INTEGRITY HEALTH CENTERS PLLC
910 HWY 62-65 N HARRISON, AR 72601

870.704.4072
FAX: 870.743.9881

Please Print All Answers

PATIENT INFORMATION

Name: ____________________Age: ________ Sex:_____ Today's Date:____________

Mailing Address:____________________ City / State:______________ Zip:__________

Home Phone:______________ Work:______________ Cell Phone: ______________

Best time to call: ________ Which #______________ Email:____________________

Social Security Number:____________ Birthdate:__________ Employer:______________

□ Married □Single □Separated □Divorced □Widowed Spouse's Name:____________________

PCP Name:____________________ Spouses Employer:____________________

PCP Phone:____________________ Spouse's Birthdate:____________________

PCP Address:____________________ Spouse's Social Security:____________________

Parents Employer (If Patient is a minor):____

Parents" Social Security 3 (If Patient is a minor:________________________________

Emergency, who do we call?______________ Phone:______________ Relationship:__________

Name of relative or friend not living with you:______________ Phone:______________

Referral Information

Who Recommended you to our office? ___ My Doctor ___Family/Friend Name:______________

Address and Phone number (if applicable):____

Health Insurance Information

Name of Insurance Company:______________ Group #:__________ Policy Number:__________

Name of Insured:______________ Inured Birthdate:__________ Relationship to Insured:__________

Accident Insurance Information

Name of YOUR Auto Insurance Company:____________________ Accident Claim #:______________

Agent Name:____________________ Agent Phone Number:____________________

Name of Liable Insurance (party at fault):______________ Phone Number:______________

Claim Number:____________________ Insured's Name:____________________

Attorney Name:____________________ Attorney's Phone Number:______________

Workman's Comp Insurance Information

Employer:____________________ Claim Number:____________________

Contact Person:____________________ Phone Number: ____________________

Please provide the receptionist with your driver's licene and insurance cards to be photocopied for your permanent medical record.

Welcome to our multi-specialty group practice, offering family practice & pain management medical care, chiropractic, physical therapy, rehabilitation, acupuncture, massage therapy, nutritional & psychological counseling. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice. This Notice is detailed on page -4- of this document. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff.

Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or all staff of this Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities. Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. If you must miss an appointment please notify us. If you do not show up for your scheduled appointment you will be charged $15.00 as a missed appointment fee that you must pay before you are seen or treated again. We are available to immediately see new patients the same day or through our 24 hour - 7-day emergency service. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.

-- please proceed to page 2 –

Initial __________

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SYMPTOM SURVEY

What is your chief problem or symptom? ____________________

When did the problem or symptoms begin and what caused your symptoms to start? ____________________

Do you have a secondary complaint or problem? ____________________

Have you seen another doctor for your problem(s)? ☐ No, If yes, who ____________________

What tests/procedures have been performed? ☐ X-Ray ☐ MRI ☐ Surgery ☐ Hospitalization ____________________

Have you had these problems or symptoms in the past? ☐ No, If yes, explain ____________________

Have you tried any other treatments for this problem(s)? ☐ No, If yes, explain ____________________

Is the problem(s) or symptoms getting worse? ☐ No, If yes, explain ____________________

√ ALL OF THE ITEMS THAT APPLY TO YOU NOW AND IN THE PAST:

☐ Arthritis / Gout	☐ Depression/Anxiety	☐ Pregnancy	☐ High Cholesterol	☐ Headaches
☐ Eye Pain–Strain	☐ Dizziness	☐ Seizures	☐ Ringing in Ears	☐ Blurred Vision
☐ Jaw Pain	☐ Hepatitis C	☐ Neck Pain / Spasms	☐ Chronic Fatigue	☐ Heart Disease- Attack
☐ Gall Stones	☐ Swallowing Difficulty	☐ Thyroid Problems	☐ Chest Pain - SOB	☐ Cancer
☐ Anemia / Bleeding	☐ Hypertension	☐ Stroke / CVA / TIA	☐ Kidney Problems	☐ Pancreatitis
☐ Shortness of Breath	☐ Irregular Heart Beat	☐ HIV / AIDS	☐ Asthma/Bronchitis	☐ Mid/Low Back Pain
☐ Shoulder/Elbow Pain	☐ Wrist or Hand Pain	☐ Neuropathy	☐ Hip/Knee/Leg Pain	☐ Foot or Ankle Pain
☐ Stomach / Ulcer Pain	☐ Diabetes	☐ Groin or Rectal Pain	☐ Female Disorders	☐ Urinary Problems
☐ Skin Problems	☐ Broken Bones	☐ Digestive Problems	☐ Emphysema / COPD	☐ Irregular Bowels

☐ Other problem(s) not listed ____________________ Due Date____________ Most Recent HGB A1C__________________

PATIENT AND FAMILY HISTORY

Race [ ] Caucasian [ ] African-Am [ ] Other -

Ethnicity [ ] Hispanic [ ] Non-Hispanic

What is your occupation? ____________________

What is your employment status? ☐ Working ☐ Sick Leave ☐ Unemployed ☐Retired ☐ Temp Disability ☐ Perm Disability Last Day of Work _________

