TOTAL HEALTH

Physical Medicine & Wellness

821 N. Nolan River Rd. • Cleburne,76033 • Phone (817) 556-2000 • Fax (817) 556-2031

PATIENT INFORMATION TODAY'S DATE: _____ DATE OF INJURY (DOI): _____

PATIENT NAME: _____ GENDER: Male ☐ Female ☐

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

MAIN PHONE #: _____ ☐ Home ☐ Cell ☐ Other: _____

ALTERNATE PHONE #: _____ ☐ Home ☐ Cell ☐ Other: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ AGE_____ SOCIAL SECURITY #: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE NAME: _____

POLICY NUMBER: _____ GROUP #: _____

POLICY HOLDER NAME: _____ POLICY HOLDER SOCIAL #: _____

POLICY HOLDER DOB: _____

SECONDARY INSURANCE NAME: _____

POLICY NUMBER: _____ GROUP #: _____

POLICY HOLDER NAME: _____ POLICY HOLDER SOCIAL #: _____

POLICY HOLDER DOB: _____

WORKER'S COMPENSATION INSURANCE CARRIER INFORMATION:

EMPLOYER: _____ SUPERVISOR: _____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP CODE: _____ PHONE #: _____ FAX #: _____

INSURANCE NAME: _____ CLAIM #: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE #: _____

ADJUSTOR: _____

ATTORNEY INFORMATION (IF APPLICABLE):

ATTORNEY NAME: _____

TEL#: _____ FAX #: _____

PATIENT SIGNATURE: _____ ***DATE:*** _____

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Health History:

What is the main reason for seeking treatment? _____

What, if anything has made the problem worse?

□ Driving □ Walking □ Working □ Bending □ Sports □ Sleeping

What, if anything has made the problem better?

□ Rest □ Ice □ Heat □ Elevation □ NSAIDS □ Pain Meds

History of Present Injury/ Illness:

□ Neck Pain /Stiffness	□ Pins/Needles in Arms	□ Light Bothers Eyes	□ Sudden Weight Loss	□ Nausea
□ Back Pain /Stiffness	□ Pins/Needles in Legs	□ Depression	□ Loss of Taste	□ Cold Feet
□ Arm/Hand Pain	□ Fatigue	□ Nervousness	□ Loss of Memory	□ Chest Pain
□ Leg/Knee Pain	□ Sleeping Difficulties	□ Tension	□ Jaw Problems	□ Fever
□ Headaches	□ Loss of Smell	□ Cold Sweats	□ Constipation	□ Fainting
□ Dizziness	□ Allergies	□ Stomach Problems	□ Shortness of Breath	
□ Asthma	□ Blurred Vision	□ Night Pain	□ Bowel/Bladder Changes	

_____

_____

Medical History:

□ Hypertensions	□ Heart Disease	□ Rheumatoid Arthritis	□ Liver Disease	□ Migraines
□ Diabetes	□ Pinched Nerve	□ Fibromyalgia	□ Kidney Disease	□ Cancer
□ High Cholesterol	□ Herniated Disc	□ Thyroid Problems	□ Osteoporosis	□ Ulcers
□ Pacemaker	□ Stroke	□ Arthritis	□ Bleeding Disorders	

Are you currently under drug and /or medical care? □ No □ Yes; What Doctor? _____

Please list all Medications / Supplements (*Be sure to include dosage and frequency*):

_____

_____

Allergies: _____

Surgeries and/or hospitalizations (*date and reason*): _____

_____

Intake the following: Cigarettes __ packs/day Alcohol __ drinks/week Caffeine __ cups/ day

Women Only: LMP: _____ Any possibility of pregnancy? □ Yes □ No

Family History:

Is there a Family History of any of the following conditions? (*Indicate what family member*)

□ Heart Disease _____ □ Diabetes _____

□ Cancer _____ □ Arthritis _____ □ Other _____

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ASSIGNMENT OF BENEFITS

I, _____, hereby instruct and direct my Insurance Company, to pay by check or electronic deposit of funds made out and mailed to: Cleburne Integrated Wellness dba Total Health , 821 N. Nolan River Rd., Cleburne, Texas 76033.

For the professional and/or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional and/or medical services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional/medical service(s) charges over and above this insurance payment,

If my current policy prohibits direct payment to a provider or facility, I hereby instruct and direct Insurance Company to make out the check to me. I understand and acknowledge that is my responsibility to forward payment to Cleburne Integrated Wellness dba Total Health.

