RETURN TO HEALTH

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____ / _____ / _____

GENDER (circle one): **Male Female Non-Binary Other:** _____ MARITAL STATUS (circle one): **S M D W**

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ EMAIL: _____ SOCIAL SECURITY NUMBER: _____-____-_____

REFERRING PHYSICIAN: _____

WERE YOU REFERRED FOR **POST-OPERATIVE** PHYSICAL THERAPY? **Y / N** DATE OF SURGERY : _____ / _____ / _____

PRIMARY CARE PHYSICIAN (if different from Referring): _____ PHONE #: _____

CLINIC NAME / ADDRESS: _____

EMERGENCY CONTACT NAME: _____ PHONE #: _____

RELATIONSHIP TO PATIENT: _____

BILLING INFORMATION

If you do not have a physical copy of your insurance card, please email a digital copy to laura@returntohealthllc.com.

PRIMARY INSURANCE CARRIER: _____ **PPO / HMO**

ID#: _____ GROUP #: _____

NAME OF POLICY HOLDER (if not the patient): _____

POLICY HOLDER DATE OF BIRTH: _____ / _____ / _____ EMPLOYER: _____

INSURANCE CARRIER: _____ **PPO / HMO**

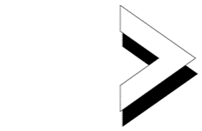
ID#: _____ GROUP #: _____

NAME OF POLICY HOLDER (if not the patient): _____

POLICY HOLDER DATE OF BIRTH: _____ / _____ / _____ EMPLOYER: _____

AUTHORIZATION & RELEASE: I authorize payment of insurance benefits to be made directly to Return to Health, LLC. I understand and agree to allow this office to use the Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care and benefits. I understand that I am responsible for all costs of care regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

PATIENT AND/OR GUARDIAN SIGNATURE: _____ DATE: _____



RETURN TO HEALTH

PERSONAL INJURY CLAIM INFORMATION

ATTORNEY NAME: _____

PHONE: _____ext. _____ FAX: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PERSON TO CONTACT: _____
PHONE:_____ CLAIM #: _____

DATE OF INCIDENT: _____

LOCATION OF INCIDENT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PERSON TO CONTACT: _____
PHONE:_____

WAS A CLAIM FILED? ____ YES _____NO

CLAIM #: _____

INCIDENT DESCRIPTION:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

RETURN TO HEALTH

PARTIAL CLAIMS AGREEMENT / JOINT CHECK AGREEMENT

Clinic and/or Doctor: *RETURN TO HEALTH, LLC*

Patient, (or if a minor), on behalf of _____ hereby **IRREVOCABLY ASSIGNS** to Return to Health in consideration of deferred billing and collection to Return to Health LLC any claim or claims, chose in action, demand and cause or causes of action, of whatsoever kind and nature, that have now or may have ln the future for injuries or damages as result of an accident or incident occurring on or about this ____day of _____ _____, to the extent of charges tor medical services or related goods provided, or for medical services or related goods, to be provided by Return to Health LLC If this assignment ls made on behalf of a minor the parent or guardian assigns only the cause *of* action such parent or guardian has for recovery of the minor's medical expenses incurred as a result of said accident or incident.

Return to Health LLC shall not be liable for any costs and/or expenses associated with any claims or litigation unless Return to Health LLC files that litigation. Return to Health LLC shall have no duty whatsoever to prosecute the claim or litigation. Nothing herein shall prevent the patient from pursuing any claim or litigation which patient otherwise has a right to pursue and which patient has not assigned to Return to Health LLC may pursue any legal remedies as your assignee to collect its medical bills. Patient may not settle any case Involving recovery of Return to Health LLC medical bills without the permission of Return to Health LLC If a lawsuit is filed by either the patient or Return to Health LLC arising from the said accident or Incident, the non-filling party may Intervene in the filed lawsuit end may not file a second lawsuit arising from the same accident or Incident.

