Total Health

Physical Medicine & Wellness

PATIENT INFORMATION **TODAY'S DATE:**_____

PATIENT NAME:_____ GENDER: MALE ___ FEMALE ___
DATE OF BIRTH:_____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP CODE:_____
PRIMARY PHONE NUMBER:_____ HOME___ CELL___ OTHER___
ALTERNATE PHONE NUMBER:_____ HOME___ CELL___ OTHER___
EMAIL ADDRESS:_____
EMERGENCY CONTACT:_____
PHONE NUMBER:_____ RELATIONSHIP:_____
OCCUPATION:_____ EMPLOYER:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____
POLICY HOLDER NAME:_____
POLICY HOLDER DATE OF BIRTH:_____
POLICY ID OR SS#:_____
(PLEASE NOTE THAT THE MAJORITY OF OUR TREATMENTS ARE NOT COVERED BY INSURANCE)

REFERRAL SOURCE

HOW DID YOU HEAR ABOUT OUR CLINIC? _____
WHO MAY WE THANK FOR REFERRING YOU? _____

RELEASE OF INFORMATION

MARITAL STATUS: ____ MARRIED ____SINGLE ____ DIVORCED ____ SEPARATED
____ WIDOWED
IF MARRIED, SPOUSE'S NAME:_____

WHO MAY WE RELEASE INFORMATION TO?
NAME:_____ PHONE NUMBER:_____
NAME:_____ PHONE NUMBER:_____

PRIMARY CARE PROVIDER NAME:_____
LOCATION: _____ PHONE NUMBER:_____
** WE ARE A SPECIALTY CLINIC, SO WE HIGHLY RECOMMEND THAT YOU HAVE A PCP FOR BASIC NEEDS

PATIENT SIGNATURE:_____

Total Health

Physical Medicine & Wellness

HEALTH HISTORY

WHAT BRINGS YOU IN TODAY?

_____

_____

IS THIS CONDITON RELATED TO AN INJURY?_____

IF YES, PROVIDE DETAILS:_____

_____

ARE YOU UNDER THE CARE OF AN ATTORNEY FOR THIS INJURY?_____

ATTORNEY NAME:_____ PHONE NUMBER:_____

CURRENT SYMPTOMS/PROBLEMS:

___ NECK PAIN/STIFFNESS	___ NERVE PAIN	___ ANXIETY	___ SUDDEN WT LOSS
___ BACK PAIN/STIFFNESS	___ MUSCLE SPASMS	___ DEPRESSION	___ ABNORMAL WT GAIN
___ARM/HAND PAIN	___ FATIGUE	___ POOR CONCENTRATION	___ VAGINAL DRYNESS
___ LEG/KNEE PAIN	___ SLEEPING DIFFICULTIES	___ MOOD SWINGS	___ LOW SEX DRIVE
___ HEADACHES	___ ALLERGY/SINUS ISSUES	___ NIGHT SWEATS	___ ERECTILE PROBLEMS
___ DIZZINESS/VERTIGO	___ FREQUENT ILLNESS	___ HOT FLASHES	___ SEVERE DRY SKIN
___ BREATHING ISSUES	___ VISION CHANGES	___ FREQUENT URINATION	___ PALPATATIONS
___ STOMACH PROBLEMS	___ HOT/COLD INTOLERANCE	___ FREQUENT UTI'S	___ CHEST PAIN
___ POOR ENDURANCE	___ IRRITABILITY	___ SUICIDAL THOUGHTS	

OTHER SYMPTOMS:_____

_____

_____

MEDICAL HISTORY (PER DIAGNOSIS OR TREATMENT)

