Today's Date: _____

NEW PATIENT INTAKE FORM

Name: _____ DOB: _____ Phone#: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Email address: _____ Social Security#: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact: _____ Phone#: _____

Relationship to patient: _____

INSURANCE INFORMATION: ☐ Self pay ☐ Private Ins. ☐ Workers' Comp. ☐ Other

Name of Insurance: _____Policy Number: _____

Subscriber: ☐ Self ☐ Other Name:_____ DOB: _____

PHARMACY INFORMATION: Name: _____ Ph: _____

Location address: _____

HOW DID YOU HEAR ABOUT US? Friend ☐ Family ☐ Member ☐ Co-Worker ☐ Website

Other ☐ (please specify): _____

PERSONAL STATUS:

Please check all that apply

Gender: Male ☐ Female ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Smoker ☐ Drinker ☐ Illicit Drug Use ☐ _____ times a week

PAST MEDICAL HISTORY:

Please check all that apply to your medical history in the section below. Please include any other information that may not be listed.

- ☐ High blood pressure/Hypertension
- ☐ High Cholesterol
- ☐ Heart Failure
- ☐ Mitral Valve Prolapse
- ☐ Seizures/Epilepsy
- ☐ Glaucoma
- ☐ Abnormal PAP
- ☐ Visual Disturbance
- ☐ What Body Area_____
- ☐ Other: _____
- ☐ Liver Disease
- ☐ Diabetes ("sugar")
- ☐ Heart Attack/By-pass Surgery
- ☐ Stroke
- ☐ Intestinal Problems
- ☐ Psychiatric Illness
- ☐ Cancer
- ☐ Muscle Spasms
- ☐ Thyroid Problems
- ☐ Kidney Disease
- ☐ Heart Murmur
- ☐ Stomach Problem
- ☐ Reflux Disease
- ☐ Arthritis
- ☐ Headaches/Dizziness
- ☐ Pain

1. Are you currently under the care of a doctor for any reason?

If yes, please explain _____

_____

2.Please list any surgeries or hospitalizations, (if applicable- those associated with this injury):

_____

_____

3. Allergies: _____

_____

4. Please list any injuries (if applicable- including previous Worker's Compensation):

_____

_____

FAMILY HISTORY

Pease list any health problems in your immediate family:

_____

_____

MEDICATIONS:

Please list all medications taken, both prescription and over the counter, including medications not taken for this injury: _____

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CONSENT FOR TREATMENT

Please read thoroughly and sign/date to verify consent for examination and treatment:

CONSENT FOR MEDICAL TREATMENT: I hereby voluntarily consent to the rendering of care, including, by not necessarily limited to, diagnostic procedures, surgical, and medical treatment, by medical doctors or their authorized designees, as may in their professional judgement be necessary. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments.

CONSENT FOR MEDICAL EXAMINATION: I understand that medical treatment may be necessary for me. I understand the examination procedures will be explained to me and I shall consent to the partial or complete examination. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow-up examinations to check abnormalities found and treated, lies with me and not my physician. I hereby release my examiner form all responsibility in connection with this exam.

Please be sure you have read the above information thoroughly in its entirety before providing your signature below.

Patient (or Guardian) Signature _____ Date _____

Witness Signature _____ Date _____

FINANCIAL AGREEMENT

Payment for all services are due at the time of the visit. We gladly accept all insurances. For insurance holders please read section below as this will apply. For all "Self-Pay" patients we accept the following forms of payment: Cash, Credit Card – Visa, MasterCard, Discover, and American Express.

INSURANCE HOLDERS

If you have health insurance, your insurance card must be presented on the first visit. *As a courtesy, Nextgen Wellness Group, Inc., verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. It is the policy of Nextgen Wellness Group, Inc. that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. The admissions coordinator will explain this information to you prior to your first visit. At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.* If your insurance carrier changes, please notify us on your next visit.

If you are covered by health insurance with medical/physical therapy/behavioral health/or chiropractic benefits, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. Any questions regarding your bills may be directed to Cristina Morales, our billing manager.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember ***that you are 100 percent responsible for all charges incurred****: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.*

We highly recommend you also contact your insurance carrier and check into your coverage. Do not assume that you will not owe anything if you have more than one insurance policy

Please be sure you have read the above information thoroughly in its entirety before providing your signature below.

