ELEVANI HEALTH GROUP, PLLC
NEW PATIENT PAPERWORK

Dear Patient:

Welcome to our clinic.

This office is a multidisciplinary doctor group. We have done this for various reasons, with the most important one being that our facility can enjoy a more comprehensive approach to your health by utilizing an integrative health care model. This means the incorporation of Medical and Chiropractic personnel, who are directly involved in your healthcare, into our scope of various services. As such, certain services and diagnostics will be administered, when clinically warranted, and billed under Elevani Health Group. As such, when you receive your explanation of benefits from your health insurance company, it will indicate the date of services and procedure codes and payments made to Elevani Health Group.

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PATIENT INFO

Name: _____
(LAST) (MI) (FIRST)

Address: _____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: Work Phone: Cell Phone:

Email Address:

DOB: / / Soc. Sec # : - -

Marital Status: S M W Spouse's Name:

Your Employer: Occupation:

Referred By:

Number:

Primary Care Physician:

PCP Phone

Name of Clinic:

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name:

Member # Group #:

Insurer's Name (If Different From Patient): Relationship to Patient:

Insurer's DOB: / Insurer's Soc. Sec #: - -

Insurer's Employer:

Person responsible for account:

I clearly understand and agree that all services rendered to me 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.

Patient/Guardian Signature **Date:**

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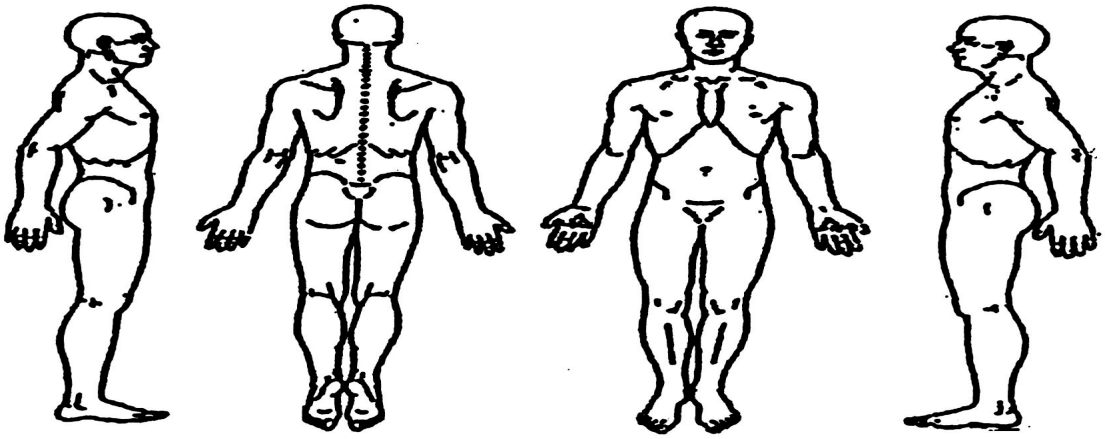
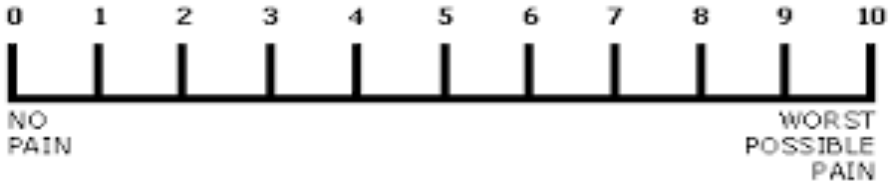
Patient Name:_____ Date: _____

1. Indicate on the drawings below where you have pain/symptoms:



2. How would you describe the type of pain?

- □ Sharp
- □ Dull
- □ Diffuse
- □ Achy
- □ Burning
- □ Shooting
- □ Stiff
- □ Numb
- □ Tingly
- □ Sharp with motion
- □ Shooting with motion
- □ Stabbing with motion
- □ Electric-like with motion
- □ Other: _____



3. How do you think your problem began? _____

4. How often do you experience your symptoms?

- □ Constantly (76-100% of the Time)
- □ Frequently (51-75% of the Time)
- □ Occasionally (26-50% of the Time)
- □ Intermittently (1-25% of the Time)

10. Rate your level of exercise activity:

□ Strenuous □ Moderate □ Light □ None

11. Indicate if you suffer from or have immediate family members with any of the following:

- □ Rheumatoid Arthritis
- □ Heart Problems
- □ Diabetes
- □ Cancer
- □ Lupus
- □ ALS

