Advance Being Clinic

So we can better serve you, please fill in ALL requested information. **Today's date** _____

◯ New Patient ◯ Returning Patient ◯ Auto Collision – Attorney Name (*if applicable*)? _____ ◯ Work Injury _____

Current Health ◯ Excellent ◯ Very Good ◯ Fair ◯ Poor **Referring Physician or Surgeon:** _____

How did you hear about us _____

Last Name _____ First Name _____ MI ____ M/F Date of Birth _____

Address _____ City _____ State _____ Zip_____

Telephone: Cell _____ Email address _____

Employer _____ Occupation _____

Marital Status: Married/ Divorced/ Widow/ Single (circle)
Spouses Name:_____ Occupation/Company_____

Emergency Contact _____ Phone # _____ Relation _____

Have you ever been to a chiropractor for this or any other condition? Yes/No _____

If yes, who? _____ Address _____ City_____ State ____ Zip __

For what condition? _____ How was your experience? _____

What condition prompted you to call/visit our office today? _____

Who is your primary care physician/family doctor including address and phone?_____

What is *chief complaint*/location of **1ST PAIN**:_____

How long have you had this symptom/pain?_____Have you had this problem before? Y or N

If yes, how was it treated and what were the results?_____

DESCRIBE the pain (circle all that apply) dull sharp aching cutting throbbing burning numbing/numbness tingling cramping spasm stinging shooting pounding constricting

Other:_____

Pain **FREQUENCY** (awake time) up to ¼ of the time ¼- ½ the time ½ to ¾ of the time **most** of the time/constant

Pain **INTENSITY** Choose/circle one of the following:

1. The pain is annoying but does not interfere w/activities &/or sleep though no narcotic medication is necessary
2. The pain is tolerated but interferes w/activities &/or sleep -some meds including narcotic meds may be necessary
3. Moderate pain – severely limits activities (recreation & socialization are severely limited) &/or prevents sleep. The use of narcotic meds may be necessary.
4. The pain is marked and prevents activities and/or sleep with narcotic meds required which may not completely control the pain

Does the pain **RADIATE** into the head, neck, shoulder, arm, hand, hip, leg, foot or other:_____

If so, please indicate Right or Left side where applicable:_____

In the AM_____	Twisting left_____	Straining_____	Sitting _____
In the PM_____	Twisting right_____	Standing	Lifting _____
Bending forward_	Bending left_____	Coughing_____	Walking_____
Bending backward_____	Bending right_____	Sneezing_____	Running_____

What is the **SEVERITY** of pain on a scale of 1(mild) to 10(severe or intolerable) 1 2 3 4 5 6 7 8 9 10

Location of **2ND PAIN/SYMPTOM**:_____

How long have you had this symptom/pain?_____Have you had this problem before? Y or N

If yes, how was it treated and what were the results:_____

DESCRIBE the pain (circle all that apply) dull sharp aching cutting throbbing burning constricting numbing/numbness tingling cramping spasm stinging shooting pounding Other:_____

Pain **FREQUENCY** (awake time) up to ¼ of the time ¼- ½ the time ½ to ¾ of the time **most** of the time/constant

Pain **INTENSITY** (circle/see details above) 1.does not affect 2. somewhat affects 3. seriously affects 4. prevents

Does the pain **RADIATE** into the head, neck, shoulder, arm, hand, hip, leg, foot or other:_____

If so, please indicate Right or Left side where applicable:_____

In the AM_____	Twisting left_____	Straining_____	Sitting _____
In the PM_____	Twisting right_____	Standing	Lifting _____
Bending forward_____	Bending left_____	Coughing_____	Walking_____
Bending backward_____	Bending right_____	Sneezing_____	Running_____

Please circle any that apply – specifics to be answered on the next page:

___ Neck Pain	___ Mid Back Pain	___ Low Back Pain	___ Pain when sneezing/coughing
___ Neck Stiffness	___ Shoulder Pain	___ Radiating Pain into buttock	___ Bowel/Bladder problems
___ Headaches	___ Arm pain/radiating	___ Radiating Pain into legs	___ Hip Pain
___ Sinus Issues	___ Hand/Arm tingling	___ Radiating in Both legs	___ Knee/Leg Pain/Problems
___ Allergies	___ Pain in Traps	___ Muscle Weakness	___ Ankle/Foot Pain/Problems

