PHONE (972) 460-4420 | FAX (972) 874-8439 |
2616 LONG PRAIRIE ROAD – FLOWER MOUND – TEXAS 75022

PATIENT INFO

Name: _____
(LAST) (MI) (FIRST)

Address: _____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: Work Phone: Cell Phone:

Email Address:

DOB: / / Soc. Sec #: - -

Driver's License #: State:

Marital Status: S M W Spouse's Name:

Your Employer: Occupation:

Employer Address: _____
(STREET) (CITY) (STATE) (ZIP)

How did you hear about the office?

Primary Care Physician:

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name:

Member #: Group #:

Insurer's Name (If Different From Patient): Relationship to Patient:

Insurer's DOB: / / Insurer's Soc. Sec #: - -

Insurer's Employer:

Person responsible for account:

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient/Guardian Signature **Date:**

_____ _____

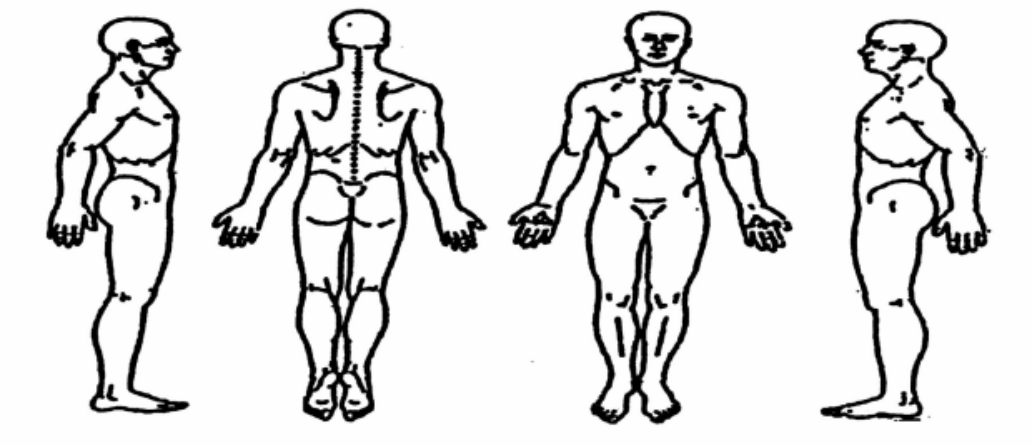
Front Desk Initials: _____

Patient Intake Form

Name: _____ **Date:** _____

Height: _____ **Weight:** _____

1. Indicate on the drawings below where you have pain/symptoms



2. Have you had any imaging in the last 2 years (Where,Date)? _____

3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. Do you have numbness, tingling, or pain in your arms or legs? Yes/No

6. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

8. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

9. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

10. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other: _____
□ Massage Therapist □ Physical Therapist □ No one

11. How long have you had this problem? _____

12. How do you think your problem began?

_____

13. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

Front Desk Initials: _____

14. Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than ½ the days	Nearly every day
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**

