(OFC) 214-351-2299 (FAX) 214-351-1122	PATIENT/CLIENT INFORMATION

WELCOME to our Office!

*Patient Name:_____Today's Date:_____

*Address: _____Home PH: _____

*City, State, Zip:_____ Work PH: _____

*Birthdate: _____ Age:_____ Sex: M F Cell PH: _____

*Which phone number do you prefer we contact you: Home Cell Work

* Email:_____. May we send you a newsletter?_____

*Emergency Contact: _____Relationship:_____ PH#: _____

*Patient Employer: _____

Physical Therapy Patients ONLY: PHYSICIAN Referral INFO

Physician Name: _____Address:_____

Physician Phone:_____ FAX:_____

Do you have a written referral from your physician? _____ If so, please give to the receptionist.

**If a MEDICARE Beneficiary -ARE YOU CURRENTLY under or RECENTLY HAD HOME HEALTHCARE?
NO YES If YES, when was your last date of home healthcare? _____and what company provided the home healthcare?_____

ALL PATIENTS

To whom may we release health information or information about your bill? Circle those that apply OR write in preferences.

Spouse Parent Doctor Caregiver _____

Signature:_____ Date:_____

Who referred you to us?_____

LOVERS LANE WELLNESS CENTER, LLC.

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment and our experience with common practice to make reasonable interferences of your best interest in allowing a person to pick up prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited expectations. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $15 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request the accounting more than once in a 12 month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means of location your request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS OR COMPLAINTS

If you want more information about out privacy practices or have question or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.
Contact officer: Kathleen Tisko,

EMAIL: dallaswellnesscare@outlook.com

PHONE: 214-351-2299

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from LOVERS LANE WELLNESS CENTER.

X _____ **Date:** _____

Patient has chosen not to sign. In lieu of patient signature, I _____, a staff member of Park Cities Physical Therapy / Lovers Lane Wellness Center, state that _____ has been given our current Notice of Privacy Practices.

X _____ **Date:** _____

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other _____

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: _____

_____

_____

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as: _____
relationship/authority of patient's representative

_____
date signed

To be completed by doctor or staff:

_____
witness to patient's signature

_____
date

_____
translated by

_____
date

Revised May 2013

Dallas Wellness Care/ LLWC, LLC Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- There are additional fees associated with other services provided, such nutrition counseling & response testing, thermography, nutritional supplements, modality only treatments (such as decompression or cold laser), heel lifts exercise bands and other patient supplies. These are not covered by insurance and those charges will be discussed with you by the Doctor.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the Doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- You may be charged a cancellation fee of $25. if a confirmed appointment is missed.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

Witness Signature: _____ Date: _____

Printed Name of Witness: _____

_____Patient initials to indicate copy received.

Patient History Questionnaire

Name:_____ **Date:**_____

Age:_____ **Current height:**_____ **Current weight:**_____

Medical and Family History: Place (S) for SELF, (F) for FAMILY if the following apply:

Arthritis	Hepatitis	Vascular Disease	Osteoporosis- any fractures?
Asthma	Kidney Disease	Seasonal Allergies	Epilepsy
Cancer Type:	High Blood Pressure High Cholesterol	Adverse Drug Reactions Drug Allergies	Auto immune disorders-Lupus, fibromyalgia, Rheumatoid Arthritis, Sjogren's etc
Diabetes	Neuropathy	Headaches	Parkinson's, Alzheimer's
Gout	Strokes	Alcohol problems	Prostate (BPH), Cancer
Heart Disease	Thyroid Disease	G.I.- reflux, IBS, Colitis, etc.	Other:

All surgeries (& approximate year): _____

_____

Injuries, Major illnesses, Accidents(& year):_____

_____

All Current Medications/Vitamins/Supplements:_____

_____

If applicable:
Are you pregnant or trying to get pregnant?_____ **Do you Smoke?** _____ **Drink Alcohol?**_____

If you have given birth, how many pregnancies?_____ **# of children**_____

Current occupation/ life style:_____

Does current job/activities include: (circle all that apply) Sitting Computer Phone Standing Lifting Travel Childcare Housework Yardwork Other:_____

List any sports, exercise, recreational activities you participate in:_____

Describe your CURRENT PROBLEM:_____

_____

When did the present problem begin?_____

Have you had special tests such as: X-ray MRI CT Scan EMG Bone Scan Other:_____

What prior treatment have you received for this condition?_____

Have you ever had the following treatments ? (circle) Physical Therapy * Chiropractic * Massage

YOUR goals for treatment:_____

Review of Systems: If you are currently having any problems in the following areas, **Please CIRCLE and explain, or check none.**

Skin: itching, rash, infection, ulcer, tumors, open wounds, other __ none

Bones, Joints, Muscles: muscle pain/cramps, joint pain/ swelling, other __ none
Last Bone Density Test:_____

Endocrine: fatigue, confusion, fainting, nervousness, hot/cold intolerance, hair loss, increased thirst with frequent urination, other __ none

Allergy/Immunology: recurrent infections, hay fever, hives, food or airborne allergies, drug sensitivity, other __ none

Head: headaches, dizziness, vertigo, jaw pain, eye pain, tooth pain, other __ none
Do you wear glasses or contacts_____?