Rate **Pain Scale** from
1 (*least pain*) to 10 (*severe pain*)

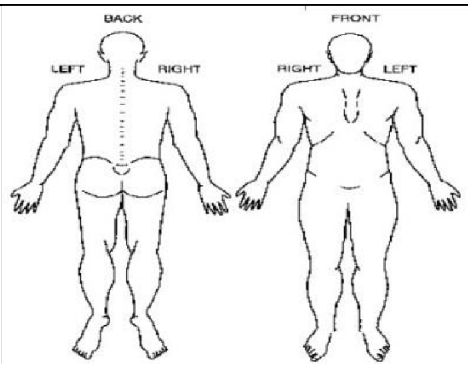
Worst _____/**10**

Current _____/**10**

Best _____/**10**

Is the pain **constant** or **intermittent**?
Please describe: _____
_____

Is it **radiating**? *If Yes, describe*:
_____
_____
_____
_____



Mark on the diagrams where your symtoms are present

Describe the pain or sensation you are experiencing:
□ Aching □ Sharp □ Shooting
□ Throbbing □ Burning □ Stiffness
□ Dull □ Swelling □ Numbness
□ Tingling □ Cramps
□ Other _____

Aggravating factors:

□ Sitting □ Standing □ Walking
□ Bending □ Lying down □ Twisting

□ Other:_____

Relieving factors:

□ Sitting □ Standing □ Rest
□ Lying down □ Heat □ Ice
□
Other:_____

In reference to prior symptoms:

_____I have NOT had prior symptoms similar to my current complaints
_____My current complaints did exist before but were dormant
_____My current complaints already existed but were worsened/aggravated

Has your history contributed to your symptoms:

_____My history HAS contributed to my symptoms
_____My history HAS NOT contributed to my symptoms
_____I am NOT SURE if my history has contributed to my symptoms

Family History – do you or your immediate family suffer from any of the following:

ARTHRITIS	YES / NO WHO_____	ASTHMA/HAYFEVER	YES / NO WHO_____
BACK PAIN/CONDITIONS	YES / NO WHO_____	BURSITIS	YES / NO WHO_____
CANCER	YES / NO WHO_____	DIABETES	YES / NO WHO_____
DISC CONDITIONS	YES / NO WHO_____	EMPHYSEMA	YES / NO WHO_____
EPILEPSY	YES / NO WHO_____	FIRBROMYALGIA	YES / NO WHO_____
HEADACHES	YES / NO WHO_____	HEART CONDITIONS	YES / NO WHO_____
HIGH BLOOD PRESSURE	YES / NO WHO_____	KIDNEY CONDITIONS	YES / NO WHO_____
LIVER CONDITIONS	YES / NO WHO_____	LUNG CONDITIONS	YES / NO WHO_____
NEURITIS	YES / NO WHO_____	SCOLIOSIS	YES / NO WHO_____
STROKE	YES / NO WHO_____	SINUS CONDITIONS	YES / NO WHO_____
INTESTINAL CONDITIONS	YES / NO WHO_____	OTHER _____	WHO_____

Please Circle (C) "Current by any conditions you have now or (P) "Past" the conditions you have had in the past or (I) "Intermittent" for conditions that come and go. If "Not Applicable" circle N/A. Please do not leave any blank.