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12. For the conditions listed below, please check the "past" column if you have had the condition in the past; If you presently have a condition listed below, please check the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Dermatitis/Eczema/Rash
□	□	Diabetes	□	□	Low Blood Pressure	□	□	Excessive Thirst
□	□	Neck Pain	□	□	Heart Attack	□	□	Frequent Urination
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Tobacco Use
□	□	Mid Back Pain	□	□	Stroke	□	□	Drug/Alcohol
□	□	Low Back Pain	□	□	Angina	□	□	Allergies
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Depression
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Systemic Lupus
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Epilepsy
□	□	Hand Pain	□	□	Painful Urination	□	□	HIV/AIDS
□	□	Hip Pain	□	□	Loss of Bladder Control			
□	□	Upper Leg Pain	□	□	Prostate Problems			
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite		**Females Only**	
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			

13. List all prescription and over-the-counter medications and nutritional supplements you are currently taking:

_____

_____

14. Do you have allergies? YES NO

Do you know what you are allergic to? YES NO
If YES, please describe what you are allergic to:

_____

16. List all surgical procedures you have undergone:

_____

_____

17. What activities do you do at work?

Sit	□ Most of the day	□ Half of the day	□ A little of the day
Stand	□ Most of the day	□ Half of the day	□ A little of the day
Computer Work	□ Most of the day	□ Half of the day	□ A little of the day
On the Phone	□ Most of the day	□ Half of the day	□ A little of the day
Drive	□ Most of the day	□ Half of the day	□ A little of the day
Other Activities	□ Perform manual labor	□ Read a lot	□ Travel frequently

18. What activities do you enjoy outside of work?

_____

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19. Have you ever been hospitalized? □ Yes □ No

If yes, why? _____

20. Have you had past trauma such as car accidents (ever?), falls, sports injuries, etc? □ Yes □ No

If yes, what and when? _____

21. Is there anything else you wish to let the doctor know about your visit today? □ Yes □ No

If yes, what? _____

How would you rate your overall health? _____

Chief of Complaint (MAIN CONCERN) _____

Location:_____ (where is the pain/problem?) **Quality:**_____ (ex: normal vs abnormal, activity, ect)

Severity:_____ (how sever is the pain/ problem on a scale Of 1-5 with 5 being the most severe) **Duration:**_____ (how long have you had this pain/ problem? When did it start?)

Timing:_____ (does the pain /problem occur at a specific time) **Context:**_____ (where were you at the onset of this pain/ Problem)

Associated signs/symptoms:_____ (what other associated problems have you been having) **Modifying factors:**_____ (what makes the pain/problem worse or better? Have you had previous episodes?)

Patient Social History:

Marital status	Single:____	Married:	Separated:____	Divorced:____	Widowed:____
Use of alcohol	Never:_____	Rarely:_____	Moderate:_____	Daily:_____	
Use of tobacco	Never:_____	Rarely:	Moderate:_____	Daily:_____	
Use of drugs	Never:_____	Rarely:_____	Moderate:_____	Daily:_____	

Past Medical History

(have you ever had the following: (circle "yes" or "no" leave blank if uncertain **)**

Measles	No Yes	Mumps	No Yes	chicken pox	No Yes
Small pox	No Yes	Scarlet fever	No Yes	Whooping cough	No Yes
Diphtheria	No Yes	pneumonia	No Yes	Rheumatic fever	No Yes
Polio	No Yes	Glaucoma	No Yes	Venereal disease	No Yes
Hernia	No Yes	Infectious mono	No Yes	Bronchitis	No Yes
Tuberculosis	No Yes	Hemorrhoids	No Yes	Hives of eczema	No Yes
Thyroid disease	No Yes	Bleeding Tendency	No Yes	Mitral valves prolepses	No Yes

Blood or plasma transfusion No Yes Date of last chest x-ray _____

INDICATE WHICH OF THE BELOW YOU HAVE EXPERIENCED IN THE LAST 1-2 MONTHS

1=NEVER 2=RARELY 3=OCCASIONALLY 4=FREQUENTLY 5=CONSTANTLY

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EYES/EARS/NOSE/THROAT/RESPIRATORY

Asthma	1 2 3 4 5
Hay fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic cough	1 2 3 4 5
Chest congestion	1 2 3 4 5
Frequent sneezing	1 2 3 4 5
Itchy/watery eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or ear infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