Ears, Nose, Throat: hearing loss, ringing in ears, infections, hoarseness, congestion, sinus problems, wheezing, cough, asthma, other __ none

Neck/ Back: pain, swelling, stiffness, loss of motion, other __none

Breasts: tenderness, swelling, lumps, discharge, other Last mammogram:_____ __ none

Cardiovascular: chest pain, swelling of extremities, shortness of breath, exercise intolerance, palpitations, other __ none
Pacemaker?_____

Gastrointestinal (stomach, intestine): nausea, vomiting, change in bowel habits, constipation, diarrhea, pain, bleeding, irritable bowel, other __none

Genitourinary(genitals, kidney, bladder); increased frequency, urgency, hesitancy, pain or bleeding with urination, infections, incontinence, sexual dysfunction, impotence, other __none

Nervous System: weakness in arms/legs, numbness/tingling, falls, tremors, neuralgia, other __ none

SYMPTOM(S) QUESTIONNAIRE

Patient Name _____ ☐ Initial Visit ☐ Subsequent Visit

Please tell us about your symptoms: _____

_____

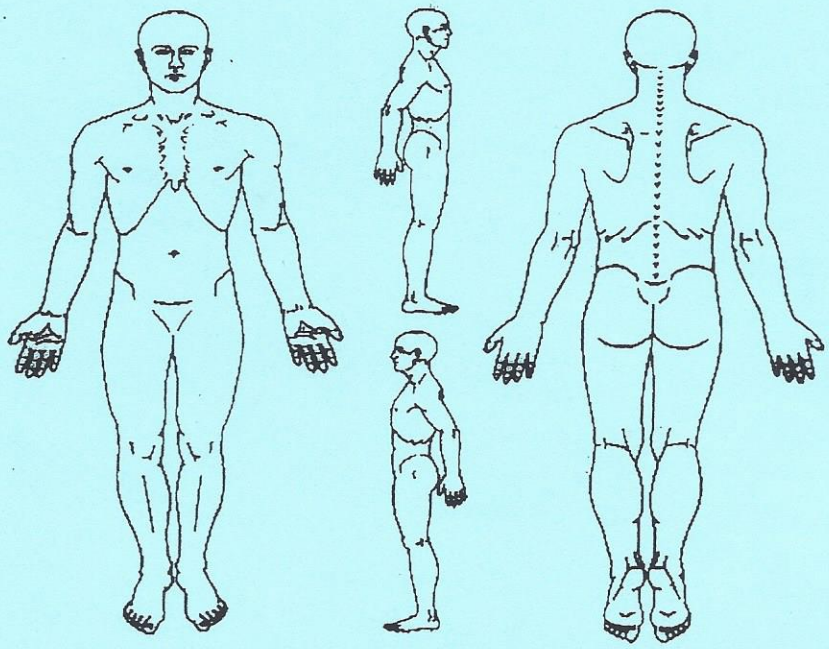
My pain / symptom(s) are getting: Better Worse About the same Other

Please use the key to mark the diagram

Pain / Discomfort Scale: (please Circle) Least 0 1 2 3 4 5 6 7 8 9 10+ Worst

A = Ache B = Burning N = Numbness S = Stiff SR = Sore

T = Tingle P = Pain W = Weak P&N = Pins & Needles



Please tell us how your symptoms are affecting your activities

HOME	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sleeping	☐	☐	☐	☐
Self Care	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐
Productivity	☐	☐	☐	☐

WORK	No Effect	Mild Effect	Moderate Effect	Severe Effect
Concentration	☐	☐	☐	☐
Duties, Activities	☐	☐	☐	☐
Mood	☐	☐	☐	☐
Travel	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐
Productivity	☐	☐	☐	☐

OTHER ACTIVITIES	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sit, Stand, Walk	☐	☐	☐	☐
Raising from Chair	☐	☐	☐	☐
Bend, Lift, Twist	☐	☐	☐	☐
Turn Head	☐	☐	☐	☐
Hobbies, Exercise, Sports	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐

Patient Signature _____ Date ____/____/____

Doctor Signature _____ Date ____/____/____