FIRBROMYALGIA	C P I N/A	IBS	C P I N/A
HIGH BLOOD PRESSURE	C P I N/A	DIARRHEA	C P I N/A
DIZZINESS/FAINTING	C P I N/A	DIGESTIONS PROBS.	C P I N/A
INSOMNIA	C P I N/A	NAUSEA	C P I N/A
MUSCLE TENSION	C P I N/A	FATIGUE	C P I N/A
ULCERS/TYPE? _____	C P I N/A	EYE/VISION PROBS.	C P I N/A
CONSTIPATION	C P I N/A	FEMALE PROBS.	C P I N/A
PROSTATE PROBLEMS.	C P I N/A	DIABETES/TYPE ?_____	C P I N/A
COLD HANDS/FEET	C P I N/A	LOSS OF MEMORY	C P I N/A
NERVOUSNESS	C P I N/A	DEPRESSION	C P I N/A
SWEATY PALMS	C P I N/A	DIFFICULTY BREATHING	C P I N/A
LOSS OF BLADDER CONTROL	C P I N/A	IRRITABILITY	C P I N/A
EAR/HEARING PROBS	C P I N/A	SPEECH DIFFICULTY	C P I N/A
HEART PROBS	C P I N/A	ANXIETY	C P I N/A
FRACTURE/BROKEN BONE	C P I N/A TYPE? _____	CHRONIC FATIGUE SYND.	C P I N/A
HYPERTENSION	C P I N/A	STROKE	C P I N/A

Have you been diagnosed with any condition or are there any conditions not listed above that affect you?

_____

Is there ANY information regarding your general health that the doctor should know about? (ie: past surgeries, hospitalizations, fractures, accidents, etc.?) _____

_____

Are you currently taking any prescription medication, over-the-counter meds or natural supplements such as vitamins or herbs? Please list all below:

Name/Describe	Purpose/Reason	Length of Time Taken

Have you ever suffered from a stroke? Y N Have you ever had spinal surgery? Y N

Have you had any surgery in the past five years? Please include all procedures even knee scoping, dental surgery, etc.?_____

OFFICE & FINACIAL POLICY

CONSENT TO TREATMENT: I hereby consent to the therapeutic procedures outlined and to be performed by **Advance Being Clinic** and their associates. I agree to be evaluated and treated for functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain. I understand that therapeutic procedures can include, but are not limited to: joint and soft tissue mobilization, home exercise programs, functional training including: posture and body mechanics, modalities, such as: heat, ice, electrical stimulation, and ultrasound, and special procedures such as: taping, neuromuscular electrical stimulation, and bladder training. I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any me. I understand that I may consult with other therapists and/or physicians at any time regarding my condition.

NONDISCRIMINATION NOTICE: Advance Being Clinic complies with applicable State and Federal civil rights laws and does not discriminate, or exclude people or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

COVID-19 WAIVER OF LIABILITY & INFORMED CONSENT: Risks of Opting for In-Person Services: I understand that by coming to the clinic, in-person, I am assuming the risk of exposure to the coronavirus (or other public health risk). I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care.

NOTICE OF PRIVACY PRACTICES: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this policy carefully. ***For more detailed information, please request a printout.***

Understand your health record and information: When receiving physical therapy services from **Advance Being Clinic**, a record is made of your treatment. This record contains your symptoms, diagnoses, examinations, assessments, evaluation, and your treatment plan. It also contains daily treatment notes and progress notes.

Our pledge regarding medical information: We understand that your medical information is personal and private. We are committed to protecting your information. Medical records are only disclosed in a limited amount of circumstances which may be regarding; treatment, payment, review for quality of care, federal, state, or local law, and lawsuits/disputes. If for any reason, you would like a copy of your entire record, please make your request in writing. For your protection, please have a proper ID with you if picking up records in the office.

ELECTRONIC COMMUNICATION CONSENT: I consent that **Advance Being Clinic** can provide their services and communicate with me via mobile phone, messages, e-mail and any kind of online communications, provided that these communications comply with privacy regulations.

APPOINTMENT REMINDERS, RESCHEDULES AND CANCELLATIONS: I understand that **Advance Being Clinic** can reach me anytime to remind me of my appointments or let me know in case of any change about my appointments. And I also understand that **Advance Being Clinic** can employ and use a third-party automated system to reach out to me for the purpose of appointments.

CONTACT INFORMATION CHANGE: I accept that I am responsible for notifying the Company when my contact information(s) change. I understand that I can opt-out at any me to receive communication via text or email.

IN SIGNING, I CONSENT TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THAT I FULLY AGREE TO ALL STATEMENTS LISTED.

