Andrew Garrett, D.C.
Clinic Director

RETURN TO HEALTH

Robert Spicer, M.D.
Medical Director

STATE WORK COMP CLAIM INFORMATION

DATE: _____

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

SSN: _____

CLAIM #: _____ DATE OF INJURY: _____

EMPLOYER: _____

EMPLOYER PHONE: _____ FAX: _____

INSURANCE COMPANY: _____

INSURANCE PHONE: _____ FAX: _____

ADJUSTER NAME: _____

ADJUSTER PHONE: _____ FAX: _____

INJURY DESCRIPTION:

_____

_____

_____

_____

RETURN TO HEALTH

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

Patient Signature:_____ **Date:**_____

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

Month & year of last yearly physical_____/_____ ☐ Never

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.

	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.	
☐19___	X-rays of _____
☐ 19___	Scan of _____
☐ 19___	Colon tests
☐ 19___	Breast x-rays
☐ 19___	Heart tests
☐ 19___	Pneumonia shot
☐ 19___	Yearly physical
☐ 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		
							Strokes		
Children							Epilepsy		
							Nervous breakdown		
							Allergies or Asthma		
							Anemia		
							Cancer		

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

Name _____

Fear Avoidance Beliefs Questionnaire (Physical Activity)

Here are some of the things other patients have told us about their pain. For each statement please mark the number from 0-6 to indicate how much physical activities such as bending, lifting, walking or driving affect or would affect your back pain.

	Completely Disagree			Unsure			Completely Agree
My pain was caused by physical activity	0	1	2	3	4	5	6
*Physical activity makes my pain worse	0	1	2	3	4	5	6
*Physical activity might harm my back	0	1	2	3	4	5	6
*I should not do physical activities which (might) make my pain worse	0	1	2	3	4	5	6
*I cannot do physical activities which (might) make my pain worse	0	1	2	3	4	5	6

FABQ(PA) Score:_____ ☐ Greater than 19 ☐ Less than 12 (For * questions only)

Fear Avoidance Beliefs Questionnaire (Work)

The following statements are about how your normal work affects or world affect your back.

	Completely Disagree			Unsure			Completely Agree
*My pain was caused by my work or by an accident at work	0	1	2	3	4	5	6
*My work aggravated my pain	0	1	2	3	4	5	6
I have a claim for compensation for my pain	0	1	2	3	4	5	6
*My work is too heavy for me	0	1	2	3	4	5	6
*My work makes or would make my pain worse	0	1	2	3	4	5	6
*My work might harm my back	0	1	2	3	4	5	6
* I should not do my regular work with my present pain	0	1	2	3	4	5	6
I cannot do my normal work with my present pain	0	1	2	3	4	5	6
I cannot do my normal work until my pain is treated	0	1	2	3	4	5	6
*I do not think that I will be back to my normal work within 3 months	0	1	2	3	4	5	6
I do not think that I will ever be able to go back to work	0	1	2	3	4	5	6

FABQ(W) Score:_____ ☐ Greater than 34 ☐ Less than 19 (For * questions only)

Date_____ Scorer: _____
(Signature)

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 _____

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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_____

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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_____

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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): θ Moving θ Changing provider θ At the request of the individual θ Consultation θ Insurance change θ Other (please describe) _____

Information to be disclosed:

θ Office notes for date(s) of service _____

θ X-ray reports of _____ for date(s) of service _____

θ MRI reports of _____ for date(s) of service _____

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

θ Complete healthcare record θ Other (please describe) _____

Special instructions: _____

Signature of patient/guardian _____ Date _____