HORMONE PROBLEMS_____ MENOPAUSE/HYSTERECTOMY_____

DEPRESSION/ANXIETY_____ ADD/ADHD _____

PROSTATE PROBLEMS_____ KIDNEY PROBLEMS_____

CARDIAC PROBLEMS_____ RESPIRATORY ISSUES_____

STOMACH PROBLEMS_____ BOWEL ISSUES_____

THYROID PROBLEMS_____ NEUROLOGIC ISSUES _____

AUTO IMMUNE PROBLEMS_____ ANEMIA/BLEEDING DISORDERS_____

OTHER:_____

SURGICAL HISTORY:_____

_____

MEDICATION ALLERGIES:_____

OTHER ALLERGIES:_____

PREFERRED PHARMACY:_____

CURRENT MEDICATIONS. PLEASE INCLUDE NAME, DOSE, FREQUENCY, AND WHO PRESCRIBES IT:

_____

_____

_____

_____

_____

CURRENT SUPPLEMENTS/VITAMINS:_____

_____

WOMEN ONLY: LMP:_____ ANY POSSIBLITY OF PREGNANCY? ____ YES ____ NO

SOCIAL HISTORY: DO YOU SMOKE? ___ YES ___ NO
OTHER TOBACCO PRODUCTS? ___ YES ___ NO
FREQUENCY OF ALCOHOL? _____ DRINKS PER WEEK
CAFFINE INTAKE? _____

IS THERE A FAMILY HISTORY OF ANY MEDICAL PROBLEMS?
CONDITION:_____ FAMILY MEMBER(S)_____
CONDITION:_____ FAMILY MEMBER(S)_____
CONDITION:_____ FAMILY MEMBER(S)_____

PATIENT SIGNATURE DATE

Total Health

Physical Medicine & Wellness

821 N. Nolan River Road Cleburne, TX 76033 **Phone: 817-556-2000** **Fax: 817-556-2031**
1301 W. Henderson Street Cleburne, TX 76033 **Phone: 817-774-0990** **Fax: 817-556-2031**

MEDICAL RECORDS RELEASE REQUEST

TO SEND OR RECEIVE MEDICAL RECORDS TO OR FROM OTHER PROVIDERS, CLINICS, OR FACILITIES, YOU MUST COMPLETE THIS MEDICAL RELEASE FORM. PLEASE FILL IT OUT COMPLETELY, AND RETURN TO US. IF YOU SHOULD HAVE ANY QUESTIONS, PLEASE DO NO HESITATE TO CONTACT OUR OFFICE.

I_____ (PATIENT NAME)_____(DOB)_____(SSN)

HEREBY AUTHORIZE THE RELEASE OF THE FOLOWING INFORMATION RELATED TO MY MEDICAL CARE:

____ MOST RECENT EXAMS AND TESTS

____ ALL OF MY MEDICAL RECORDS, INCLUDING BUT NOT LIMITED TO TREATMENT NOTES, REPORTS OR STUDIES THAT WERE PERFORMED AT YOUR OFFICE.

____ OTHER

I AUTHORIZE RELEASE OF MY INFORMATION TO TOTAL HEALTH FROM:

NAME OF PROVIDER:_____

ADDRESS OR PHONE NUMBER OF PROVIDER/CLINIC:_____

_____

I AUTHORIZE RELEASE OF MY INFORMATION FROM TOTAL HEALTH TO:

NAME OF PROVIDER:_____

ADDRESS OR PHONE NUMBER OF PROVIDER/CLINIC:_____

_____

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 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.

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

Total Health
Physical Medicine & Wellness

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 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 MY INSURANCE COMPANY TO MAKE OUT THE CHECK TO ME. I UNDERSTAND AND ACKNOWLEDGE THAT IT 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 AUTHORIZED CLEBURNE INTEGRATED WELLNESS DBA TOTAL HEALTH TO DEPOSIT ANY CHECK(S) RECEIVED 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 DBA TOTAL HEALTH TO INITIATE A COMPLAINT TO THE INSURANCE COMMISSIONER FOR ANY REASON ON MY BEHALF.

SIGNATURE OF PATIENT/POLICY HOLDER DATE

Total Health
Physical Medicine & Wellness

Nolan River Location: Phone: (817) 556-2000 Henderson St (World Gym) Location: (817) 774-0990

Fax: (817) 556-2031

GENERAL OFFICE POLICIES AND PROCEDURES.