In the event Return to Health LLC seeks and receives payment from a Workers' Compensation insurance policy for Its medical treatment of patient then this Partial Claims Assignment / Joint Check Agreement shall not apply. This Partial Claim Assignment / Joint Check Agreement Is applicable to any claims involving work related injuries, against employers (including employers who do not subscribe to Workers' Compensation Insurance) or third parties.

I irrevocably instruct and direct any third party, whether or not I am represented by an attorney, making payment in settlement of damages incurred by patient as a result of said accident *or* incident, to make such payment by check, draft or other remittance jointly payable to Return to Health LLC and patient *I* parent/ guardian (and/or Attorney) and deliver such payment to 4474 Spring Valley Rd Farmers Branch TX 75244.

Return to Health LLC will provide or provided direct medical care for injuries for which patient ls currently seeking treatment. The patient promises to pay usual and customary charges for Return to Health LLC. medical treatment.

Signed this _____ Day of _____, 20__ _____

Patient/Parent/or Guardian

RETURN TO HEALTH

LIMITED POWER OF ATTORNEY

I hereby irrevocably grant Return to Health LLC the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from Insurance company for the medical services or related goods provided to me by Return to Health LLC

Signed this _____ Day of _____, 2024 _____

Patient/Parent/or Guardian

INSTRUCTIONS TO MY ATTORNEY

I hereby authorize and direct any attorney retained by me at any time to pay directly to Return to Health LLC. All money for services rendered or goods provided to me, and to withhold such sums from the proceeds of my portion of any settlement, claim. judgment or jury verdict. THIS INSTRUCTION IS IRREVOCABLE UNLESS ALL PARTIES AGREE TO REVOKE THE INSTRUCTION IN WRITING.

Signed this _____ Day of _____, 2024 _____

Patient/Parent/or Guardian

As used in the above **BASIC AGREEMENT; PARTIAL CLAIMS ASSIGNMENT/JOINT CHECK AGREEMENT; LIMITED POWER OF ATTORNEY; and INSTRUCTIONS TO MY ATTORNEY**, the term Return to Health LLC., shall mean Return to Health. I have read the above sections and I fully understand them.

Signed this _____ Day of _____, 2024 _____

Patient/Parent/or Guardian

RETURN TO HEALTH

CONSENT TO TREAT

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 Doctor 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 on 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 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 / GUARDIAN SIGNATURE: _____ DATE: _____

PRINT PATIENT NAME: _____

WITNESS / STAFF SIGNATURE: _____ DATE: _____

RETURN TO HEALTH

HIPAA – Release of Information

Name: _____ Date of Birth: _____/____/_____

Release of Information:

_____ I authorize the release of information including the diagnosis, records, examination performed, treatment rendered to me, appointment scheduling, and claims information.

This information may be released to:

NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____

_____ Information is NOT to be released to anyone.

How may we contact you? *(check all that apply):*

____ Phone Calls to Personal/Cell #

____ Text Message to Personal/Cell #

____ Email

____ Work #: _____

If unable to reach me:

[ ] you may leave a detailed message.

[ ] please leave a message asking me to return your call.

[ ] _____

The best time to reach me is (days)_____ between (times)_____.

This Release of Information will remain in effect until terminated by me in writing.

Legal Representative or Patient Signature: _____Date:____/____/_____

RETURN TO HEALTH

Attendance Agreement

In order to maximize the benefits of therapy, it is very important that scheduled appointments be attended. The consistency of attending therapy sessions gives you the best opportunity to obtain maximum treatment benefit and assist in meeting your goals. A missed or late appointment disrupts therapy schedules that impact both you and other patients. In signing this form, you indicate that you understand the attendance policy and the results of not keeping your appointments.

We anticipate that you will adhere to the following:

- I understand that if I arrive more than fifteen (15) minutes late, I may not receive therapy that day, depending on the providers' schedule(s), patient volume, and/or equipment availability and that the appointment can be rescheduled for a time/date that fits within the upcoming schedule.

- I understand that three (3) consecutive "no-call, no-shows" within a treatment plan of care, are grounds for discharge from therapy. The referring physician will be notified of my failure to show for appointments and the resulting discharge from therapy.

- I understand that if my regular provider is not available, I could be given the option to see another provider if one is available.