_____	_____	_____
Print Name	**Signature (If minor, responsible party)**	**Date**

KNOW YOUR INSURANCE BENEFITS: This is an agreement between **Advance Being Clinic** and the Patient/Responsible Party signed on this form. By executing this agreement, you are responsible for all medical bills and other charges that result from services rendered by **Advance Being Clinic**, deductible and co-payments are due at me services are rendered. If not paid by the following visit, a fee will be assessed. No EXCEPTIONS. It is our pleasure to assist you in maximizing your insurance benefit by completing your claim forms. As a courtesy, in addition to filing your claim, we will initially ask for your ***estimated*** *co-payment*. This is only an estimate based upon the information available to us. Once your carrier has paid the claim, any remaining balance is your responsibility**. Remember benefits quoted are not a guarantee of payment.**

ASSIGNMENT OF BENEFITS: I hereby instruct and assign my insurance carrier to **Advance Being Clinic** for the professional/medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. This assignment will remain in effect until l revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment, via fax transmittal or hard copy. Medical records will be accessible to all therapists of **Advance Being Clinic**.

FINANCIAL POLICY: Advance Being Clinic is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. All insurance companies are not the same in what they consider to be usual and customary fees. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We recommend that you read over your policy and contact your carrier if you have any questions regarding your coverage.

CONCIERGE SERVICES: All concierge services and packages are non-refundable and non-transferable, and cannot be paused or extended, whether you are on a monthly or annual membership/package. Please note that these services are not covered by your insurance carrier, and no exceptions can be made. Concierge packages renew on the anniversary date, not the calendar date. Please note that all monthly and annual concierge packages are set to renew automatically, and your account will be charged accordingly unless we receive your cancellation request at least 7 days prior to the renewal date.

MEDIA WAIVER RELEASE: AUDIO, PHOTO, & VIDEO RELEASE: I hereby give my consent to **Advance Being Clinic** the absolute and unrestricted right and: permission to take my photo, audio, and video, to reproduce, distribute and display my image, likeness, name and any other identifying characteristics, for all business, education, and marketing purposes, including but not limited to advancing **Advance Being Clinic** services and programs. I expressly release **Advance Being Clinic** from any and all claims whatsoever in connection with the use and reproduction of my image, voice, likeness, name or any other identifying characteristics in the above-mentioned materials. I understand that there is no compensation for the use of the audio, photos, and/or videos of me. Unless otherwise noted the form will be valid for the life me of its existence. I understand that I may opt-out at any me and need to request in writing. **____YES (Consent) ____NO(Decline)**

DENIAL, DELAY OR NEGLIGENCE: Advance Being Clinic is not responsible if your insurance carrier denies, delays, or is negligent with its estimated co-payments. When delayed, we will extend the reimbursement period up to thirty (30) days from date of service. This me period will not be extended to pa ents who provide us with the incorrect insurance information, fail to keep the information current or fail to fill out the necessary forms which their insurance carrier may request in a timely manner. If your insurance carrier postpone payment for more than 90 days, we ask that you make the remaining payment while we work together to get the insurance carrier to pay the obligated amount. Services are due and payable at the me they are rendered unless other arrangements are made in advance. A 10% finance charge will apply on accounts 60 days past due. If the account becomes past due, we will take necessary steps in contacting you to collect this debt. If these attempts do not generate a response from you, your account could be subject to the following fees: Finance Charges (currently 10%), In House Collection Fees, Collection Agency fees and any Attorney fees. If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable on or before the due date specified on the statement and is past due if not paid on or before that date. We do charge interest (10%) on all past due accounts; interest will begin accruing once the account becomes 60 days past due. **_____ Initial**

ARBITRATION PROVISION: Any dispute, claim or controversy arising out of or relating to this Agreement or the breach, termination, enforcement, interpretation or validity thereof, including the determination of the scope or applicability of this agreement to arbitrate, shall be determined by arbitration in Denton County, Texas before one arbitrator. The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures. Judgment on the Award may be entered in any court having jurisdiction. This clause shall not preclude par es from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction. Allocation of Fees and Costs: The arbitrator may, in the Award, allocate all or part of the costs of the arbitration, including the fees of the arbitrator and the reasonable attorneys' fees of the prevailing party.

