



Adjust Regenerative Medicine

Dr. Preston Clay Alexander, MD Dr. Austin Sanford, DC
Ebony Jenkins FNP

Dear Patient:

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 Adjust Regenerative Medicine. 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 Adjust Regenerative Medicine.

Phone 972-701-9355
Adjust Regenerative Medicine
13450 Inwood RD, Suite 100 • Dallas, TX 75244



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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 # : - -

Driver's License #:

State:

Marital Status: S M W

Spouse's Name:

Your Employer:

Occupation:

Employer Address:

(STREET)

(CITY)

(STATE)

(ZIP)

Referred By:

Primary Care Physician:

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:

PATIENT INTAKE FORM

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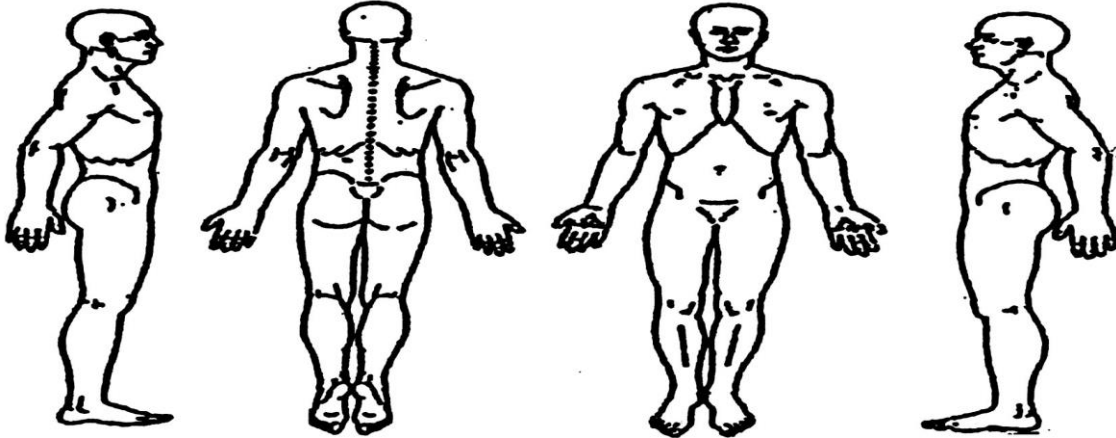
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Patient Name: _____ Date: _____

1. Today's problem will be filed as: Insurance/ Self Pay Auto Accident Workman's Compensation

2. What is your primary area of concern/ pain? _____

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



4. How would you describe the type of pain?

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Numb |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Tingly |
| <input type="checkbox"/> Diffuse | <input type="checkbox"/> Sharp with motion |
| <input type="checkbox"/> Achy | <input type="checkbox"/> Shooting with motion |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing with motion |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric-like with motion |
| <input type="checkbox"/> Stiff | <input type="checkbox"/> Other: _____ |

5. How long have you had this problem? _____

6. How do you think your problem began? _____

7. How often do you experience your symptoms?

- | | |
|---|---|
| <input type="checkbox"/> Constantly (76-100% of the Time) | <input type="checkbox"/> Occasionally (26-50% of the Time) |
| <input type="checkbox"/> Frequently (51-75% of the Time) | <input type="checkbox"/> Intermittently (1-25% of the Time) |

8. On a scale from 0-10 (10 being the worst), how would you rate your pain?

0 1 2 3 4 5 6 7 8 9 10 *(Please circle)*

9. What aggravates your problem? _____

10. What alleviates your problem? _____

11. How are your symptoms changing with time?

- | | | |
|--|---|---|
| <input type="checkbox"/> Getting worse | <input type="checkbox"/> Staying the same | <input type="checkbox"/> Getting better |
|--|---|---|



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

Have you been tested for allergies? YES NO

Are you allergic to Penicillin? YES NO

If answer is YES, have you ever been tested to confirm you are allergic to Penicillin?

YES NO

19. List all surgical procedures you have undergone:

20. What activities do you do at work?

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Sit | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer Work | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the Phone | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Drive | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Other Activities | <input type="checkbox"/> Perform manual labor | <input type="checkbox"/> Read a lot | <input type="checkbox"/> Travel frequently |

21. What activities do you enjoy outside of work?

22. Have you ever been hospitalized? Yes No

If yes, why? _____

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

If yes, what and when? _____

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

If yes, what? _____

Patient Signature _____ Date _____

Insurance Verification Disclosure/Agreement



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As a courtesy, Adjust Regenerative Medicine 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:

Adjust Regenerative Medicine

Expiration Date of Authorization

This authorization is effective through 12/2022 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 Adjust Regenerative Medicine 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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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.

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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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Mizi Abiad , APRN NP-C

Release of Medical Records

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

From:

To:

Adjust Regenerative Medicine

Mail to:

Fax to:

Print Name

Signature

Social Security Number

Date of Birth

Date

Adjust Regenerative Medicine

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Mizi Abiad , APRN NP-C

ASSIGNMENT OF BENEFITS

Patient hereby irrevocably acknowledges full financial responsibility for all services provided to patient by Adjust Regenerative Medicine (Provider), as consideration for such Provider services. Patient irrevocably assigns to Adjust Regenerative Medicine (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 Adjust Regenerative Medicine (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 Adjust Regenerative Medicine (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 Adjust Regenerative Medicine (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 Adjust Regenerative Medicine (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 _____

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