Patient (or Guardian) Signature _____ Date _____

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice explains the ways in which we may use and disclose medical information about you. It describes your rights and certain obligations we have regarding the use and disclosure of your medical information. The law requires us to (1) Ensure your medical information is protected; (2) Provide you with this Notice describing our legal duties and privacy practices with respect to medical information about you; (3) Follow the current terms of the Notice in effect.

WAYS WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following sections describe different ways that we may use and disclose your medical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure will be listed. All of the ways we are permitted to use and disclose information, however, will fall within one of the following categories.

Some information such as certain drug and alcohol information, HIV information and mental health information is entitled to special restrictions related to its use and disclosure. Our office shall abide by all applicable state and federal laws related to the protection of this information.

1. Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other personnel who are involved in your care. For example, a doctor treating you may need to know if you have diabetes because diabetes may slow the healing process. We may also share medical information about you with our office personnel or other providers, agencies or facilities in order to provide or coordinate such things as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside our office who may be involved in your continuing medical care after you leave our office such as other health care providers, transport companies, community agencies and family members.

2. Payment. We may use and disclose medical information about the treatment and services you receive at our office so that payment may be collected from you, an insurance company or a third party. For example, we may need to give information to your health plan about treatment you received at our office so your health plan will pay us or reimburse you. We may also tell your health plan about a proposed treatment in order to obtain prior approval or to determine whether your plan will cover the treatment.

3. Health Care Operations. We may use and disclose medical information about you to support our office operations. These uses and disclosures are made to improve our quality of care. Your medical information may also be used or disclosed to comply with laws and regulations, for contractual obligations, patients. claims, grievances or lawsuits, health care contracting, legal services, business planning and development, business management and administration, the sale of all or part of our office to another entity, underwriting and other insurance activities. For example, we may review medical information to find ways to improve treatment and services to our patients. We may also disclose information to doctors, nurses, technicians, and other personnel for performance improvement and educational purposes.

4. Appointment Reminders. We may contact you to remind you that you have an appointment at our office.

5. Treatment Alternatives. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

6. Health-Related Benefits and Services. We may contact you to tell you about benefits or services that we provide.

7. Others Involved in Your Care. We may release medical information to anyone involved in your medical care, For example, a friend, family member, personal representative, or an individual you identify. We may give information to someone who helps pay for your care or we may tell your family or friends about your general condition.

8. Research. Your medical information may be important to further research efforts. We may use and disclose your medical information for research purposes, subject to the confidentiality provisions of state and federal law.

9. As Required By Law. We will disclose medical information about you when required to do so by federal or state law; If asked to do so by law enforcement in response to a court or administrative order, subpoena, discovery request,

warrant, summons or other lawful process; or for intelligence, counterintelligence, and other national security activities authorized or required by law.

10. To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you for public health purposes or when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat

11. Workers' Compensation. We may use or disclose medical information about you for Workers' Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries or illness.

12. Inmates. If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release medical information about you to the correctional institution as authorized or required by law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Although the medical information we obtain about you is the property of our office, you do have the following rights:

1. **Inspect and Copy**. With certain exceptions, you have the right to inspect and/or receive a copy of your medical and billing information. To inspect and/or to receive a copy of your information, you must submit your request in writing to our **Office Manager at 14665 Midway Rd. Ste. 110, Addison, TX 75001.** If you request a copy of the information, we may charge a fee for these services. We may deny your request to inspect and/or to receive a copy in certain limited circumstances. If you are denied access to medical information, in most cases, you may have the denial reviewed. Another licensed health care professional chosen by the Our office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
2. **Request an Amendment or Addendum**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record). You have the right to request an amendment or addendum for as long as the information is kept by or our office. To request an amendment, your request must be made in writing and submitted to our **Office Manager**. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: Was not created by our office; Is not part of the medical information kept by or for Our office; Is not part of the information which you would be permitted to inspect and copy; or Is accurate and complete in the record. An addendum must not be longer than 250 words per alleged incomplete or incorrect item in your record.
3. **Accounting of Disclosures**. You have the right to receive a list of the disclosures we have made of medical information about you that were for purposes other than treatment, payment, health care operations and certain other purposes. To request this accounting of disclosures, you must submit your request in writing to our **Office Manager**. Your request must state a time period that may not be longer than the six previous years and may not include dates before April 14, 2003. You are entitled to one accounting within any 12-month period at no cost. If you request a second accounting within that 12-month period, we may charge you for the cost of compiling the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
4. **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information to a family member about a surgery you had. ***We are not required to agree to your request*.** If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide emergency treatment. To request a restriction, you must make your request in writing to our **Office Manager**. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

