dallaswellnesscenter.com
214.965.9355

ENTRANCE APPLICATION

WELCOME!... WE ARE HONORED YOU CHOSE US TO EVALUATE YOUR CONDITION.
SO WE MAY FILE YOUR INSURANCE FORMS FOR YOU, WOULD YOU PLEASE FILL OUT THE PERSONAL INFORMATION BELOW?
IF YOU NEED ASSISTANCE PLEASE INFORM THE FRONT DESK PERSON. THANK YOU!

First Name _____ Middle _____ Last _____

Gender ❑ Male ❑ Female Home Phone _____ Cell Phone _____

Address _____

City _____ State _____ ZIP _____

Social Security Number ___ - ___ - ____ E-mail Address _____

Birthdate _____ Age _____ **Marital Status** S M W D

Employer _____ Work Phone _____

Spouse's Name _____ Spouse's Birthdate _____

Person responsible for this account _____

DOB of Insured Party _____

Social Security Number ___ - ___ - ____

Name of their employer _____ City _____

Employer Phone _____

Children- Names & Ages _____

_____ _____

In case of emergency, whom should we contact? _____ _____

Relationship of Emergency Contact: _____ _____

Phone _____

FAMILY PHYSICIAN: _____

What is your primary complaint? _____

_____

IS THIS WORKMAN'S COMPENSATION? _____ **IS THIS PERSONAL INJURY?** _____

Patient Informed Consent

I, _____, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature _____

(Office use only)	Account Number	Date

dallaswellnesscenter.com
214.965.9355

Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, HealthSource shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

PATIENT SIGNATURE _____ INSURED'S SIGNATURE _____

DATE _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to HealthSource all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/Guardian _____ Date _____

dallas wellness center

dallaswellnesscenter.com
214.965.9355

HIPAA Declaration

The Practice:

(a) Is required by federal law to maintain the privacy of your Protected Health Information and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your Protected Health Information.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your Protected Health Information than that which is provided for under federal law

(c) Is required to abide by the terms of the Privacy Notice

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your Protected Health Information that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation

(f) Will not retaliate against you for filing a complaint

EFFECTIVE DATE

This Notice is in effect as of 7/26/04

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

_____
PATIENT

_____
DATE

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Acknowledgment
Patient's acknowledgment of this notice could not be obtained because:

__Patient refused to sign
__Communication barrier prohibited obtaining acknowledgment
__Emergency circumstances
__Other
Details:

_____
Signature of Practice

_____
Date

dallas wellness center

dallaswellnesscenter.com
214.965.9355

NAME: DATE: / / Account#:

HISTORY OF ILLNESS / INJURY / PAIN

LOCATION

Chief complaint and its location: _____

_____

What caused the onset? _____

_____

Date of onset? / /

TIMING AND DURATION

How often do you experience this pain? _____Constant _____Frequent _____Intermittent _____Occasional

SEVERITY

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate
6 = Moderate to Severe 7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity
9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? _____Inflexibility _____Stiffness _____Spasms _____Cramps

Other: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____Deadness _____Prickly _____Numb _____Crawling _____Tingling
_____Stabbing _____Hurting _____Pulsating _____Pins & Needles _____Pounding
_____Burning _____Shooting _____Throbbing _____Stinging
_____Dull _____Sharp _____Aching _____Excruciating

ADDITIONAL ASSOCIATED SIGNS AND SYMPTOMS

If this pain radiates or travels, please identify where to: _____

_____

MODIFYING FACTORS

What aggravates the pain/symptom?

_____Flashing lights _____Sneezing _____Lifting _____Exercising _____Looking up/down
_____Coughing _____Sitting _____Stooping _____Looking side/side _____Anger
_____Standing _____Depression _____Stress _____Driving _____Walking
_____Getting out of bed _____Pushing _____Emotional upset _____Pulling _____Repetitive movement
_____Carrying _____Straining at BM _____Climbing stairs _____Walking uphill _____Getting in/out of car

Other: _____

What relieves this pain/symptom?

