Restoration Health INTEGRATED CARE PROVIDER

PATIENT REGISTRATION FORM

Please Print

DOS: _____

Patient Name (First, Middle, Last) _____ Date of Birth: _____

Preferred Name: _____ Gender: ☐ *Male* ☐ *Female* | Marital Status: ☐ *Married* ☐ *Single* ☐ *Child* ☐ *Divorced* ☐ Widow

Referred by: _____

If child, List Mother's Name: _____ Father's Name: _____

Patient's Home Address: _____ City: _____ State: _____ Zip: _____

Cell #: _____ Home #: _____ Email: _____

Occupation: _____ Employer Name: _____

Emergency Contact: _____Phone #:_____ Relationship: ☐ Spouse ☐ Other

Primary Care Physician: _____

GUARANTOR/ RESPONSIBLE PARTY: ☐ Check if same as patient

Name: _____ Date of Birth: _____ Relationship: Spouse Other

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ ☐ Cell ☐ Home DL #: _____ State: _____ Employer:

_____ Phone: _____ SS#: _____

Primary Insurance: (provide copy of card)

Insurance Company: _____ Phone #: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Subscribers Name: _____ ID#:_____ Grp #/Name:_____

Date of Birth: _____ Last four of SS#: _____

Secondary Insurance: (provide copy of card)

Insurance Company: _____ Phone #: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Subscribers Name: _____ ID#:_____Grp #/Name:_____

Date of Birth: _____ Last four of SS#: _____

Assignment of Benefits

I hereby assign all medical benefits and hereby authorize my insurance carrier, including Medicare, private insurance, and any health plan, to issue payment(s) directly to EH Medical, PLLC for medical services rendered to myself and/or my dependents. I understand that ultimately, I am responsible for any amount(s) not covered by insurance. I hereby authorize EH Medical, PLLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims, pursue appeals on denied or partially paid claims that are generated in the course of examination or treatment. A photocopy or scan of this document is considered as valid as the original. This order will remain in effect until revoked by me in writing.

Printed Name: _____ Relationship to Patient: _____

Signature of Patient/Guardian: _____ DOS: _____

Restoration Health INTEGRATED CARE PROVIDER

PAST & CURRENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____ DOS: _____

Primary Compliant: _____

Secondary Complaint: _____

Please indicate Left or Right or circle Both when applicable and specify whether pain or stiffness:

Musculoskeletal & Extremities:

			FREQUENCY		
Head/Shoulders feels Heavy/Tired	Left	Right	Intermittent	Frequently	Constantly _____
Neck Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly _____
Upper Back Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly _____
Mid Back Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly _____
Lower Back Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly _____
Hip Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly _____
Sciatica	Left	Right	Intermittent	Frequently	Constantly _____
Pain with Cough or Sneeze	Left	Right	Intermittent	Frequently	Constantly _____
Strain with Bowel Movement	Left	Right	Intermittent	Frequently	Constantly _____
Jaw Pain/Clicking/Popping	Left	Right	Intermittent	Frequently	Constantly _____
Shoulder Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly _____
Arms - Numb/Ting/Pain	Left	Right	Intermittent	Frequently	Constantly _____
Elbow - Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly _____
Wrist - Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly _____
Hands/ Fingers - Numb/Tingling / Pain	Left	Right	Intermittent	Frequently	Constantly _____
Legs - Numb/Tinging/Pain	Left	Right	Intermittent	Frequently	Constantly _____
Knee Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly _____
Foot/Ankle - Pain/Stiffness	Left	Right	Intermittent	Frequently	Constantly _____
Feet/Toes - Numb/Tingling/Pain	Left	Right	Intermittent	Frequently	Constantly _____

Review of Symptoms: (please check all that apply) ☐ **NOT APPLICABLE**

Constitutional:	☐ Fever / Chills	☐ Fatigue	☐ Night Sweats	☐ Other_____
HEENT:	☐ Facial Swelling	☐ Nosebleeds	☐ Visual Disturbance	☐ Other_____
Cardiovascular:	☐ Chest Pain	☐ Leg Swelling	☐ Other_____	
Respiratory:	☐ Shortness of Breath	☐ Chest Tightness	☐ Other_____	
Gastrointestinal:	☐ Blood in Stool	☐ Constipation	☐ Diarrhea	☐ Digestive Issues
Genitourinary:	☐ Difficulty urinating	☐ Pain when urinating	☐ Blood in urine	☐ Other_____
Neurological:	☐ Numbness	☐ Limb/Muscle Weakness	☐ Balance Issues	☐ Other_____
Hematologic:	☐ Bruising	☐ Easy Bleeding	☐ Other_____	
Psychological:	☐ Confusion	☐ Nervous/ Anxiousness	☐ Suicide Open	☐ Other_____
Skin:	☐ Changes in skin color	☐ Rashes/ Lesions	☐ Wounds	☐ Other_____
Allergic/ Immunologic:	☐ Hay Fever	☐ Allergies to new food/ clothes/medication	☐ Other_____	

Patient SIGN: _____ DOS: _____

Provider Signature:
Jimmy Labrecque, DC

Date Reviewed: _____

Restoration Health INTEGRATED CARE PROVIDER

PATIENT HEALTH HISTORY (continued...)