15. What aggravates your problem?

_____

16. What alleviates your problem?

_____

17. Females only: When was your last Menstrual period? _____

18. What is your: Height_____ Weight _____ Date of Birth _____

Occupation_____

19. Have you had labs done recently (within last 6 months)? □ Yes □ No
If "Yes", when?_____

20. Have you ever been told you had diabetes or a problem with blood sugar? Yes/No

21. For each of the conditions listed below, place a check in the "Past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "Present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	Kidney Disorders	□	□	**Gastric reflux**
□	□	Neck Pain	□	□	Bladder Infection	□	□	**Irritable Bowel – Syndrome/IBS**
□	□	Upper Back Pain	□	□	Painful Urination			
□	□	Mid-Back Pain	□	□	Loss of Bladder Control	□	□	**Neuropathy**
□	□	Low Back Pain	□	□	Abnormal Weight Loss	□	□	**Weakness**
□	□	Shoulder Pain	□	□	***Abnormal Weight Gain***	□	□	**Fibromyalgia**
□	□	Elbow/Upper Arm	□	□	Loss of Appetite	□	□	**Gout**
□	□	Wrist Pain	□	□	**Abdominal Pain**	□	□	**Sleep apnea**
□	□	Hand Pain	□	□	**Ulcer**	□	□	**Snoring**
□	□	Hip Pain	□	□	Hepatitis	□	□	**Shortness of breath**
□	□	Upper Leg Pain	□	□	**Gall Bladder Disorder**	□	□	**Palpitations**
□	□	Knee Pain	□	□	Liver	□	□	**Heart arrhythmia**
□	□	Ankle/Foot Pain	□	□	***General Fatigue***	□	□	**Anxiety**
□	□	Jaw Pain	□	□	Muscular Incoordination	□	□	***Sexual dysfunction***
□	□	Joint Pain/Stiffness	□	□	Visual Disturbances	□	□	**Itching**
□	□	Arthritis	□	□	**Dizziness**	□	□	**Psoriasis**
□	□	Rheum. Arthritis	□	□	**Diabetes**	□	□	***Hyperthyroid***
□	□	Cancer	□	□	**Excessive Thirst**	□	□	***Hypothyroid***
□	□	Tumor	□	□	**Frequent Urination**			
□	□	Asthma	□	□	Smoking/Tobacco Use	**For Males Only**		
□	□	**Chronic Sinusitis**	□	□	Drug/Alcohol Dependence	□	□	**Prostate**
□	□	**Other Breathing Abnormalities**	□	□	Allergies	□	□	***Low – T***
			□	□	**Depression**	□	□	***ED***
□	□	**Dermatitis**	□	□	Systemic Lupus			
□	□	**Rash**	□	□	Epilepsy	**For Females Only**		
□	□	Eczema	□	□	HIV/AIDS	□	□	*Birth Control Pills*
□	□	**High Blood Pressure**	□	□	**Anemia**	□	□	***Hot flashes***
□	□	**Heart Attack**	□	□	**Vitamin D Deficiency**	□	□	***Polycystic ovarian***
□	□	**Chest Pains**			**Metabolic syndrome**	***disease***		
□	□	**Stroke**	□	□	**pre-diabetic**	□	□	***Infertility***
□	□	**Angina**	□	□	**Bariatric surgery**	□	□	***Painful periods***
□	□	Kidney Stones	□	□	***Sleep Disturbances***	□	□	**Hormonal Replacement**
			□	□	***Mood changes***	□	□	Pregnancy

Other:_____

Front Desk Initials: _____

22. List all prescription medications you are currently taking:

_____
_____
_____

23. List all of the over-the-counter medications you are currently taking:

_____
_____
_____

24. List all Allergies (medications, food, seasonal, etc.) you may have:

_____
_____
_____

25. List all surgical procedures you have had:

_____
_____
_____

26. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

27. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

28. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

29. What activities do you do outside of work? _____

30. What concerns you the most about your problem; what does it prevent you from doing?

_____

30. Have you ever been hospitalized? □ Yes □ No

If Yes, why? _____

31. Indicate if you have any immediate family members with any of the following (Please indicate the relationship to you):

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer (see add. Forms) □ ALS
□ Other: _____

32. Have you had any past injuries or trauma, such as car accidents (ever?), falls, sports injuries, etc.?

□ Yes □ No If "Yes", please provide details:

_____
_____

33. Is there anything else you wish to let us know about you visit today? □ Yes □ No

If "Yes", please provide details:

_____
_____

Patient Signature: _____ **Date:** _____

Front Desk Initials: _____

Insurance Verification Disclosure/Agreement

As a courtesy, Medical Massage Rx & Reclaim Physicians Medical will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Front Desk Initials: _____

Consent to Treat a Minor

I _____ (Parent/Guardian) hereby authorize Medical Massage Rx and whomever they designate to administer massage treatment, soft tissue therapy, examination and evaluation as deemed necessary to my child, _____ (child's name).

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____

Informed Consent

Dear Patient,

Every type of health care is associated with some risk of a potential problem. We want you to be informed about potential problems associated with medical massage health care before consenting to treatment. This is called informed consent.

In this office, we use trained assistants who may assist the physician with portions of your consultation, examination, physical therapy application, massage therapy, exercise instruction, etc. On the occasion when your physician is unavailable, your care may be handled by another physician or trained assistant.