_____Resting _____Sleeping _____Lifting _____Exercising _____Looking up/down
_____Shower _____Advil _____Stooping _____Looking side/side _____Anger
_____Mineral Ice _____Other: _____

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

Patient history was obtained from: _____Patient _____Father _____Mother _____Son _____Daughter

Have you seen anyone for this condition? _____YES _____NO WHOM? _____

Do you have a pacemaker? _____YES _____NO Are you Pregnant? _____YES _____NO
Do you think you may be pregnant? _____YES _____NO

Doctor Signature: _____

Patient Signature: _____

dallas wellness center

dallaswellnesscenter.com
214.965.9355

NAME: **DATE:** / / **Account#:**

P = Present • **N** = Not Present • **PN** = If it has ever been present in the past

P	N		PN
		Weakness	
		Fatigue	
		Fever	
		Chills	
		Night Sweats	
		Fainting	
		Nervousness	
		Concentration Loss	
		Dizzy Spells	
		Irritability	
		Depression	
		Memory Loss	
		Loss of Sleep	
		Headache	
		Apprehension	

P	N		PN
		Muscle Pain	
		Muscle Weakness	
		Muscle Cramps	
		Joint Stiffness	
		Joint Tenderness	
		Spinal Curvature	
		Back Pain	
		Hot Joints	
		Joint Swelling	
		Stiff Neck	
		Soreness	
		Lumps	
		Masses	

P	N		PN
		Seizures	
		Vertigo	
		Dizziness	
		Tremors	
		Loss of Sensation	
		Loss of Coordination	
		Weak Grip	
		Paralysis	
		Difficulty of Speech	
		Tingling	
		Numbness	

P	N		PN
		Animal Dander	
		Latex	
		Food Allergies	
		Penicillin	
		Pollen	
		Second Hand Smoke	
		Grasses	
		Sulfa Drugs	
		Dairy Products	
		Perfumes	
		Hay	

FOR DOCTOR'S USE ONLY – PLEASE PROCEED TO PAGE 4

Check additional form for additional Review of Systems
OPTION FOR ESTABLISHED E & M SERVICES OR SHARED COMMON FILE

