PURE WELLNESS CHIROPRACTIC

4637 Hedgcoxe Rd
Suite 110
Plano, TX 75024
972-491-1400

PATIENT INFORMATION

Date: ___/___/___ Male: ____ Female: ____

Name: _____

Preferred to be called: _____ Mr. Mrs. Ms. Miss Dr.

Birthdate: ___/___/___ Age: _____ SS#: _____-____-_____ DL#: _____

Home Address: _____ City: _____ Zip Code: _____

Single: ___ Married: ___ Divorced: ___ Separated: ___ E-Mail: _____

Hm#: _____ Cell#: _____ Work#: _____

Where and when are the best times to reach you? _____

Employer: _____ # of Years Employed: _____

Occupation: _____ Employer Address: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

_____

GUARANTOR INFORMATION

Name: _____ Relation to patient: _____

Insurance Provider: _____

Hm#: _____ Cell#: _____ Work#: _____

Employer: _____ Employer Address: _____

# of Years Employed: _____ Birthdate: ___/___/___ SS#: _____-_____-_____

EMERGENCY NOTIFICATION INFORMATION

In the event of an emergency, is there someone who lives near you and/or a physician we can contact?

Name: _____ Relation to patient: _____

Hm#: _____ Cell#: _____ Work#: _____

Physician: _____ Office#: _____

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HEALTH CARE AUTHORIZATION FORM

Patient Name _____

Patient SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **PURE WELLNESS CHIROPRACTIC** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

****** I give permission to Pure Wellness Chiropractic to use my address, phone numbers, and clinical records to contact me with birthday cards, holiday related cards, thank you notes, recall cards, informational e-mail, and information about alternative treatments or other health related information.

****** By Signing this form you are giving the chiropractic offices of Pure Wellness Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to Dr. Mary Surkein, the privacy official of Pure Wellness Chiropractic. The written notice must contain the following information:

A. Your name, social security number and date of birth
B. A clear statement of your intent to revoke this AUTHORIZATION
C. The date of your request, and your signature

The revocation is not effective until it is received by the privacy official. Pure Wellness Chiropractic requests this AUTHORIZATION. If you refuse this AUTHORIZATION, Pure Wellness Chiropractic will not refuse to provide treatment. You have the right to inspect or copy the PHI to be used/disclosed.

A COPY OF THIS AUTHORIZATION WILL BE PROVIDED FOR YOU

Patient Name _____

Signature _____

Date _____

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INFORMED CONSENT TO CHIROPRACTIC CARE

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

A. While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.

B. There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.

C. There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused by spinal adjustments or chiropractic treatment. Chiropractic treatment, including spinal adjustment has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall wellbeing. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

Patient Signature (or Legal Guardian)_____

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Assignment of Benefits/ Contractual Lien/ Assignment of Cause of Action

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to Mary Surkein, D.C., 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 adjuster for purposed of processing my claim for benefits and payment of serviced 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, or 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 the 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, you are hereby tendered demand to pay in full the bill for services rendered the physician/facility named above within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to 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 Pure Wellness Chiropractic, and to send all checks to 4637 Hedgcoxe Rd, Suite 110, Plano TX 75024.

THIRD PARTY LIABILITY: 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 the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment form any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing and 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.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep my appointments as recommended to me by my caring doctor at the 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 that failure to do so may jeopardize my case.

Signature of patient and/or responsible parties: _____ Date _____

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Health Questionnaire

Where are you hurting today?

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

What is the cause of your pain? _____

Rate your pain: (1= not severe 10= very severe) 1 2 3 4 5 6 7 8 9 10

List any doctors seen for this condition: _____

Did you receive any treatment and if so what treatment: _____

_____

Have you had similar symptoms before? Y or N If yes, explain: _____

Have you had chiropractic treatment previously? Y or N If yes, where: _____

Are you currently taking any medications? Y or N If yes, then list: _____

_____

Have you been hospitalized? Y or N If yes, explain: _____

List any surgeries: _____

What are your health goals? Monthly: _____

Yearly: _____

Do you have a desire to lose weight? _____ Do you have trouble with weight loss? _____

If yes, what have you tried that has failed? _____

_____

Habits	Exercise	Family History				
			Diabetes	Heart	Kidney	Cancer
○ Smoking Packs/Day____	○ None	Mother	__	__	__	__
○ Alcohol Drinks/Day____	○ Moderate	Father	__	__	__	__
○ Coffee Cups/Day_____	○ Daily	Brother # __	__	__	__	__
		Sister # __	__	__	__	__

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Please mark if you currently or previously have had the following symptoms:

