



**RETURN TO HEALTH**  
**Patient and Insurance Information**

Name		DOB:	
Address		Apt #	
Town		State	ZIP
Home Phone	Work Phone	Cell Phone:	
Email		Soc Sec #	
Marital Status	M S D Sep		
Referred By			
Emergency Contact:		Contact Phone #:	
Address			
Town		State	ZIP
<b>Health Insurance Info</b>			
Carrier		Ins Co phone	
Address			
Policy #		Group #	
Patient Relationship to the insured	Self Spouse Child Other		
If you are covered under another persons insurance.... Please complete			
Name of Insured			
Address of insured			
Phone of insured		Sex	Birth date
Insured's Employer			
Address			
Employer Phone		Plan Name	



## RETURN TO HEALTH

### **Responsible Party Auto Accident Insurance:**

Policy Number

Carrier

Address

City

State

ZIP

Phone

Person To Contact...

Claim #

Date of Accident

Patient Relationship to the insured

Self

Spouse

Child

Other

### **Personal Injury Protection (PIP):**

Policy Number

Carrier

Address

City

State

ZIP

Phone

Person To Contact...

Claim #

Date of Accident

Patient Relationship to the insured

Self

Spouse

Child

Other

### **Attorney Name:**

Attorney Phone Number:

Address

City

State

ZIP

Phone

Person To Contact...

Claim #

**COMPLETE HISTORY FORM** (Please try to answer all questions on both sides. This information will be treated as confidential.)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_

**PAST HEALTH HISTORY**

Have you ever had any of the following conditions? Check "NOW" if you have problem NOW. Check "PAST" if you had problem in the PAST. Check "NEVER" if you have NEVER HAD this problem. Month & year of last yearly physical \_\_\_\_\_ / \_\_\_\_\_  Never

	Now	Past	Never		Now	Past	Never		Now	Past	Never
Anemia/blood disease				Tuberculosis				Kidney disease			
Thyroid trouble				Pneumonia				Back pain			
Diabetes				Stomach ulcers				Epileptic seizures			
Rheumatic fever				Liver disease				Alcohol or drugs			
High blood pressure				Jaundice				Auto injury			
Heart problems				Cancer				Work injury			

List medications you take regularly? \_\_\_\_\_

What drugs are you allergic to? \_\_\_\_\_

Have you had all your "shots" (immunizations)?  Yes  No

Name and address of previous family doctor: \_\_\_\_\_

Do you want to be notified when your yearly physical & blood tests are due?  Yes  No

Please list any SERIOUS illnesses, hospitalizations, cancers, or surgeries you have had.

Date	Illness or Operation	Doctor and/or Hospital	Mark X and enter Date if you have had.
			<input type="checkbox"/> 19__ X-rays of _____
			<input type="checkbox"/> 19__ Scan of _____
			<input type="checkbox"/> 19__ Colon tests
			<input type="checkbox"/> 19__ Breast x-rays
			<input type="checkbox"/> 19__ Heart tests
			<input type="checkbox"/> 19__ Pneumonia shot
			<input type="checkbox"/> 19__ Yearly physical
			<input type="checkbox"/> 19__ Yearly blood tests

**FAMILY HEALTH** ("Blood" relations only) Check "✓" if adopted.

Relative	Names	Age	Sex	Health Problems	If dead, cause of death	Age	Has any relation had	Yes	No
Father			M				Tuberculosis		
Mother			F				Heart disease		
Brothers & Sisters							High blood pressure		
							Alcoholism		
							Kidney disease		
							Diabetes		
Children							Strokes		
							Epilepsy		
							Nervous breakdown		
							Allergies or Asthma		
							Anemia		
						Cancer			

Please turn page! Please fill out the back of this sheet!



**RETURN TO HEALTH**

4474 Spring Valley Rd.  
Farmers Branch, TX 75244

(P): (469) 677-0076

(F): (469) 677-0195

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of land-based and aquatic physiotherapy on me (or on the patient named below, for whom I am legally responsible) by Dr. Andrew Garrett, DC and/or other licensed doctors of chiropractic who now or in the future work at Return to Health, LLC.