Patient Name: _____ Date of Birth: _____ DOS: _____

General Health Issues:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Asthma
- ☐ Balance Issues
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Blood Clots
- ☐ Cancer: _____
- ☐ Chemical Dependency
- ☐ Diabetes- Type:_____
- ☐ Digestive Issues

☐ **NO SIGNIFICANT MEDICAL HISTORY**

- ☐ Emphysema/ COPD
- ☐ Epilepsy
- ☐ Feeling Foggy
- ☐ Fatigue
- ☐ Fibromyagia
- ☐ Fractures Glaucoma
- ☐ Gout
- ☐ Gallbladder
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disk
- ☐ High /Low Blood Pressure
- ☐ High Cholesterol
- ☐ Headache/Migraines
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker as of:_____
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease
- ☐ Pinched Nerve
- ☐ Polio
- ☐ Prostate Issues
- ☐ Prosthesis
- ☐ Rheumatic Arthritis
- ☐ Stroke
- ☐ Sleep Apnea
- ☐ Thyroid Issues
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers
- ☐ Whooping Cough
- ☐ Other:_____ _____ _ _____

Previous Hospitalizations/Surgeries History: *(please indicate a date to your surgery)*

☐ **NO SURGERY HISTORY**

- ☐ Arthroscope (circle)- Hip / Knee / Shoulder / Other:_____ Right | Left
- ☐ Brain Surgery: _____
- ☐ Breast Surgery: _____
- ☐ Heart Bypass: _____
- ☐ Gall Bladder Removed: _____
- ☐ Colon Surgery: _____
- ☐ Cosmetic Surgery: _____
- ☐ Fracture Surgery: _____ *Location*
- ☐ Gastric Bypass/Banding: _____
- ☐ Hip Replacement: _____
- ☐ Hysterectomy (circle) - Full / Partial : _____
- ☐ Knee Replacement(circle) - Right / Left : _____ *Date*

Knee Brace: N Y- _____ Date & Given by who?

- ☐ Kidney Stone Surgery:_____
- ☐ Prostate Surgery :_____
- ☐ Spine Surgery: _____ *Date* | _____ *Type*

Back Brace: N Y- _____ Date & Given by who?

- ☐ Tonsil/ Adenoid Surgery: _____
- ☐ Valve Replacement Surgery:_____
- ☐ Other: _____ _____

Patient/Guardian Signature: _____ DOS: _____

_____ _____

Provider Signature: Jimmy Labrecque, DC **Date Reviewed:**

Restoration Health INTEGRATED CARE PROVIDER

PATIENT HEALTH HISTORY (continued...)

Patient Name: _____ Date of Birth: _____ DOS: _____

Family Medical History ***(circle all that apply)*** **Living / Deceased**

FATHER:	Heart	Cancer	Diabetes	High/Low Blood Pressure	Other: _____	Living	Deceased
MOTEHR:	Heart	Cancer	Diabetes	High/Low Blood Pressure	Other: _____	Living	Deceased
SIBLING:	Heart	Cancer	Diabetes	High/Low Blood Pressure	Other: _____	Living	Deceased

Social History & Lifestyle (please check box)

Use of Alcohol	☐ Daily	☐ 1-2 x week	☐ Socially	☐ N/A	Other: _____
Recreational Drugs	☐ Daily	☐ 1-2 x week	☐ Socially	☐ N/A	Other: _____
Smoking	☐ Daily	☐ 1-2 x week	☐ Socially	☐ N/A	Other: _____
Caffiene	☐ Daily	☐ 1-2 x week	☐ Never	☐ N/A	Other: _____
Exercise	☐ Daily	☐ 1-2 x week	☐ Never	☐ N/A	Other: _____

Medications *(include non-prescription)* ☐ **NO MEDICATION**

1. _____ Dosage: _____ Frequency: _____
2. _____ Dosage: _____ Frequency: _____
3. _____ Dosage: _____ Frequency: _____
4. _____ Dosage: _____ Frequency: _____
5. _____ Dosage: _____ Frequency: _____
6. _____ Dosage: _____ Frequency: _____