5. **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to our **Office Manager**. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

6. **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

CHANGES TO OUR PRIVACY PRACTICES AND THIS NOTICE

We reserve the right to change our office's privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at our office. The Notice will contain the effective date on the first page in the top right-hand corner. In addition, at any time you may request a copy of the current Notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our **Office Manager 14665 Midway Road, Ste. 110, Addison, TX 75001**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we will retain our records of the care provided to you as required by law.

Patient's Signature:_____ Date: _____

Responsible Party's Signature:_____ Date: _____

(if patient is a dependent, is incapacitated, etc.)

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WELLNESS GROUP

DOL CASE INFORMATION SHEET

Patient Name: _____

DOB: _____

Phone #: _____

DOI: _____

Injured Body Areas: _____

Describe how injury occurred: _____

Employer: _____

Employer Address: _____

Job Title: _____

Work #: _____

Did you file a CA-1 or CA-2? _____

Case #: _____

Do you have any existing DOL cases? _____

If yes, do you need assistance with these cases? _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Patient Address:_____ **City/State/Zip:**_____

Phone:_____

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name:_____ **Facility Phone:**_____
Facility Address:_____ **Facility Fax:**_____
City, ST, Zip:_____

Dates and Type of information to disclose:

- DOS_____to_____
- Specific Information Requested:_____

_____

_____

The purpose of this disclosure is:

- Change of Insurance or Physician
- Continuation of Care
- Referral
- Other_____
-

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Nextgen Wellness Group, Inc.
14665 Midway Rd Suite #110
Addison, TX 75001

Phone: (972) 382-9992
Fax: (469) 802-0070

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Nextgen Wellness Clinic. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by HIPPA and PHI rules and laws. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative Date

BEHAVIORAL ASSESSMENT PACKET
(BAP)

Patient Name:_____ Date: _____

1. Please rate your overall satisfaction with life:

0	1	2	3	4	5	6	7	8	9	10

Totally unsatisfied Perfectly satisfied

2. Are you currently employed? Yes No Will you return to this job? Yes No

3. Are you struggling with financial concerns? Yes No Please describe:_____

4. Are you struggling with mobility? Yes No Please describe:_____

5. Are you having difficulty with hygiene/self-care? Yes No Please describe:_____

6. Are you struggling to tend to activities of daily life? Yes No Please describe:_____

7. Are you able to enjoy recreational activities? Yes No Please describe:_____

8. Are you struggling with concentration, memory, or communication? Yes No Please describe:_____

9. Are you having difficulty getting along with others? Yes No Please describe:_____

10. Are you having problems sleeping? Yes No Please describe:_____

11. Do you experience mood swings? Yes No Please describe:_____

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12. Do you use alcohol or drugs? Yes No Please describe (frequency/quantity):_____

13. Are you experiencing pain? Yes No Please rate your current level of pain:

0	1	2	3	4	5	6	7	8	9	10

No pain Agonizing pain

14. Do you feel overwhelmed? Yes No Please describe:_____

15. Do you feel nervous, anxious, or restless? Yes No Please describe:_____

16. Do you feel sad, upset, or worthless? Yes No Please describe:_____

17. Do you feel angry, frustrated, or irritable? Yes No Please describe:_____

18. Please provide any additional information that may be helpful to include:

I would like to talk to a counselor about some of the above issues: Yes No

_____ _____

Patient Signature Date

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HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) **
1. Authorization
(Name) _____ **here** by authorize
(**AHR Medical Group / Nextgen Wellness Clinic**) to use and disclose the protected health information
2. Effective Period
This authorization for release of information covers the period of healthcare from:
□ 90 Days to 180 Days **OR**
□ All past, present, and future periods.

3. Extent of Authorization
□ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
OR
□ I authorize the release of my complete health record with the exception of the following information:
□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment

Name of individual who you authorize release of info to: _____
Relationship to you: _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of patient or personal representative Date

_____ _____
Signature of Witness Date

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