I have had an opportunity to discuss with Dr. Andrew Garrett, DC and/or with other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the health care providers at Return to Health, LLC to be able to anticipate and explain all risks and complications, and I wish to rely upon my healthcare providers to exercise reasonable judgment during the course of the procedure, based upon the information I have provided to them and the facts then known by my healthcare providers.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at Return to Health, LLC.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_



## RETURN TO HEALTH

4474 Spring Valley Rd.  
Farmers Branch, TX 75244  
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### *HIPAA AUTHORIZATION FORM*

I understand that under the Health and Portability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly. Most specifically to: (1) obtain payment from designated third-party payers, (2) conduct normal health care operations such as quality assessments or evaluations, prior authorizations, and physician certifications.

By my signature below, I consent to, and acknowledge that the healthcare providers at Return to Health, LLC may use and disclose my Protected Healthcare Information (PHI) to carry out the following:

1. Plan and provide for my care and treatment
2. Communicate to other healthcare professionals who may contribute or participate in my care and treatment
3. Obtain authorization, confirm service provided and collect payment from third-party payers
4. Perform routine healthcare operations such as the review of records from healthcare professionals

I also consent to Return to Health, LLC to:

1. Leave a message at my phone number on file to assist the practice in carrying out routine healthcare operations such as appointment reminders, insurance items and call pertaining to my clinical care
2. Mail to my address on file any items that assist the practice in carrying out routine healthcare operations such as appointment reminders, test results, patient information forms and patient statements.

INITIALS: \_\_\_\_\_

I understand that I have the right:

1. To request restrictions as to how my Protected Health Information (PHI) may be used or disclosed to carry out treatment, payment or healthcare operations, and that the healthcare providers at Return to Health, LLC is not required to agree to the restrictions requested
2. To review the Return to Health, LLC's Notice of Privacy Practices and acknowledge that a copy has been given to me
3. To revoke this consent in writing, except to the extent that Return to Health, LLC may have already made PHI available to obtain payment from designated third-party payers or conduct normal health care operations prior to this request.

I acknowledge that I have read and understand all the above information and have answered the questions with complete and up-to-date information.

Signature \_\_\_\_\_ Date \_\_\_\_\_



**RETURN TO HEALTH**

4474 Spring Valley Rd  
Farmers Branch, TX 75244  
(P): (469) 677-0076  
(F): (469) 677-0195

**Authorization to Release Medical Records Acknowledgement**

I Understand that:

- This Authorization is voluntary, and I have the right to refuse to sign it.
- This Authorization will remain in effect for one year from the date of the signature below unless you specify a different date here: \_\_\_\_\_ (date).
- If I sign this Authorization, I may revoke it later by sending a written notice of revocation to the privacy office at the practice. Note: The only exception to your right to revoke is if the practice has already acted in reliance upon the Authorization.
- The information disclosed pursuant to this Authorization, except information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.
- Once signed, the Practice will provide me with a copy of this Authorization.

Signature of patient/guardian \_\_\_\_\_

Date \_\_\_\_\_



**RETURN TO HEALTH**  
 4474 Spring Valley Rd  
 Farmers Branch, TX 75244  
 (P): (469) 677-0076  
 (F): (469) 677-0195

## Authorization to Release Medical Records

**TITLE 22 EXAMINING BOARDS  
 PART 9 TEXAS MEDICAL BOARD  
 CHAPTER 165 MEDICAL RECORDS  
 RULE §165.2 Medical Record Release and Charges**

Deadline for Release of Records. The requested copies of medical and/or billing records or a summary or narrative of the records shall be furnished by the physician within 15 business days after the date of receipt of the request for furnishing the information

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Claim Number(s)/DOI: \_\_\_\_\_

**This information is to be REQUESTED FROM:**

Agency/Business Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**This information is to be DISCLOSED TO:**

**Return to Health, LLC  
 4474 Spring Valley Rd.  
 Dallas, TX 75254  
 (P): (469) 677-0076  
 (F): (469) 677-0195**

**For the purpose of (please check one):**  Moving  Changing provider  At the request of the individual  
 Consultation  Insurance change  Other (please describe) \_\_\_\_\_

**Information to be disclosed:**

Office notes for date(s) of service \_\_\_\_\_

X-ray reports of \_\_\_\_\_ for date(s) of service \_\_\_\_\_

MRI reports of \_\_\_\_\_ for date(s) of service \_\_\_\_\_

CD(s) containing images of above marked studies  Photographs or other images

Complete healthcare record  Other (please describe) \_\_\_\_\_

Special instructions: \_\_\_\_\_

Signature of patient/guardian \_\_\_\_\_ Date \_\_\_\_\_