_____Previous Review of Systems reviewed. Date of previous Review of Systems was: _____/_____/_____

System Reviewed

_____Constitutional _____Musculoskeletal _____Neurological _____Allergic

_____Other, please note: _____

_____No change in systems review

_____Previous Past History reviewed and updated. Date of Past History update: _____/_____/_____

_____No change in Past History _____See old Past History for changes

_____Previous Social History reviewed and updated. Date of Social History updated: _____/_____/_____

_____No change in Social History _____See old Social History for changes

_____Previous Family History reviewed and updated. Date of Family History updated: _____/_____/_____

_____No change in Family History _____See old Family History for changes

Doctor Signature: _____

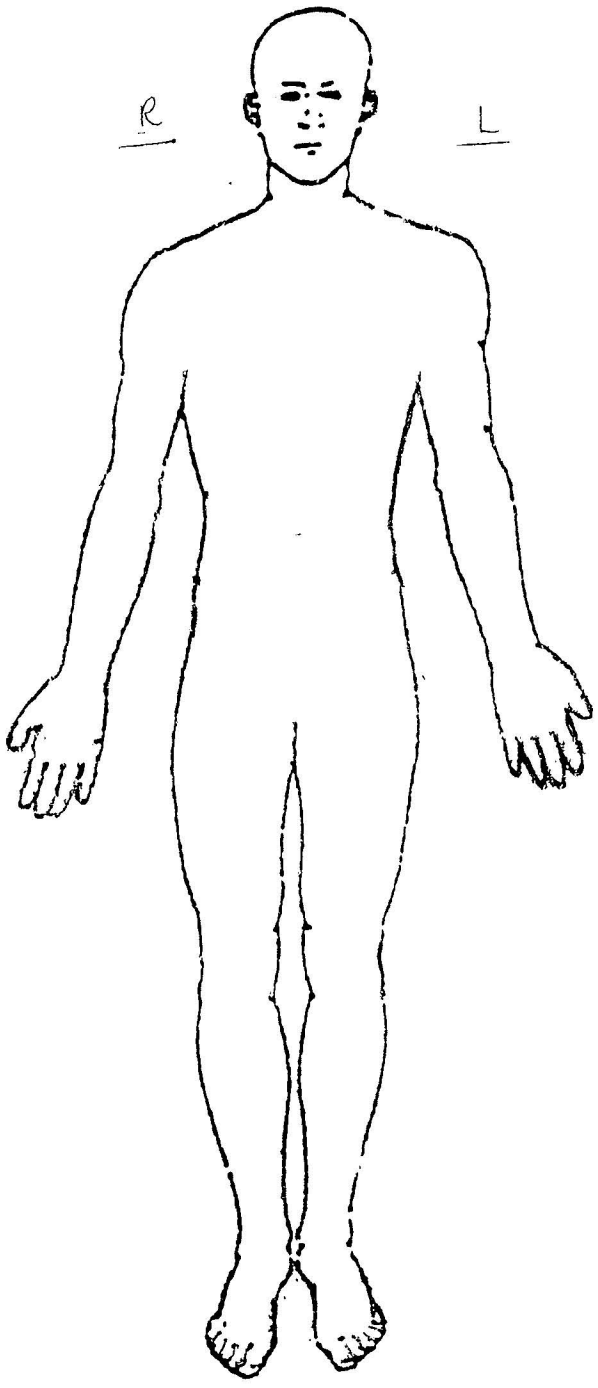
Patient Signature: _____

dallas wellness center

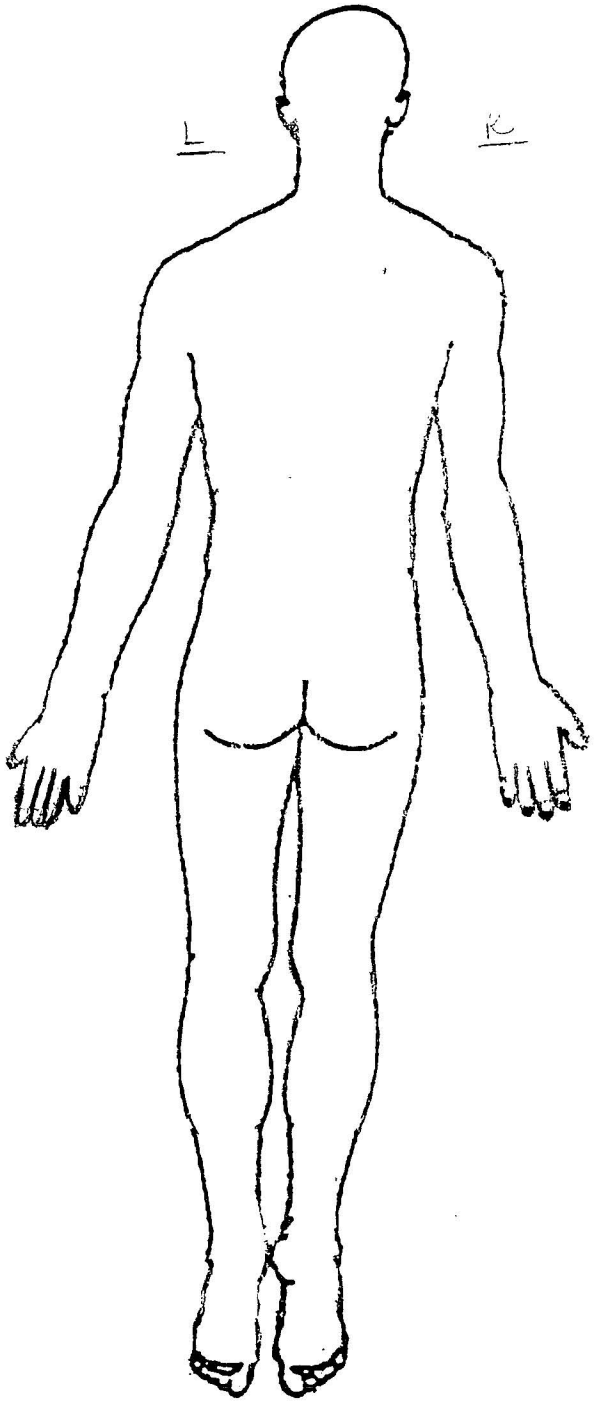
dallaswellnesscenter.com
214.965.9355

Patient Name: _____ Date: _____

Put a **"X"** or a **"Circle"** where your pain is. Thank You!



FRONT SIDE



BACK SIDE