stooping ☐ Twisting ☐ Turning ☐ Lifting – How much weight _____________
Physical activity at work: ☐ Sedentary ☐ Light manual labor ☐ Heavy Labor

Telephone use at work ☐ None ☐ Moderate ☐ Heavy ☐ Traditional receiver ☐ Headset

Do any work activities aggravate your complaints? ____
____
____

HEALTH HABITS

Exercise/Sports/Hobbies:
1.) Type __________________ Frequency ____________ 2.) Type _______________ Frequency _______________

3.) Type ___________________ Frequency _____________ 4.) Type _______________ Frequency _________________

Sleep:
Hours/Night _________ Sleep Quality _______________
Do you sleep on your: ☐ Back ☐ Side ☐ Stomach

Smoking/Drinking/Diet: (how much and how often)
Tea/Coffee: __________ Liquor/Beer: _______________ Cigarettes/Tobacco: ________________

HEALTH HISTORY

Please list ALL surgeries, hospitalizations, fractures/dislocations you have had

Type ____ Date ____________________________
Type ____ Date ____________________________
Type ____ Date ____________________________

Please list ALL previous accidents and falls

What ____ When ___________________________
What ____ When ___________________________
What ____ When ___________________________

Please list ALL medications and / or vitamins you take

Name ______________ For What _________________ Name ____________________ For What _________________
Name ______________ For What _________________ Name ____________________ For What _________________
Name ______________ For What _________________ Name ____________________ For What _________________

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). The doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Relief Care** ☐ **Corrective Care**

☐ Check here if you want the doctor to select the type of care appropriate for your condition.

METHOD OF PAYMENT
Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my medical status.

In addition, I understand that it is my full responsibility to inform this office of any changes to my medical insurance policy if I choose to use said insurance for the treatment I will receive. I also understand that most insurance policies have an annual visit limitation for the individual benefits I receive, and it is my sole responsibility to keep track of these visits throughout the duration of my treatment.

____ ________________________________
Print Patient Name Date

____
Patient/Legal Guardian Signature

Patient General Questionnaire

Patient Name:____ DOB: ___________________________

Do you have any of the following conditions?

	Yes	No		Yes	No
Implanted Pacemaker	☐	☐	Are you allergic to latex	☐	☐
			Are you pregnant	☐	☐
Thrompophlebitis	☐	☐			
Epilepsy	☐	☐	Are you under treatment for any Acute medical condition	☐	☐
Malignant Lesions	☐	☐	Are you suffering from any chronic muscle or nerve disorder other than currently being treated	☐	☐
Varicose Veins	☐	☐			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform this office of any changes in medical status.

____ ___________________________

Print Patient Name Date

____

Patient/Legal Guardian Signature

Patient Comments: ____

____

____

____

____

24 Business Hour Cancellation Policy

This cancellation policy is standard in the medical field and will be strictly enforced.

On occasion, there will be understandable reasons for missing an appointment. However, when you are able to notify us of your intention to cancel/reschedule with **24 BUSINESS HOURS IN ADVANCE,** it gives us an opportunity to schedule someone else for that time slot. This is important because others may be on a waiting list or may also be looking for an opportunity to reschedule for a different time. Therefore, as much advance notice as possible is always appreciated.

IF YOU CANCEL YOUR APPOINTMENT WITH LESS THAN 24 BUSINESS HOURS NOTICE OR SIMPLY DO NOT SHOW UP, YOU WILL BE CHARGED $25.00 FOR THE MISSED APPOINTMENT.

Because it is illegal to bill your insurance company for a missed appointment, you will end up paying the full fee out-of-pocket, resulting in a much higher payment than you may have paid for a kept appointment. For many, this creates an unnecessary hardship. In addition, it is possible that your therapy would be suspended until the fee is paid.

Arriving late without notification: We will wait 15 minutes, after which we will assume you are not going to make your appointment. In such a case, you will be charged for the missed appointment.

OFFICE PHONE NUMBER: 972-829-8620

Please make any cancellations less than 24 hours in advance by using this telephone number. If less than 24 hours please do not cancel by email or by any other means than by this phone number. This cancellation number is also plainly available on the front of the business card.

Please sign below to indicate you have read, understand, and agree to abide by the cancellation policy.

____ ____________________
Print Patient Name Date

____
Patient/Legal Guardian Signature

221 Regency Pkwy. # 101 Mansfield, TX 76063 (817) 453-0430

Notice of Doctor's Lien and Irrevocable Assignment and Directive of Proceeds

I hereby authorize my health care provider, Curis Functional Health, hereinafter "Provider," to furnish to my attorney, insurance company or other person or entity involved in my claim with a full report of my case history, examination, diagnosis treatment, prognosis, or other medical/billing resulting in my treatment by Provider. I also authorize Curis Functional Health to disclose such information to its attorney and any billing or collection entity that it may retain.