Stroke: Stroke is the most serious problem associated with massage therapy. Stroke means that a portion of the brain does not receive oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death.

Soft Tissue Injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform your physician.

Other Problems: There may be other problems or complications that might arise from massage therapy treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

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Front Desk Initials: _____

Massage therapy is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always provide you with the best care and if results are not acceptable, we will refer you to another health care provider who we feel may assist your condition.

If you have any questions on the above information, please ask your physician. Once you have a full understanding, please sign and date below.

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Secondary Number: _____

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

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Front Desk Initials: _____

Assignment of Benefits

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, grants and conveys for deferred payment to Reclaim Physicians Medical Group, a lien and assignment against the proceeds of the patient's insurance settlement with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Reclaim Physicians Medical Group, and to 913 S. Main St., Unit 212, Grapevine, TX 76051.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Functional Medicine of Irving, and to send any and all checks to 913 S. Main St., Unit 212, Grapevine, TX 76051

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

By my signature be it known that I have read and fully understand the above contract.

Patient Name (Printed) _____Date _____

Patient Signature _____

Parent/Guardian Signature _____

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Front Desk Initials: _____

HIPAA Disclosure

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

All Patient Medical Records

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

Medical Massage Rx

Personal Representatives:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I hereby authorize the request and release of PHI held by Medical Massage Rx to the above personal representative. By appointing the person named on this form as a personal representative, I understand that I am authorizing Medical Massage Rx to give this person access to PHI, the right to talk to Medical Massage Rx about medical care, and the right to make decisions that will bind me.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize Medical Massage Rx to use my protected information for the listed reasons.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

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Massage Appointment Policy & Credit Card Authorization

In order to better accommodate our growing number of patients on waiting lists, we are encouraging patients that have an appointment and must reschedule, to give as much advanced notice as possible. Less than 24-hour's notice is considered a no-show.

We require a credit card to be kept on file thus authorizing Medical Massage RX to bill your credit card a $35 service fee in the event you do not honor your scheduled appointment.

We allow 3 grace cancellations (no-shows) before we begin charging you this fee, as we understand life happens.

I, _____ authorize Medical Massage Rx to charge the credit card below in the event I do not comply with the massage appointment cancellation policy stated above.

Circle One: VISA MC AMEX DISCOVER

Credit Card #: _____

Expiration Date: _____/_____ CVV #: _____

Patient Name (Printed): _____

Guardian Name (Printed): _____

Patient/Guardian Signature: _____

Date: _____

Therapeutic Massage Guidelines

*All deductibles, co-pays and co-insurance payments due at time of service

*No children may be present in the room with you or unattended in the waiting room during your therapeutic massage.

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Front Desk Initials: _____

FINANCIAL POLICY

Please initial next to each section indicating your acknowledgement:

_____All current balances, co-payments, co-insurance and deductibles are **due and payable PRIOR to services** being rendered and is required by your insurance to be paid at each visit. We accept cash, check, VISA, MasterCard, Discover, and American Express. We do not accept post-dated checks.

_____**REFERRALS:** If you have a managed care plan, an HMO, or similar plan that requires a referral, you will need a referral from your primary care physician to see our providers. If your insurance requires a referral that is generated through them, you must reach out to your primary care office for them to call your insurance. It is not our policy to generate a referral for ourselves. **If we have not received this referral prior to your arrival at our office, your appointment will either be rescheduled or you may be responsible for the entire bill. It is your responsibility to know if a referral is required and to obtain one.**

_____**INSURANCE BENEFITS:** Please be aware that when a patient requires a visit to a health care provider, there are diagnostic tests or procedures that may be suggested for appropriate care that may be done by one of our providers. These procedures may be done during the normal course of the exam by specialized personnel. Although necessary as part of routine evaluations, insurance companies often categorize these as procedures. The possible procedures which often are performed in this practice during your visit include, **but are not limited to**:

Trigger Point Injections	B-12 Injections
Autonomic Nervous System Tests	NCV/EMG tests
US guided Injections	Doppler Studies
EKG Evaluations	Joint Injections
PRP/Amnio therapies	Physical Rehabilitation/PT