Allergies *(include all known allergies; food, medication, environmental)* ☐ **NO KNOWN ALLERGIES**

1. _____ *Reaction:* _____
2. _____ *Reaction:* _____
3. _____ *Reaction:* _____
4. _____ *Reaction:* _____

Vitamins/ Supplements *(include brands)* ☐ **NO SUPPLEMENTS**

1. _____
2. _____
3. _____
4. _____
5. _____

Patient/Guardian Signature: _____ DOS: _____

Provider Signature:
Jimmy Labrecque, DC

Date Reviewed:

Restoration Health INTEGRATED CARE PROVIDER

Patient Rights & Responsibilities

Pt. Name: _____ Date of Birth: _____ Appointment Date: _____

Patients have the RIGHT

- to be treated with dignity and respect.
- to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- to have their treatment and other patient information kept private. Only by law may records be released without patient permission.
- to access care easily and in a timely fashion.
- to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- to share in developing their plan of care.
- to the delivery of services in a culturally competent manner.
- to information about the organization, its providers, services, and role in the treatment process.
- to information about provider work history and training.
- to information about clinical guidelines used in providing and managing their care.
- to know about advocacy and community groups and prevention services.
- to freely file a complaint, grievance, or appeal, and to learn how to do so.
- to know about laws that relate to their rights and responsibilities.
- to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities.

Patients have the RESPONSIBILITY

- to treat those giving them care with dignity and respect.
- to give providers the information they need, in order to provide the best possible care.
- to ask their providers questions about their care.
- to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
- to let their provider know when the treatment plan no longer works for them.
- to tell their provider about medication changes, including medications given to them by others.
- to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- to let their provider know about their insurance coverage, and any changes to it.
- to let their provider know about problems with paying fees.
- to report fraud and abuse.
- to openly report concerns about quality of care.
- to let their provider know about any changes to their contact information (name, address, etc).

Patients have the RIGHT and the RESPONSIBILITY to understand and help develop plans and goals to improve their health.

Printed Name: _____ Relationship to Patient: _____

Signature of Patient/Guardian: _____ DOS: _____

7948 Davis Blvd. Ste 200 North Richland Hills, TX 76182 Phone: (817) 577-6061 Fax: (817) 577-2345

Restoration Health INTEGRATED CARE PROVIDER

HIPAA Privacy Authorization Form

Patient Name: _____ Date of Birth: _____ Appointment Date: _____

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

This authorization affects your rights regarding the privacy of your personal healthcare information. You have the right to receive a copy of this HIPAA Privacy Authorization Form. **Please read it carefully before signing.**

Disclosure of Protected Health Information

☐ I do not authorize this office to discuss or release my medical records or private information to anyone, including family members, or any entity.
***This option is not available for our minor patients; we must have written documentation indicating the adult caregiver(s) with whom we may discuss the child's care.**

☐ I hereby authorize and give permission to this office to use and/or disclose my protected health information described below for the purpose(s) of treatment and care to the family member(s) or friend(s) listed below:

Person #1:_____ Relationship: _____

☐ I hereby authorize the release of my **COMPLETE** Health Record to the individual listed above
☐ I hereby authorize the release of my **PARTIAL** Health Record to the individual listed above.
Exclusions: Mental health records, Communicable , Alcohol/drug abuse treatment ; Other: _____

Person #2:_____ Relationship: _____

☐ I hereby authorize the release of my **COMPLETE** Health Record to the individual listed above
☐ I hereby authorize the release of my **PARTIAL** Health Record to the individual listed above.
Exclusions: Mental health records, Communicable , Alcohol/drug abuse treatment ; Other: _____

Patient Communication.

I understand the office must use one or more means of communication to keep me informed on all matters which relate to my treatment, appointments, billing/financial, feedback requests, and office operations and notifications.

☐ I hereby authorize the office to communicate with me via text, phone calls, email, and postal mail

☐ I do not authorize the office to contact me at my work, SMS text or email

This authorization shall be in force until properly revoked by me at which time this authorization expires.
To revoke my authorization, I must submita Revocation of Authorization Notice to this office. Attn: Medical Records Manager.
This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct or as permitted by law.
EH Medical, PLLC and its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that information used or disclosed according to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA, federal or state law.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be affected by my signing/not signing this release.