- A photocopy of this assignment shall be considered as effective and valid as the original
- I authorize Cleburne Integrated Wellness dba Total Health to deposit any check(s) receive for payment on my account.
- I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case.
- I authorize Cleburne Integrated Wellness to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____

Signature of Patient/Policy Holder Date

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CONSENTS/ADMISSIONS

AUTHORIZATION TO RELEASE INFORMATION

Cleburne Integrated Wellness dba Total Health is authorized to release any of my medical records to any insurance companies having coverage on me, to my employer (if coverage is under a group insurance plan), or to my attorney.

AUTHORIZATION OF INSURANCE BENEFITS AND RIGHT OF RECOVERY

I hereby irrevocably assign and transfer to Total Health all rights, title and interest in the benefits payable for services rendered by Total Health, provided in my policy(ies) of insurance, but not construed to be an obligation of Total Health to pursue such recovery. Provided, however, this assignment and transfer shall not take away my standing to make claim or sue for benefits individually should coverage be denied by any insurance carrier(s). I will pay Total Health for all charges incurred or alternatively for all charges more than the sums actually paid following said policy(ies). I hereby authorize the insurance company(ies) listed in my coverage to pay directly to Total Health all benefits due to services rendered therein.

RESPONSIBILITY AGREEMENT

Although I have requested the provider to file with my insurance company on my behalf, I clearly understand that it is my responsibility to make sure any balance due at the end of ninety days from the date a claim is filed, be paid in full or payment arrangements be made with the Business Office.

AUTHORIZATION TO OBTAIN INFORMATION

I hereby authorize any hospital, doctor or medical provider who has treatment or examined me for any injuries and/or illness release Total Health any of my medical records pertaining to services rendered.

CONSENT FOR TREATMENT

I hereby authorize by my signature, Total Health and/or its licensed providers, professionals and such assistants to evaluate and treat my condition; to render any and all medical care deemed necessary and any additional care and supplies that are recommended. I understand that the diagnosis or treatment of my by Total Health and/or its employees may be conditioned upon my consent.

A photo static copy of this authorization shall be considered as effective and valid as original.

I have read and understand the above and agree to abide by these conditions.

Patient Signature & Date:

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Medical Record Release Request

To release your medical records to a new provider or receive a copy for yourself or your attorney, you must complete this Medical Release form. Please fill it out completely and return it to us. If you should have any questions, please do not hesitate to contact our office.

I, (Patient Name) _____(SSN), _____, (DOB)_____

Hereby authorize the release of the following information:

- ☐ Most recent exam and tests
- ☐ All of my Medical Records, (including but not limited to treatment notes, reports or studies that were Performed at your office)
- ☐ Other: _____

Please forward the documentation to:

Name of Provider: _____

Documentation will be sent by:

- ☐ Secure Fax: _____
- ☐ Address: _____
- ☐ Secure Email: _____

I understand that the records are for the care, treatment or medical services provided to me, and retained by you are confidential and are being disclosed for the purpose of:

- ☐ Continuation of Care
- ☐ Litigation

I further understand that without this authorization, the provider would not be permitted to disclose this information, as indicated by law. I further understand these medical records can be faxed or transmitted electronically.

I recognize that I may revoke this consent at any time except to the extent that the information has already been released in reliance of this form. If not revoked, this consent will expire one year from the date signed.

I agree further not to sue or hold the provider of the information, its employees or agents, responsible for any issues, claims or causes of action arising out of the release of information in conformance with the terms of this release.

_____

_____

Patient Signature (or Parent/Guardian if Patient is a Minor) & Date

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NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I understand the privacy practices of:

Cleburne Integrated Wellness dba Total Health

Cleburne Integrated Wellness dba Total Health has provided me a copy of their privacy practices to review. I understand that I can have a paper copy of those policies at any time upon request. I understand that if I have any questions about this notice I can contact the office directly, I can call 817-556-2000 or by writing Attn: Privacy Practices 821 N. Nolan River Rd. Cleburne, TX 76033

Patient Signature _____ Date _____

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X-ray Questionnaire: *For Women Only*

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Please check one of the following statements that apply to you.

- ☐ There is a possibility that I may be pregnant.
- ☐ Yes, I am pregnant.
- ☐ No, I am not pregnant.
- ☐ I request that x-rays not be taken because there is a possibility of pregnancy or because:

_____

_____

Date of my last menstrual period: _____

_____ _____

Patient's Signature Date