Depending on your insurance policy provisions, these procedures and others may fall under a separate benefit other than your office co-pay, such as a deductible or coinsurance. In most cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Therefore, any estimate for services will be considered an estimate only and any payment will be considered a partial-payment only until such time that the insurance company processes your claim. Your insurance is a contract between you and your insurance carrier; payment for services is ultimately your responsibility. It is extremely important for you to know your coverage. Many of the diagnostic and therapeutic procedures performed in our office (such as those listed above and others) are considered additional costs by your insurance company. Your health care providers are not aware of what additional costs may be incurred and will not review that with you. As health care providers, our physicians may recommend a diagnostic or therapeutic procedure available only to specialist physicians in order to provide you with the best possible treatment. If you have concerns regarding the cost of any procedure, you may ask your doctor if you can discuss the cost with our business staff BEFORE the procedure is performed to decide if you would like to have it done.

_____**WAIVER OF CONFIDENTIALITY:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment and the type of treatment received at our office may become a matter of public record or disclosed to third parties.

_____ **DIVORCE:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible to us for those subsequent charges.

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Front Desk Initials: _____

_____ **TRANSFERRING OF RECORDS:** You will need to request in writing, and pay a reasonable copying fee (currently $25) PRIOR to sending copies of your records to another doctor or organization. You authorize us to include all relevant information, including your payment history and hereby indemnify and hold us harmless for any claims or damages resulting from our providing records pursuant to your request. If you request records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

_____ **PERSONAL INJURY:** If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. Payment of the bill remains the patient's responsibility.

_____ **LIABILITY:** If you are being treated for a 3rd party liability claims and do not have an attorney, we will require that you allow us to bill your health insurance or file on your Personal Injury Protection. Upon settlement of your claim, YOU WILL BE RESPONSIBLE FOR ANY BALANCE OWED ON YOUR ACCOUNT REGARDLESS OF THE AMOUNT OF SETTLEMENT YOU RECEIVE FROM THE INSURANCE COMPANY. Please understand upon settlement of your claim, the 3rd party carrier will NOT PAY US DIRECTLY; however, you remain fully responsible for payment of your account. If you do not have health insurance or PIP, we must have a letter of protection on file from an attorney. Otherwise, you will be responsible for payment in full at the time services are rendered. We have the right, at our sole discretion, to refuse to accept a letter of protection for payment of your services.

_____ **FORMS FEE:** Please allow 5-7 business days to complete all forms that require a physician signature and medical review (i.e., Worker's Comp, FMLA, Short-term disability (STD), other extended leave of absence, etc.) The physician must take the time to fill out the forms and as such may charge for each record requested, a $30.00 Forms Fee. Each time a correction needs to be made to a form; another Forms Fee will be charged to the account. There is no exception to this rule. Additional medical records request will also have a $40.00 assigned fee.

_____ **NO SHOW/CANCELLATION COURTESY:** We are committed to making you an appointment at your earliest convenience; likewise, we require a call at least 24 hours in advance if you are unable to keep your appointment to allow for other patients to be seen. If you "no show" for an appointment or cancel with less than 24 hours' notice, you will be charged a $35.00 fee. Multiple missed appointments may result in our request for you to find another provider.

_____ **RETURNED CHECK FEE:** There is a $35.00 fee for checks returned for any reason and will be added to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

_____ **PATIENT BALANCE POLICY:** After filing with the insurance company, we will promptly mail you a patient statement. Payment in full is due upon receipt of this statement and is a courtesy from our office. If you have any questions or dispute the balance, it is your responsibility to contact our billing office within 30 days. Accounts past 30 days will be considered past due and may be referred to outside resources for further management. If you are unable to pay the balance due in full, you must contact our billing office to discuss a payment schedule or arrangements. Any late fees incurred on past due balances will be included in any mutually agreed upon arrangements.

_____ **BANKRUPTCY:** If we attempt to collect a debt and you have filed for bankruptcy, and we are listed as a creditor, please advise us of this and we will cease collection activity immediately.

Patient Name: _____Date: _____

Parent/Guardian Name: _____

Patient Signature: _____ (Parent/Guardian if minor)

Front Desk Initials: _____

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