Houston Regenerative Therapy

947 Gessner Rd #A250 Houston, TX 77024 Phone: (713) 587-0900 Fax: (832) 831-9061

Patient Intake

GENERAL INFORMATION

Name: __________________ DOB: __________________ Age: ____ Gender: M F

Home Address: __________________ City: ___________ State: _________ Zip: ______

Home Phone: ___________ Cell Phone: ___________ Email Address: _______________

Marital Status: S M D

Spouse's Name: __________________________

Children's Names: _________________ Age: ____ Name: _________________ Age: ___

EMERGENCY CONTACT

Name: ____________________ Relationship: _____________ Phone: ________________

How were you **referred** to our office?______________________________________

DOCTOR INFORMATION

Name of Primary Care Doctor/Clinic: ____
Phone Number: ________________________________

Name of specialist/Clinic: ____________________________________
Phone Number: __________________________

Name of specialist/Clinic: ____________________________________
Phone Number: __________________________

Please list your conditions that you want help from us. List most important to the least.

1.______________________________ How long?_______ Getting worse? Y N

2.______________________________ How long?_______ Getting worse? Y N

3.______________________________ How long?_______ Getting worse? Y N

4.______________________________ How long?_______ Getting worse? Y N

5.______________________________ How long?_______ Getting worse? Y N

Please list all medications you are currently taking.

____

Please list all supplements you are currently taking. (vitamins, minerals, herbs)

____

Please list all major surgeries you have had (type & date)

____

Please list any allergies to medication or food.

____

Please CHECK if you have any of the following that applies:

Alcohol Cigarettes Drug Usage

HEALTH HISTORY

Are you currently experiencing any of the following conditions:

Pacemaker	Herniated Disc	Thyroid Problems	Arthritis
Diabetes	Heart Disease	Osteoporosis	Anemia
Cancer	High Blood Pressure	Liver Disease	Goiter
Stroke	High Cholesterol	Kidney Disease	Ulcers
Migraines	Multiple Sclerosis	Rheumatoid	Epilepsy
Arthritis	Prostate Problems	Aids/HIV	Asthma
Fatigue	Blurred Vision	Chest Pain	Cold Sweats
Depression	Stomach Problems	Loss of Taste	Loss of Smell
Memory Loss	Sudden Weight Loss	Constipation	Nausea
Eczema	Sleeping Difficulties	Cold Feet	Dizziness
Nervousness	Shortness of Breath		

I hereby certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient’s Name _________________________

Patient’s / Guardian’s Signature __________________ Date _______________

Patient's Name

Patient Quality Of Life Survey

Please take several minutes to answer these questions so we can help you get better.

(Please circle as many that apply)

How have you taken care of your health in the past?

- Medications
- Emergency Room
- Routine Medical
- Exercise
- Nutrition/Diet
- Holistic Care
- Vitamins
- Chiropractic

How did the previous method(s) work out for you?

- Bad results
- Some results
- Great results
- Nothing changed
- Still trying
- Frustrated

How have others been affected by your health condition?

- No one is affected
- Haven't noticed any problem
- They tell me to do something
- People avoid me

What are you afraid this might be (or beginning) to affect (or will affect)?

- Job
- Kids
- Future ability
- Marriage
- Self-esteem
- Sleep
- Time
- Finances
- Freedom

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

____

What has that cost you?

Time **Money** **Happiness** **Freedom** **Sleep**

What are you most concerned with regarding your problem?

____

What would be different/better without this problem? Please be specific

____

What do you desire most to get from working with us?

____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

____

What would it mean to you if we have a solution for you?

____

Yes I want you to help me improve my over all health!

Yes I want you to help me with my weight!

____

RADIOGRAPH CONSENT

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition.

By signing below, you give your consent to allow Houston Regenerative Therapy, LLC and its representatives, as deemed by the examining physician to take radiographs of your spine and/or extremities. I also hereby declare that to my knowledge that I am not pregnant (Female Only)

Patient's Name: ____________________________________

Signature of Patient / or Guardian of said Minor: _______________________ Date: ___________

CONSENT TO EVALUATE AND TREAT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended Chiropractic, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. I understand that results are not guaranteed. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (Chiropractor, Nurse Practitioner, or Physician Assistant), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I Understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to muscle strain, cervical myelopathy, disc and vertebral injury, bruises, fractures, dislocations and sprains. Rare complications include, but not limited to stroke; electric stimulation - skin irritation and electrical burn; ultrasound - periosteal burn and skin irritation; tapotement - skin irritations and bruises. I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

Patient's Name: _______________________________

Patient's / Guardian's Signature: ________________________________ Date: _________________

FINANCIAL AUTHORIZATION

I also clearly understand that if I do not follow the Doctors and/or physician's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I understand in the event my account goes to collections, I am responsible for any and all collections fees.

I understand that I am financially responsible for all fees incurred for the services provided, regardless of any applicable insurance or benefit payments, and I agree to ensure full payment. 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.

NAME OF GUARANTOR (person responsible for guaranteeing payment for all services)

____

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.

Patient's Name: _____________________________

Patient's / Guardian's Signature: ______________________________ Date: ________________

Minor's Name: ________________________

Guardians Signature of Authorizing care for minor: ________________ Date: ________________

I hereby authorize Houston Regenerative Therapy, LLC to administer care as deemed necessary to my child, a minor under the age of 18 years old.

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT & CONSENT (CONSENT TO USE PHI)

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Houston Regenerative Therapy, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below, I give my permission to use and disclose my health information as stated in the notice of privacy practices.

Patient's Name: ______________________________

Patient or Legally Authorized Individual Signature: _______________________ Date: ___________

Houston Regenerative Therapy

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Photo Consent and Release Form

Without expectation of compensation or other remuneration, now or in the future, I hereby give my consent to Houston Regenerative Therapy, its affiliates, and agents, to use my image and likeness and/or any interview statements from me in its publications, advertising or other media activities (including the Internet). This consent includes, but is not limited to:

(a) Permission to interview, film, photograph, tape, or otherwise make a video reproduction of me and/or record my voice;

(b) Permission to use my name; and

(c) Permission to use quotes from the interview(s) (or excerpts of such quotes), the film, photograph(s), tape(s) or reproduction(s) of me, and/or recording of my voice, in part or in whole, in its publications, in newspapers, magazines and other print media, on television, radio and electronic media (including the Internet), in theatrical media and/or in mailings for educational and awareness.

By signing the below, I affirm that I am at least 18 years old and I have read and understand the above. This consent is given in perpetuity and does not require prior approval by me.

Patient's Name: ____________________________

Signature: ________________________________ **Date:** __________________

The below signed parent or legal guardian of the above-named minor child hereby consents to and gives permission to the above on behalf of such minor child. Minor is any child under the age of 18.

Patient's Name: ____________________________

Signature of Parent or Legal Guardian: __________________________________