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

Welcome to Total Health! We are excited that you have chosen us for your healthcare needs. We appreciate the confidence that you have put into us as a healthcare team, and we look forward to exceeding your expectations. Listed below are some of our clinic's policies and procedures that we would like to make you aware of. Communication is key here, and we want you to know what to expect.

1) Total Health is a specialty clinic. Our clinic focuses on hormone imbalances, thyroid difficulties, the adrenal system, inflammatory concerns/issues, joint/muscle injections and/or injuries, and holistic based care. We also provide IV Therapy and Aesthetics. We do not provide primary care, and strongly recommend that you have a PCP. We do not provide sick visits.

2) Because Total Health is not a primary care clinic, we do not have an after hours on call service. Should you need assistance after hours, we recommend that you call your PCP, go to your nearest ER, or be seen at an urgent care clinic. For emergencies, please call 911.

3) Medication refills require a 72-hour notice. We respectfully request that you do not wait until you are out of medication completely to request a refill. This could delay your request, causing you to be out of medication for several days. Please call your pharmacy first to request a refill, and they will send a refill request to us.

4) Our patients currently being seen in the office for visits are our number one priority, and will always be taken care of first. Our goal is to give all of our patients 100% of our attention while they are here. When calling the clinic with questions/concerns outside of a scheduled appointment please allow 24 hours for a returned phone call. We will get back with you sooner if at all possible.

5) Please allow up to 2 weeks for lab results to be completed. We will call you once lab results are available and have been thoroughly reviewed by your provider. We recommend that all new patients, or patients with new concerns, schedule a follow up appointment for 2 weeks after their initial appointment and/or lab draw for a lab review visit.

6) Cancelations of appointments require a 24-hour notice. We understand that emergencies do happen and will be considered. Should you no-show or cancel appointments without notice on 3 occasions, you may be discharged from our care. If you are greater than 10 minutes late for your appointment, we will request that you reschedule.

We are glad that you are here, and we look forward to serving you!

Total Health
Physical Medicine & Wellness

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose you protected health information (PHI) to carry out treatment, payment or health care operations, and for other purposed that are permitted or required by law. It also describes your rights to access and control you protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that related to your past, present, or future physical or mental health or condition and related health care services. We are required to provide this notice to you by the Health Insurance Portability and Accountability Act ("HIPAA").

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care, wellness programs, and treatments for the purpose of providing health care and wellness services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose you protected health information to provide, coordinate, or manage your health care, wellness any related services. This includes the coordination or management of your health care with a third party or other licensed individuals involved with your healthcare and wellness programs. For example, we would disclose your protected health information, as necessary, to a physician of whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you, or we would disclose your protected health information to your physical therapists, trainers, and/or nutritionist as part of your health and wellness program.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a procedure may require that your relevant protected health information be disclosed to the health plan to obtain approval.

Healthcare Operations: We may use or disclose, as needed, your health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review, activities, licensing, and conducting or arranging for other business activities. For example, we may use a sign in sheet at the registration desk where you will be asked to sign you name, and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third-party business associates who perform various activities (for example, billing and transcription services) for any health plan. The business associates will also be required to protect your health information.

We may use or disclose your protected health information in the following situations without your authorization. The situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, worker's compensation, inmates, required uses and disclosures. Under the law, we must make disclosures to you when required.

Patient Signature Date

Total Health

Physical Medicine & Wellness

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 BENFITS AND RIGHT OF RECOVERY

I hereby irrevocably assign and transfer to Total Health all rights, title and interest to the benefits payable for services rendered by Total Health, provided in my policy(ies) of insurance, but not construed to be an obligation to 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 additional care and supplies that are recommended. I understand that the diagnosis or treatment of me by Total Health and/or its employees may be conditioned upon my consent.

OFFICE POLICIES AND PROCEDURES

I acknowledge that I have received a copy of Total Health's General Office Policies and Procedures, and I have retained a copy for my records.

A photostatic 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