Printed Name:_____ Relationship to Patient: _____ Date of Appointment:

Signature of Patient/Guardian:_____ _____

Restoration Health INTEGRATED CARE PROVIDER

X-Ray Explanation & Consent

Pt. Name: _____ Preferred Name: _____ DOB: _____ Appointment Date: _____

The purpose of x-rays taken in this office are to analyze and diagnose potential conditions requiring medical treatment.

By signing below, I understand that the doctor examining and analyzing the x-rays will meet with me (the patient or patient's representative) at a later date to discuss any and all findings. If I am informed of any "unusual finding" during the review of the x-rays, I understand that I must then make a determination to seek additional advice, diagnosis, or treatment for said "unusual finding".

FEMALE

Consent to evaluate(please check box):

MINOR

Pregnancy Release:

- ☐ Minor child's first day of last menstrual cycle was on _____ (date)
- ☐ Minor child is NOT pregnant
- ☐ Minor child's has not begun this reproductive process

I, Parent/Legal Guardian, of child, hereby acknowledge the necessity for diagnostic x-rays and grant permission for my child to receive such necessary diagnostic x-rays.

ADULT WOMAN

Pregnancy Release:

- ☐ First day of my last menstrual cycle was on _____ (date)
- ☐ I am not pregnant
- ☐ I am no longer subject to this reproductive cycle

MALE

Consent to evaluate(please check box):

	MINOR *ADULT*
Initial: _____	I hereby acknowledge the necessity diagnostic x-rays and consent receive such necessary diagnostic x-rays.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I, therefore, do hereby consent to have the diagnostic x-ray examination my healthcare provider has deemed necessary in my minor child's case

Printed Name: _____ Date of Appointment: _____

Patient Signiture: _____

Relationship to Patient: (please circle) Mother Father Legal Guardian Self

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Restoration Health INTEGRATED CARE PROVIDER

Informed Consent

Pt. Name: _____ Preferred Name: _____ DOB: _____ Appointment Date: _____

Consent to Treat

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care and therapeutic exercises centrally involve what is known as a chiropractic adjustment and active stretching and strengthening. We use our hands, or an instrument, to reposition anatomical structures such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological function and overall well-being. It is important that you understand, as with all types of health care approaches, results are not guaranteed and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including but not limited to: muscle spasms, aggravating and/or temporary increase of symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related to 1 in 1,000,000 to 1 in 2,000,000 cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1,219 events per 1,000,000 persons per year and the risk of death has been estimated as 104 per 1,000,000 users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

My signature below represents that:

- I have read, or have had read to me, the above consent.
- I appreciate that it is not possible to consider every possible complication to care.
- I have also had an opportunity to ask questions about this consent and, by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance.
- I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.
- I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor(s) of chiropractic practicing at this facility now, or in the future.
- I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. Additionally, the explained the risks associated with my refusal of treatment have been discussed with me by a licensed provider of this facility.

Date of Appointment:

Signature of Patient/Guardian: _____ _____

Printed Name: _____ Relationship to Patient: _____

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Restoration Health INTEGRATED CARE PROVIDER

Office Insurance Policy

Pt. Name: _____ Preferred Name: _____ DOB: _____ Date: _____

Office Insurance Policy

Our office is pleased to accept your insurance to cover a portion of your care. We will file your claim and assist you in every way that we can. However, it must be fully understood that the contract is between you and your insurance company. You are fully responsible for all charges incurred at this office whether or not covered or paid by your insurance company.

1. Since by taking your insurance on assignment we have to wait for payment. This courtesy may be withdrawn at any time. By accepting your insurance, our office is granting credit. In the event of default to pay, insurance or patient fees, reasonable collection charges or attorney fees will be forwarded to the patient.

2. Our office does not guarantee that your insurance will pay. We will make every attempt at the beginning of your care to verify your insurance coverage. If for some reason your insurance claim is denied after our attempts to recover the compensation for services rendered to you, you will be responsible for the full amount of your bill.

3. Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.

4. Only the functional care amount will be billed to the insurance company. Most insurances companies do not cover all charges or the full amount of the charges.

5. The office manager, patient, and/or guardian must sign, in advance, all special arrangements regarding finances. You are responsible for paying your portion of the care plan on the specified dates listed on the financial care agreement.

6. All x-rays and patient records are to remain permanent record of this office. The fee paid for treatment x-rays is for analysis only. The film itself is property of this office.

I understand and agree that health & accident insurance policies are an arrangement between me & an insurance company. Furthermore, I understand that this office will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that I am personally responsible for payment of all services rendered to me. I also understand that if I suspend or terminate care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. Furthermore, I authorize this office to obtain a credit report if deemed necessary.

Date of Appointment:

Signature of Patient/Guardian:_____ _____

Printed Name:_____ Relationship to Patient: _____