I further, for good and valuable consideration of which is hereby acknowledged, assign and transfer, irrevocable, to provider all rights, title and interest that I may now have or that I may have in the future to any and all benefits, proceeds, and/or monies that may be due me from any third-party and/or payer, including but not limited to third party liability payers, personal injury protection (PIP) coverage, underinsured/ uninsured coverage, third partied and group health plans as a result of the accident or injury event for which Provider has rendered and/or will render medical goods and services on my behalf.

I further irrevocably assign entitlement to benefits, proceeds and/or monies to Provider and irrevocably grant a lien to the extent of my indebtedness to Provider and irrevocably direct any third –partied and/or payers, including but not limited to third-party liability payers, personal injury protection (PIP) coverage, Medpay, underinsured/uninsured coverage, homeowners coverage, third parties and group health plans to make benefits, proceeds and/or monies payable to include Provider. I additionally issue this directive that no money, check, draft, electronic transfer, or any other payment is to be made to myself or my attorneys or my heirs or assigns from the above listed third-parties and payers without including Curis Functional Health as a payee on such disbursements.

I further irrevocably direct my attorney representing me as a result of the accident, occurrence, or injury-causing event to protect Provider's total charges out of any recovery that is obtained on my behalf by directing and forwarding payment of said recovery to Provider to the extent of my total indebtedness to Provider. I fully understand that my attorney shall abide buy this irrevocable assignment, directive, and notice without further consultation with me and shall disclose to Provider and/or its representatives, agents, independent contractors and attorneys any and all information related to my claim(s) and settlement, judgment, verdict or recovery.

I further agree to fully inform Provider to any and all potential third-parties and/or payers, personal injury protection (PIP) coverage, underinsured/uninsured coverage, third parties or group health plans that may be liable for my injuries and to provide the names and addresses of any attorney(s) that may represent me nor or in the future concerning this accident, occurrence or injury event. I fully understand that this irrevocable assignment, directive and notice or lien shall remain with respect to any future attorney that I retain.

Patient Initials:________________________

221 Regency Pkwy. # 101 Mansfield, TX 76063 (817) 453-0430

I further agree to defend, indemnify, and hold harmless Provider against any payer(s) and its agents, representatives, employees, officers, directors, partners, shareholders, affiliates, attorneys, subcontractors, independent contractors, heirs, assigns and all other persons, firms, corporations, associations, or

partnerships or other entities from any and all claims, actions, cause of actions, damages, costs, expenses, compensation, or otherwise on account of or in any way growing out of the direct payment to provider. I fully understand that it is my sole responsibility to maintain any and all claims, causes of action, appeals, and conditions to recover against any and all potential third-parties and/or payers, including but not limited to third-party liability payers, personal injury protection (PIP) coverage, underinsured/uninsured coverage, third parties and group health plans.

I further fully understand and agree that regardless of my execution of this agreement, that I am directly and fully responsible to Provider for medical goods and services provided and/or that will be provided to me and that this agreement is made solely for additional protection to Provider and in consideration of Provider awaiting payment. It is hereby understood and agreed that my responsibility for payment is not contingent upon any settlement, claim, judgment, verdict, recovery or otherwise that I may obtain. I also understand that any payments made on my behalf, whether by insurance companies, attorneys, or myself, if less than the full amount of my outstanding balance, is only partial payment toward my account. Any such partial payment is not and will not be considered and “offer in compromise: or release me from my remaining balance owed to Curis Functional Health.

It is further understood and agree that I shall fully inform and notify any third parties and payers, including but not limited to third-party liability payers, personal injury protection (PIP) coverage, underinsured/uninsured coverage, third parties and group health plans and/or my attorneys, or Irrevocable Assignment, Directive and Notice.

I further agree to waive for two years after any settlement is reached the statute of limitations applicable to Provider’s claims, causes of action, rights and/or remedies in collecting its total charges pursuant to this Irrevocable Assignment, Directive and Notice, or pursuant to any remedy available to Provider in collecting its total charges, damages, interest, court costs of collection and any other relief to which Provider in collecting its total charges, damages, interest, court costs of collection and any other relief to which provider may be entitled. In addition to any cause of action available under Texas law or any other applicable state’s laws, I understand and agree that Provider may seek a recovery from me and my attorney, agents, heirs, or assigns for breach of contract if I do not comply with this agreement.

This Irrevocable Assignment, Directive and Notice of Lien shall be irrevocable upon execution by me.