General Symptoms	Cardiovascular	Muscle and Joints	Skin and Allergies
○ Convulsions ○ Dizziness ○ Fainting ○ Headache ○ Nervousness ○ Numbness ○ Wheezing	○ Blood Pressure ○ Pain Over Heart ○ Poor Circulation ○ Heart Trouble ○ Rapid Heart ○ Slow Heart ○ Strokes ○ Swelling Ankles ○ Varicose Veins	○ Low Back Problems ○ Pain Btwn Shoulder Blades ○ Neck Problems ○ Arm Problems ○ Leg Problems ○ Swollen Joints ○ Stiff Joints ○ Sore Muscles ○ Weak Muscles ○ Walking Problems ○ Ruptures ○ Broken Bones	○ Boils ○ Bruising Easily ○ Dryness ○ Eczema ○ Hives ○ Itching ○ Sensitive Skin ○ Allergies: ○ _____ ○ _____ ○ _____

Gastrointestinal	Urinary	For Women Only
○ Belching/Gas ○ Colon Trouble ○ Constipation ○ Diarrhea ○ Excessive Hunger ○ Excessive Thirst ○ Hemorrhoids ○ Liver Trouble ○ Nausea ○ Pain Over Stomach ○ Poor Appetite ○ Poor Digestion ○ Vomiting ○ Bloody Stool ○ Weight Trouble	○ Blood In Urine ○ Frequent Urination ○ Kidney Infection ○ Painful Urination ○ Prostate Trouble ○ Bladder Trouble	○ Cramps/Backaches ○ Excessive Flow ○ Hot Flashes ○ Irregular Cycle ○ Miscarriage ○ Painful Periods ○ Vaginal Discharge ○ Breast Pain ○ Pregnant At This Time

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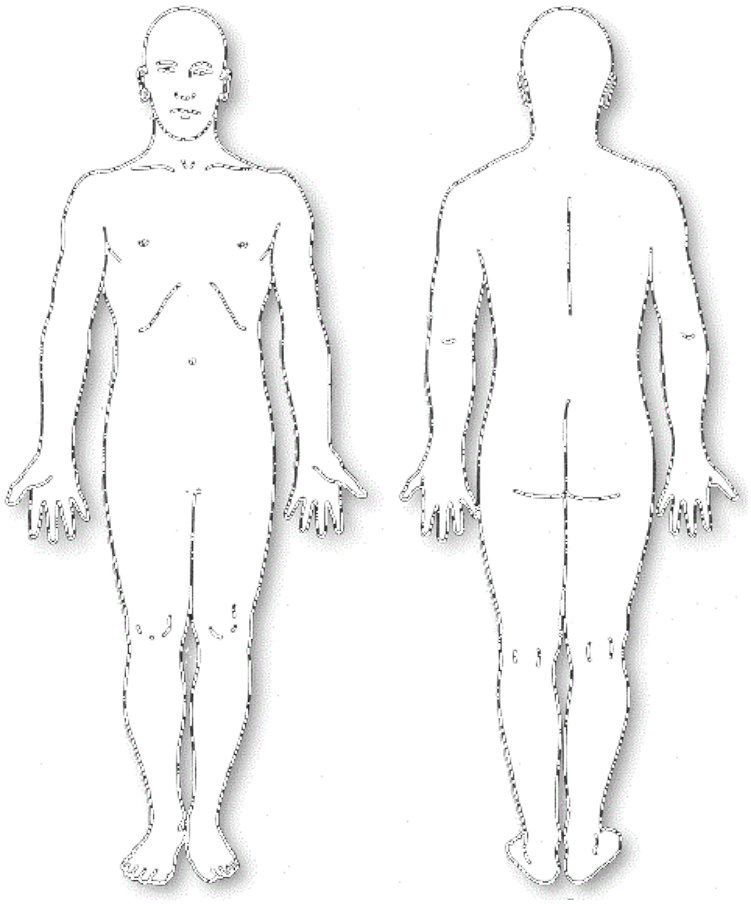
Please mark areas & types of pain on the following drawing using the codes listed below
N- Numbness T-Tingling S- Soreness P- Pain A- Ache St- Stiffness



I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any account authorized to be paid directly to the doctor's office will be credited to any account or receipt. However, I clearly understand and agree that all services rendered 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.

I hereby authorize the doctor to examine and treat any condition as he deems appropriate through the use of Chiropractic Health Care and I give authority to these procedures to be performed. It is understood and agreed the amount paid to the doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

_____ _____

Patient's / Guardian's Signature Date

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Appointment Agreement

Please understand that when an appointment is scheduled for you, a specific time is set aside and reserved for you on the master schedule.

Failure to cancel without appropriate notice prevents us from filling vacancies in our schedule and often prevents patients in need from receiving necessary treatment. We are here to help you and all our patients receive the very best care in a timely manner. We do understand that things come up from time to time unexpectedly, so we just ask for a phone call to help assist you and our other patients.

I understand and agree to the following:

1) **It is my responsibility to notify at least 24 hours prior to my scheduled appointment if I am unable to keep my scheduled appointment.**
2) **I agree that I will be charged $25.00 in the event that I miss an appointment and fail to cancel 24 hours prior to the scheduled appointment.**
3) **I agree that if I am more than 15 minutes late for my appointment, that my appointment will be considered "missed" and I will be charged $25.00.**

Patient Name _____

Patient Signature _____

Date _____

Thank you so very much. Know that is an honor to serve you!

-Dr. Mary Surkein, D.C.