BY SIGNING THIS AGREEMENT, YOU ARE AGREEING TO HAVE ANY ISSUE RELATING TO THIS AGREEMENT DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

_____	_____	_____
Print Name	**Signature (If minor, responsible party)**	**Date**

APPOINTMENT POLICY: It has always been our policy here at **Advance Being Clinic** to give our patients the benefit of the doubt when they forget to show up for an appointment or cancel an appointment with less than 24 hours-notice. There may be a charge for a missed appointment or cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally. Even if it is a last-minute cancellation, we greatly appreciate you notifying us so we can attempt to schedule our waiting list patients into your space.

In an instance of a cancellation without 24 hours-notice, or no-show to a scheduled appointment, we reserve the right to charge a $ 25 fee. Subject to change without notice.

Failure to provide credit card number on file will result in a standard cash rate charge for any subsequent Cancellation/ No Show Agreement infractions. No shows are to be paid by the following session or within one week of the incident, if not paid at that me they will be invoiced with a processing fee. In addition, 3 "no-shows" (missed appointments without prior or any notification) OR cancellations less than 24 hours in advance combined may result in the loss of your physical therapy benefits. We are obliged to notify your referring physician about an attendance or compliance problems and your physician may decide to discontinue your course of therapy. **This charge will not be covered by insurance, but will have to be paid by you personally.**

We reserve the right to cancel all future appointments and withhold scheduling future appointments if:
1)The first and second penalty fees are not paid within a week of the offense,
2) Offenses including and a er the third offense are not paid by the next appointment or within a week, whichever occurs first.

If you decide not to an end your appointment on the same day due to a Doctor preference, this will be considered a no-show. Your commitment to a ending your appointments, being punctual, and following your home exercise program is crucial for us to help you recover from your injuries. We guarantee the me and day of your scheduled appointment. We are happy to provide a print out of your future appointments. **Appointment text and email are only a courtesy reminder.** You are fully responsible for all scheduled appointments. Thank you! **Initial _____**

AGREEMENT FOR CREDIT CARD TRANSACTIONS: It is our policy to obtain credit card information. We will automatically charge your credit card on file for any outstanding balance (any outstanding balances (including, but not limited to: co-pays, coinsurance, deductibles or late cancellation) charges during each scheduled appointment. Your payment each visit is an es mate of payment, according to your insurance carrier. For confirmation of claims, please refer to your Explanation of Benefits according to your insurance carrier. If there is ever any overpayment, we will issue you a refund for the difference. If you wish to update your credit card information, please let us know.

If you require a receipt for your payments, please ask each me, and we will be happy to provide one. Please be assured that your credit card information is protected according to our high standards and in compliance with applicable laws. We store it in our encrypted, HIPAA compliant file to ensure maximum security.

As the authorized personnel listed below, I hereby authorize **Advance Being Clinic** to keep my credit card information on file, which includes the account number, CV Code, expiration date, and billing zip code associated with the credit card. I understand that I am required to provide my credit card information at the me of service. **Initial _____**

AGREEMENT FOR CREDIT CARD TRANSACTIONS: In order to make the payment process more convenient for everyone, we require that you sign below indicating your understanding that we will automatically charge your credit card on file for any outstanding balances (including, but not limited to: co-pays, coinsurance, deductibles or late cancellation) charges during each scheduled appointment. Your credit card information is very well protected according to our own very high standards and in accordance with the applicable laws within our encrypted, HIPAA compliant file. **Advance Being Clinic** will not disclose any of your credit card information to anyone. If you would like a receipt, we'd be more than happy to provide one for you. Just ask at the front desk each me. I, the authorized personnel listed below, approve **Advance Being Clinic** Clinic to have my credit card information on file which entails the account number, CV Code, expiration date, and the billing zip code that is associated with the credit card.

CC # _____ Credit Card or HSA
Security Code___ ___ ___ ___ Expiration Date ___ ___ /___ ___ Billing Zip Code _____

I approve Advance Being Clinic to charge my credit card on file regarding any payments that I owe which consist and are not limited to invoices, physical therapy treatment sessions, and any balances that I may have. I have read and understand the above agreement.

_____ _____ _____
Print Name Signature (If minor, responsible party) Date