Following these guidelines will greatly assist in maintaining the flow of the clinic and allow clinicians to provide optimal care to all patients.

In signing this form, you indicate that you understand the attendance policy and the results of not keeping your appointments.

Patient/Guardian Signature _____ Date _____

RETURN TO HEALTH

PATIENT HISTORY FORM

Name: _____ Height: _____ Weight: _____

Are you **pregnant** or think you could be? [ ] **YES** [ ] **NO**

Do you have a **pacemaker**? [ ] **YES** [ ] **NO**

Have you **fallen** within the past 6 months? [ ] **YES** [ ] **NO**

Medical/Surgical History

Please check if you **have ever had** or **currently have**:

MUSCULOSKELETAL	*NEUROMUSCULAR*	*CARDIO/PULMONARY*	*OTHER*
__ Arthritis (Osteo/Rheumatoid)	__ Stroke/TIA	__ Heart Attack	__ Cancer
__ Osteoporosis	__ Head Injury	__ Hypertension	__ Diabetes
__ Fractures or Broken Bones	__ Parkinson Disease	__ Heart Disease	__ Autoimmune
__ Spinal Surgery	__ Fibromyalgia	__ COPD	__ Infectious Disease
__ Back / Neck Pain	__ Nerve Pain/Damage	__ Asthma	
__ Joint Pain	__ Seizures	__ Vascular Issues: _____	
__ Bone or Joint Surgery			

Other Problems Not Listed: _____

_____

Please list surgeries and the dates performed: _____

_____

_____

Please list all current medications and dosages (*you can also provide a list that we can scan into your e-chart)*:

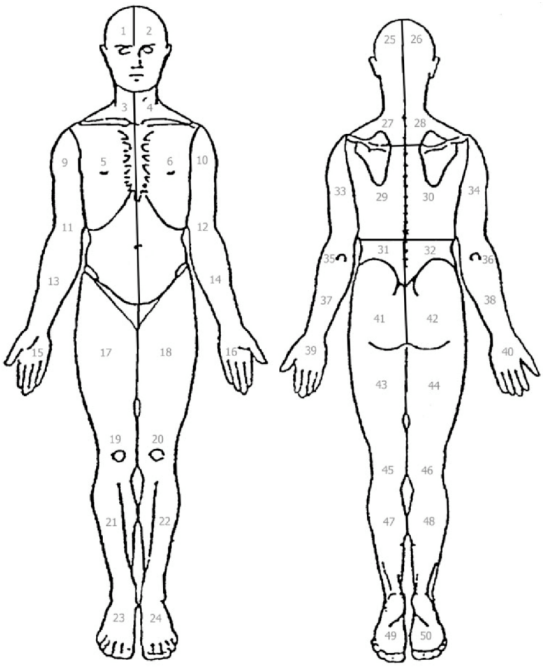
Medication Name	**Dosage**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

RETURN TO HEALTH

Please rate your pain level **MOST** (85 – 100%) of the time over the past **7 DAYS**:

[0 = no pain ---10 = worst pain imaginable] **0 1 2 3 4 5 6 7 8 9 10**

Indicate areas of pain, tightness, numbness, or tingling on the diagram.



Briefly describe the reason for your visit today:

_____
_____
_____

Please list anything you have found that **aggravates**, or makes your pain/symptoms *worse*:

_____
_____
_____

Please list anything you have found that **relieves**, or makes your pain/symptoms *less*:

_____
_____
_____

In the past **6 months**, have you had any of the following diagnostic tests for your injury/condition? (Check all that apply.)

__ X-Ray (DATE: _____) __ Nerve Study (DATE: _____)

__ MRI (DATE: _____) __ Ultrasound (DATE: _____)

__ CT Scan (DATE: _____) __ Bone Scan (DATE: _____)

__ OTHER: _____ (DATE: _____)

Do you regularly see a **Pain Management Specialist** for your injury/condition?

____ YES ____ NO

Physician Name / Practice: _____

In the past **6 months**, have you received any pain management procedures such as injections or nerve ablations for your injury/condition?

____ YES ____ NO