WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

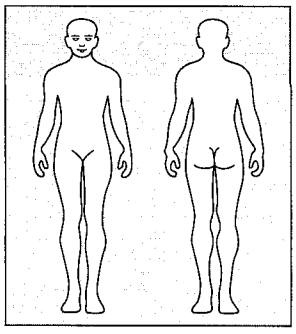
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray _____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other _____		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____

Pharmacy Name_____

Pharmacy Phone (____) _____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

Thomas Lenahan DC
3269 Independence Parkway
Plano Texas 75075
O) 972-596-3182 F) 972-596-8496

FINANCIAL POLICIES

PAYMENT FOR SERVICE

Unless prior arrangements have been made, services are to be paid for on the date they are rendered.

INSURANCE PROCEDURE

As a courtesy to you, we will file your claim with your insurance company and wait for their payment on your account. As you know, the health industry is changing everyday and they are looking for every possible way to cut their costs. The filing and follow-up process costs us time and money and does not remove you from the following responsibilities:

1. **Knowing what your insurance policy will and will not cover;**
2. **Knowing the amount of your deductible or co-pay⊗Remember-most insurance companies make it "challenging for us to obtain this information.**
3. **Reading your Explanation of Benefits (EOB) so that you are aware of what is and is not being paid.**

Other than contractual adjustments between Dr. Lenahan and your insurance company, **you are responsible for all charges your insurance company does not pay within 90 days.** If a claim is denied twice, you are then responsible for the payment. Please notify us if you change insurance companies.

AUTO INSURANCE

If you are receiving Personal Injury Protection (PIP) coverage from an auto accident, you are responsible for letting us know any other charges if any other charges have been submitted against your claim.

If the insurance check is sent to you, please bring it to our office within the week. **Once again, you are responsible for all charges your insurance does not pay for within 90 days.**

If you have nay questions regarding your bill, our charges, or any financial arrangements, please feel free to contact us at any time.

AUTHORIZATION ASSIGNMENT & RELEASE FORM

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to Dr. Thomas Lenahan DC as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I have read and agree to follow the above financial policies and assignment of benefits.

PATIENT SIGNATURE_____DATE_____

CORNERSTONE WELLNESS CENTER

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Cornerstone Wellness Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information:

Treatment – We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment – We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation – We may disclose your health information as necessary to comply with State Workers' compensation Laws.

Emergencies – We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health – As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings – We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement – We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons – We may disclose your health information to coroners or medical examiners.

Organ Donation – We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research – We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety – It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies – We may disclose your health information for military, national security, prisoner and government benefits purposes

Marketing – We will not use your health information for marketing communications without your written authorization.

Change of Ownership – In the event that Cornerstone Wellness Center is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights – You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Cornerstone Wellness Center is not required to agree to the restriction that you requested. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request. You have the right to inspect and copy your health information. You have a right to request that Cornerstone Wellness Center amend your protected health information. Please be advised, however, that Cornerstone Wellness Center is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial. You have a right to receive an accounting of disclosures of your protected health information made by Cornerstone Wellness Center. You have a right to a paper copy of this Notice of Privacy Practices any time upon request.

Changes to this Notice of Privacy Practices – Cornerstone Wellness Center reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Cornerstone Wellness Center is required by law to comply with this Notice.

Cornerstone Wellness Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you want more information about your privacy rights, please contact: Dr. Thomas Lenahan by calling this office at 972-596-3182. If Dr. Thomas Lenahan is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints – Complaints about your Privacy rights, or how Cornerstone Wellness Center has handled your health information should be directed to Dr. Thomas Lenahan by calling this office at 972-596-3182. If Dr. Thomas Lenahan is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201

This notice is effective as of 11/15 /2007

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

CORNERSTONE WELLNESS CENTER

Patient Name: _____

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **Cornerstone Wellness Center's** "NOTICE OF PRIVACY PRACTICES," revision date 11/15/2007.

As required by the Privacy Regulations, Dr. Thomas Lenahan from **Cornerstone Wellness Center** has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that **Cornerstone Wellness Center** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

- ☐ I wish to file a "Request for Restriction" of my Protected Health Information.
- ☐ I wish to file a "Request for Alternative Communications" of my Protected Health Information.
- ☐ I wish to Object to the following in the "Notice of Privacy Practices"

_____

_____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

Signature: _____ Date: _____

Authorization to Use of Disclose Protected Health Information

As required by the Privacy Regulations, Cornerstone Wellness Center may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

- ☐ I hereby authorize this office to use my address, phone number, and clinical records to contact me with birthday cards, holiday related cards, thank you cards, office promotions, newsletters, information about treatment alternatives or other health related information.

This authorization will expire at the end on _____.

I understand I have the right to: Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses of disclosure pursuant to this authorization. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization. Inspect a copy of Patient Health Information being used or disclosed under federal law. Refuse to sign this authorization. Receive a copy of this authorization. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information

Signature: _____ Date: _____

(Office Use Only) _____