430 Hawkins Run Suite 3. Midlothian, TX 76065 **Phone:** 214-817-8603

PATIENT INFORMATION Date ___________

Legal Name: ____________________________________

Address: ____________________________________

City: __________________ State: ______ Zip: ________

Mobile 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. # ________________

Chiropractic History

Have you ever seen a chiropractor before? □ No □ Yes If yes, how long ago? ____________________

What was the name of the chiropractor? _____________________

Did the treatment help? □ Yes □ No □ Mixed □ Other: _____________________

Are you seeking chiropractic for: □ Health maintenance/optimization □ Health problems □ Both?

What do you hope to achieve with chiropractic care?

____

____

____

____

____

____

____

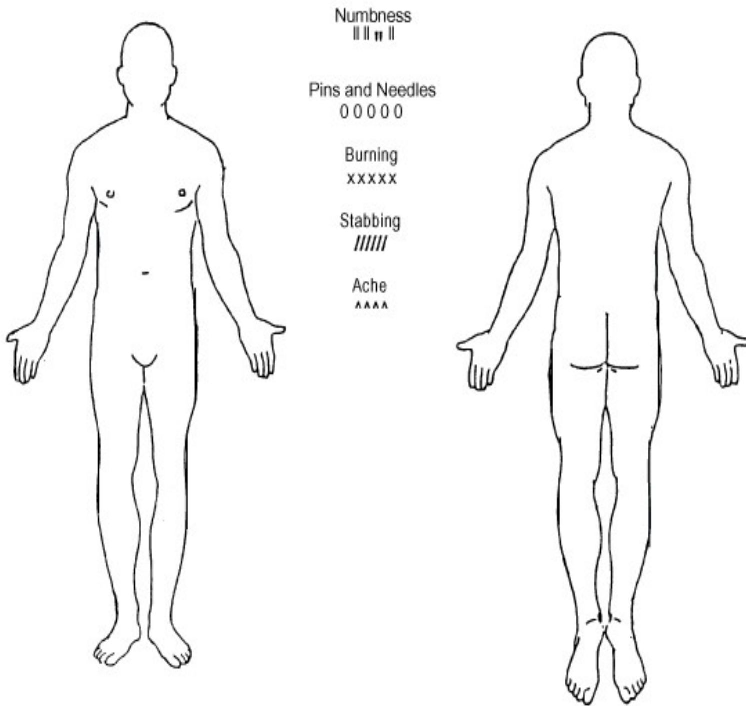
____

Chief Complaint

0 = no pain, 10 = unbearable pain

0	1	2	3	4	5	6	7	8	9	10

Indicate on the drawings below where you have pain/symptoms



How often do you experience the symptoms?

Constantly (76-100% of the day)

Frequently (51-75% of the day)

Occasionally (26-50% of the day)

Intermittently (0-25% of the day)

How would you describe the type of pain?

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

How are your symptoms changing with time?

____

How much has the problem interfered with your work/social activities?

____

How long have you had this problem? ____

How do you think your problem began? ____

Do you consider this problem to be severe? ◻ Yes ◻ Yes, at times ◻ No ◻ Unsure

What list any and all activities that make the pain worse?

____
____
____

What list any and all activities that reduce the pain?

____
____
____

Who else have you seen for your problem?

____

Patient General Questionnaire

	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					

Terms of Acceptance

The goal of Curis Functional Health office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand and we hope this document(s) will clarify those issues for you. Please read the below and if you have any questions please feel free to ask one of our staff members.

HIPPA/Privacy Disclosure

Federal law requires that we obtain your written acknowledgement of receipt of the Notice of Privacy Practices. I acknowledge that I have received and or been offered the Notice of Privacy Practices. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.
I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

Communications

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? May we contact you via phone or email regarding your care?

Yes [] **No []**

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Curis Functional Health, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There is a fee charged for all appointments that are not canceled **24 BUSINESS HOURS** prior to scheduled visit and for consecutive no show/last minuet reschedule appointments. Please note that for Monday appointments, an early cancellation would need to occur the Friday prior. If you are **7 minutes** late to your scheduled appointment your appointment will be rescheduled. There is no exception to this policy. In the event of contagious illness, I understand and agree I will not come to the office and will communicate with Curis Functional Health. If I miss or late cancel my scheduled session, the credit card on file will be charged the fee. If the card is declined, payment isn't processed, or the charge is disputed, I consent to waive my confidentiality with regards to attendance and financial matters in order to resolve my financial obligations. _______________(initials)

Court Action Policy and Fees

Clients are discouraged from having their clinician &/Curis Functional Health, LLC subpoenaed or having to provide records for the purpose of litigation. Clinicians are trained to work with clients from a non-adversarial position, not forensically, and do not have the expertise to appear in court. Forensics is an area of clinical specialization and we're happy to provide recommendations for those outside services.
Even though you are responsible for the testimony fee, it does not mean that the testimony of the clinician will be solely in your favor. S/he can only testify to the facts of the case and her/his professional opinion.
If the clinician is to receive a subpoena, then the attorney or office staff will need to call the office and set up time for the subpoena to be served during office hours. A minimum of 14 days' notice of any court appearance is required so that schedule changes for clients can be made within a reasonable time frame. Please note if a subpoena is received without a minimum of 14 days' notice there will be an additional $500express charge.