____ ______________________

Patient/Responsible Party/Guardian Signature Date

______________________________________ ______________________

Print Name Date of Injury

____

Print Address and Phone Number

Credit Card Authorization Policy & Signature Form

This form authorizes Curis Functional Health to keep my credit card on file and manually charge the fee for service to this credit card number in the event that:

Payment was not rendered at time of service
I am not present to pay for my minor child at the time of service.
Therapist provides consultation outside of sessions (billed per 15 minutes)
I missed my scheduled appointment
I cancelled with less than or equal to 24 hours of notice
I'm on a therapy payment plan, in which case debits will be made on the agreed upon dates
My account has an outstanding balance and bas been delinquent for IO business days

I, the undersigned, have read and agree to the credit card authorization policy.

Client Signature Printed Name Date

Card Type: **VISA** **MC** **AMEX** **DISC** **OTHER**

Card Number:____

Expiration Date:_______________________

3 Digit Code on the back of Card: ___________

5 Digit Billing Zip Code:_________________

Name of Credit Card Holder:___________________________________

Signature to Authorize Credit Card use:___________________________

Date:____________

HIPAA PRIVACY NOTIFICATION & PRACTICE REQUIREMENTS

Curis Functional Health:

(a) Is required by federal law to maintain the privacy of your Personal Health Information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, (the practice) may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

(c) Is required to abide by the terms of the Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

(g) Will provide to you, for your convenience, the office's HIPPA Compliance book upon request.

(h) Additionally, the Patient Rights & Responsibilities document explains the Office's responsibilities toward the patient and the patients toward the office. Every patient will be given this document for review at their leisure.

EFFECTIVE DATE:
This Notice is in effect as of 01/01/2020.

PATIENT ACKNOWLEDGEMENT:
By subscribing my name below, I acknowledge having read the Notice; I understand it and agree to its terms.

______________________________________ ____________________
Print Patient Name Date

____
Patient/Legal Guardian Signature

Informed Consent to Treat

- **The nature of the chiropractic adjustment.**
  I will use my hands or a mechanical instrument, upon your body, in such a way, as to move your joints. This may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may also feel or sense a movement of the joint. Some patients will feel some stiffness and soreness following the first few days of treatment.

- **The material risks inherent in chiropractic adjustment.**
  As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, diaphragmatic paralysis, cervical myelopathy, costovertebral strains and separations and rib fractures. In extremely rare instances, 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.

- **The probability of those risks occurring.**
  Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during the examination. Stroke has been the subject of tremendous disagreement within the medical community. One prominent authority claims that there is at most a one-in-a-million chance of such an outcome. As a policy, to reduce your risk, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

- **Ancillary (Modality) treatment.**
  In addition to chiropractic adjustments, I intend to use the following treatments which have been listed with their known risks:
  - ***Electrical stimulation*** – Skin burns. Our equipment monitors stimulation levels to avoid this from happening.
  - ***Ultrasound therapy*** – burning of periosteum of bone and soft tissues
  - ***Low Level Laser Light Therapy*** – only used when not contraindicated. There are no known risks with the levels of light that we use.
  - ***Physiotherapy*** – used to rehabilitate muscles, ligaments and nerves. Possible side effects are:
    - Muscle strain and/or reinjury of presented complaint(s)
    - Ligamentous strain, sprain or reinjury
    - Possible reinjury of presented complaint(s)
  - ***Manual therapy*** – used to release muscle tension, skeletal subluxation and toxins. This can cause muscle stiffness and aches as well as headaches and/or bruising of the soft tissues. Drinking plenty of water should aid in a quick recovery if these symptoms arise.

- **The availability and nature of other treatment options.**
  Other treatment options for your condition include:
  - Self-administered, over-the-counter analgesics and rest or exercise, etc.
  - Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and painkillers, etc.
  - Hospitalization with traction
  - Surgery

- **The material risks inherent in such options and the probability of such risks occurring include:**
  - Overuse of over-the-counter medications can produce undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the counter medicines.
  - Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks - some with rather high probabilities.
  - Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.
  - The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.
- **The risks and dangers attendant to remaining untreated.**
  Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.
- **Treatment Outcome Possibilities**
  The treatment provided in this clinic has proven to be effective in treating a variety of illnesses and health problems. The outcome of treatments provided have the following possibilities: the symptoms or illness you have sought care for may improve, may remain unchanged, or have the possibility of getting worse. We strive to ensure that your care is complete and that you will be satisfied with your outcome.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. I have read or have had someone read to me the above explanation of the chiropractic adjustment and related treatments and possible risks with undergoing/receiving chiropractic and physiotherapy treatment and in not receiving such treatment. By signing below, I state that I have weighed the risks involved in undergoing/receiving Chiropractic Treatment and all rehabilitation therapy and I have decided that it is in my best interest to undergo/receive chiropractic treatment as well as all other treatments and services offered and provided by Curis Functional Health. Having been informed of the risks, I hereby give my consent to any and all treatment deemed necessary for any reason. I understand that if I have any questions regarding treatment or services, I may ask the doctor or staff at any time.

____ ____________________
Print Patient Name Date

____
Patient/Legal Guardian Signature