MUSCULAR/SKELETAL

Muscle aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint pain	1 2 3 4 5
Low back pain	1 2 3 4 5
Neck pain	1 2 3 4 5
Wrist/hand pain	1 2 3 4 5
Elbow pain	1 2 3 4 5
Shoulder pain	1 2 3 4 5
Hip pain	1 2 3 4 5
Knee pain	1 2 3 4 5
Ankle/foot pain	1 2 3 4 5
Shoulder blades	1 2 3 4 5

NEUROLOGICAL

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5

X_____

Patient signature Date

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Insurance Verification Disclosure/Agreement

As a courtesy, Elevani Health Group / will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

HIPAA Disclosure

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

All Patient Medical Records

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

Elevani Health Group /

Expiration Date of Authorization
This authorization is effective through 12/2017 unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize Elevani Health Group / Office Manager to use my protected information for the listed reasons.

Patient
Name (Printed) _____

Patient
Signature _____ Date _____

Parent/Guardian
Signature _____Date_____

Office Manager _____Date _____

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NEW PATIENT PAPERWORK

Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the physician's hands or with the use of a machine. Frequently, adjustments create a "popping" or "clicking" sound/sensation in the areas being treated.

In this office, we use trained assistants who may assist the physician with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. On the occasion when your physician is unavailable, your care may be handled by another physician or trained assistant.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The chiropractic adjustment that is related to the vertebral artery stroke is called Extension-Rotation-Thrust Atlas Adjustment. We DO NOT use this type of adjustments on our patients. Other type of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractic would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disk Herniations: Disk herniations that create pressure on a spinal nerve or the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustment, traction, etc. This includes both in the neck and back. Yet, occasionally, chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely, surgery may cause a disk problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment (or treatment) may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or mid-back. They extend from your back to your front chest area. Rarely, a chiropractic adjustment will crack a rib bone and this is referred to as a fracture. This occurs only on patients who have weakened bones from conditions such as osteoporosis. Osteoporosis can be detected on your x-rays. We adjust all patients very carefully, and especially with those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform your physician.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always provide you with the best care and if results are not acceptable, we will refer you to another health care provider who we feel may assist your condition.

If you have any questions on the above information, please ask your physician. Once you have a full understanding, please sign and date below.

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

Secondary Number: _____

Patient Name (Printed)_____Date _____

Patient Signature _____

Parent/Guardian Signature _____

Witnessed By_____Date _____

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Release of Medical Records

I,_____, hereby authorize the release of my medical records

From:

_____

_____

_____

To:

Elevani Health Group /

□ Mail to: 520 E Northwest Hwy suite 102 – Grapevine, TX 76051

□ Fax to: 817*328*1933

_____
Print Name

_____
Signature

_____
Social Security Number

_____
Date of Birth

_____
Date

Elevani Health Group

APEX PHYSICAL MEDICINE

ASSIGNMENT OF BENEFITS

Patient hereby irrevocably acknowledges full financial responsibility for all services provided to patient by Elevani Health Group / (Provider), as consideration for such Provider services. Patient irrevocably assigns to Elevani Health Group / (Provider), any and all benefits payable by or from any insurance or health care plan(s) coverage maintained by Patient as consideration for the total fee for those charges incurred by Patient as a result of those services rendered by Provider. Patient also assigns to Elevani Health Group / (Provider): (i) any and all benefits payable by or from any automobile medical payment coverage maintained by Patient or any party under whose policy of insurance Patient may have a lawful right of recovery, (ii) any and all benefits payable by or under any third party liability insurance coverage to which Patient may have a right of recovery due to the injuries for which Patient has sought Provider's health care services, and (iii) a "common law lien interest" in, and all contractual rights and claims to, any and all future insurance proceeds Patient has against any insurance company, health care benefit plan, or any other party contractually liable to Patient for payment of all or any portion of the health care services rendered by Elevani Health Group / (Provider), and the resultant charges therefore, to the Patient as a result of the injuries sustained by Patient. This irrevocable Assignment of Benefits, conveyance of lien interest and contractual rights to and for those charges attributable to Elevani Health Group / (Provider) health care services shall extend to, but not be limited to, Provider's entitlement to any and all insurance proceeds remitted as a result of any insurance claim for damages by the Patient which has given rise to the above referenced health care services provider by Elevani Health Group / (Provider).

By my signature be it known that I have read and fully understand the above contract.

Patient Signature _____(Print)_____

Custodian Parent/Legal Guardian_____(Print)_____

Witness_____(Print)_____

Date_____