Court Action Fees are as follows:

1.	Correspondence & Letter of Opinion: (billed in 15 min increments)	$200 per hour
2.	Preparation Time: (billed in 15 min increments)	$200 per hour
3.	Phone Calls: (billed in 15 min increments)	$200 per hour
4.	Filing Documents with court	$100
5.	Minimum charge for court appearance	$1,000 ≤ half day $2,000 for full day

Attorney fees: I, the client, agree to pay all attorney's fees and costs that are incurred by the clinician &/ Curis Functional Health, LLC as a result of any court action. Reimbursement is due in full at time of appearance.
Retainer: A retainer of $1500 is due within 48 hours of subpoena. The remainder of the cost will be billed at the court appearance and will be due upon receipt the same day.
If the therapist/physician is subpoenaed and the case is reset with less than 72-hour notice prior to the beginning of the day of the scheduled subpoena and or testimony is not given, then the client will be billed $1000. Bills for court related actions are presented to clients on a weekly basis and payment is expected upon receipt. A zero balance will need to be kept at all times.

Consent to Evaluate and Treat a Minor:

I, ________________________________ being the parent(s) or legal guardian(s) of ______________________________, have read and fully understand the above terms of acceptance and hereby

grant permission for my child to receive chiropractic care by a Curis Functional Health chiropractor & whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary.

- **Consent to Treat Minor without Parent Present**

In the event I am not able to be present I give consent for ___________to be treated/seen by ______________ without my presence (going forward for any chiropractic appointments). If you are needed present at any chiropractic appointments Curis Functional Health will notify you prior to the appointment via email and phone.

Consent to Release:

In the event that Curis Functional Health would need to communicate your healthcare information, to whom may we do so? Consent to Release is valid for one year. Purpose for this consent is for authorization/utilization review, payment billing, coordination or care and or other.

- Spouse: ____
- Children: ____
- Insurance Company: ____
- Attorney: ____
- Other: ____

NO ONE ___________ Declined to Consent Date: __________

I acknowledge that Curis Functional Health may use my information to coordinate care and cannot protect my confidentiality from the cell phone and email providers. I understand that I may revoke, in writing, my consent to allow the above named organization to release this information at any time, except to the extent that action will have been taken on information released prior to the revocation of my consent. Otherwise, this consent begins today and is valid for 12 months, renewing automatically until care terminates.

Acknowledgement of ALL Consents

I have read and fully understand **ALL OF THE ABOVE** consents and agree to the consents.
I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

Signature________________ Date: ___________

Integrated Patient Questionnaire

Curis Functional Health is an **Integrated Wellness Center.** What does Integrated mean? It means Doctors of Chiropractic, Mental Health Professionals & Dietitians / Nutritionists all working together to provide a greater spectrum of services. This model allows you the convenience of a multi-disciplinary approach without the headache of juggling multiple doctors at multiple locations on multiple schedules. You shouldn't have to put off dealing with one problem while you deal with another. You deserve quick, concise, expert patient care for all of your needs, and you deserve all of those experts working together to know what each other are doing for you and why.

HELP US HELP YOU AND THE ONES YOU LOVE

Here is a list of some of the more common problems that our staff are especially well trained to deal with.

Please check those that you or your immediate family suffer from:
X = you F= family member

	__Neck Pain	__Lower Back Pain
	__General Chronic Pain	__Chronic Arthritis
	__Fibromyalgia	__Bulging or Herniated Disc
	__Neuropathy (Arms or Legs)	__Sciatica
	__Knee Pain or Degeneration	__Shoulder Pain or Degeneration
	__Rolled Shoulders or "Humpback"	__Trigger Points (Knots or Spasms in your muscles)
	__Carpal Tunnel Symptoms	__Headache
	__Insomnia, Anxiety, Worry or Panicked	__Trouble Coping after Difficult life changes
	__Feeling down, depressed, Apathetic	__Chronic Fatigue or Difficulty sleeping
	__Trouble in your relationships __Parenting Problems	__History of Trauma
	__Feeling Anxious, Tense, Stressed	__Difficulty Managing Weight
	__Emotional Eating/ Overeating	__Diabetes/ Pre Diabetes
	__Lack of Exercise, Physically Unfit	__Other Problems that haven't previously responded to treatment?

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:

(a) Payment was not rendered at time of service
(b) I am not present to pay for my minor child at the time of service
(c) Therapist provides consultation outside of sessions (billed per 15 minutes)
(d) I missed my scheduled appointment
(e) I cancelled with less than or equal to 24 hours of notice
(f) I'm on a therapy payment plan, in which case debits will be made on the agreed upon dates
(g) My account has an outstanding balance and has been delinquent for 10 business days

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

____________________ ______________
Signature Date

Name of Credit Card Holder: ____

Card Type: VISA MC AMEX DISC OTHER

Card Number: ____

Expiration Date: _____________________________

3 Digit Code on the back of Card: ______________

5 Digit Billing Zip Code: ______________________