Do you use tobacco? ☐ No ☐Yes:___ Packs per/day ☐Former: Years___ ___per day

Do you consume alcohol? ☐ No ☐Yes Frequency: ☐Rarely ☐Occasionally ☐Social

Do you have a history of substance abuse? ☐ No ☐Yes Frequency:: ☐Rarely ☐Occasionally ☐Social

Do you drink caffeinated drinks? ☐No ☐Yes Frequency:____ Drinks Per Day

Do you take supplements/vitamins? ☐No ☐Yes

Severe accidents or trauma & dates ____________________

List all drug / chemical / latex / iodine **allergies:** ____________________

List all current and past medications / drugs:

Drug Name: ____________________

List all physicians you have seen in the past 5 years?

Name ____________________ For What? ____________________

FAMILY HISTORY

	Living:	Age:	If living, any know health conditions	Deceased: Cause of death:	
Father	☐	_____	____________________	☐	____________
Mother	☐	_____	____________________	☐	____________
Brother(s)	☐	_____	____________________	☐	____________
Sister(s)	☐	_____	____________________	☐	____________
Son	☐	_____	____________________	☐	____________
Daughter	☐	_____	____________________	☐	____________
Maternal Grandfather	☐	_____	____________________	☐	____________
Maternal Grandmother	☐	_____	____________________	☐	____________

- please proceed to page 3 -

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PAIN QUESTIONNAIRE

Describe your pain (check all that apply):

Complaint	Chief Complaint	Secondary Complaint
Nauseating		
Recurring		
Stabbing		
Dull Ache		
Sharp		
Deep Ache		
Throbbing		
Tingling		
Shooting		
Pressure-Like		
Pulling		
While Resting		
Daily		
During Physical Activity		
Nightly		
Other		

Is your pain □ Constant□ Intermittent
Onset of pain□ Sudden□ Gradual

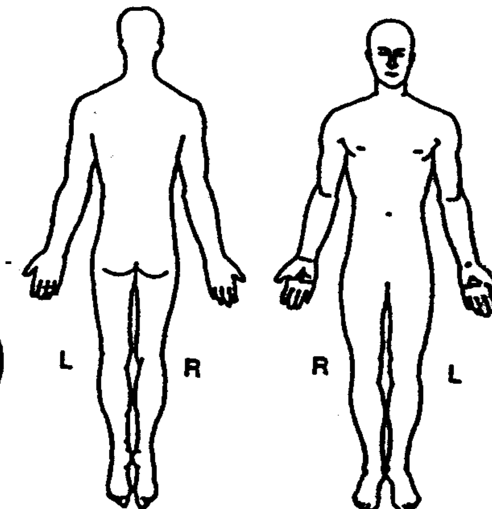
□ Traumatic ___________
□ Chronic _____________
□ Post Surgical
□ Work Related
□ Motor Vehicle
□ Unknown

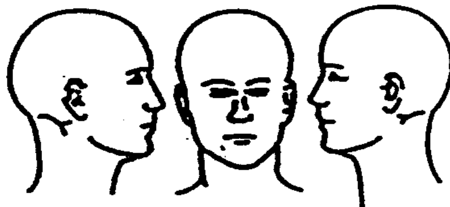
On a scale of 1 to 10 how would you rate your pain level for your chief complaint? _______ (1 = Mild, 10 = Intense)
On a scale of 1 to 10 how would you rate your pan level for your secondary complaint?________ (1 = mild,10=Intense)

What if anything gives you relief? ____

Circle location(s) of your symptoms on body drawing. Outline using symbols for the type of sensation

Pain	: : : : : : : : : : :
Numbness	+ + + + + +
Burning	/ / / / / / / / / /
Ache	X X X X X X





-please proceed to page 4 –

Initial ____________

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HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT – ASSIGNMENT OF BENEFITS – AUTHORIZATION & LIEN

This office is committed to providing patients with quality health care services delivered with dignity, respect and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff. This Facility is required by law to abide by the terms of this Health Care Privacy Notice, Patient Bill of Rights and Informed Consent as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility. Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility. Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you. You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice. You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility. I understand that this Facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care, a guarantee of improvement or complete recovery cannot and has not been made and it is even possible that no change will occur. Our Facility further wants you to understand your Patient Bill of Rights, options for care and risks of treatments rendered by us. In the practice of medicine, surgery, chiropractic, spinal or joint manipulations / adjustments, podiatry, psychological counseling, massage, physical, occupation, speech & respiratory therapy there are some risks. These risks may include but are not limited to soreness, dizziness, fractures or joint injury, disk injuries, strokes, heart-attacks, dislocations, sprains-strains, drug interactions, procedural complications, reactions and/or other injuries which maybe short or long term or side effects which cannot be pre-determined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. As our patient you can voluntarily stop care or ask questions about reasonable alternatives to the procedures we will recommend including but not limited to rest,, home applications of therapy, prescription or over-the-counter medications, exercises and/or referral to a medical/surgical specialist. In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment. Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you. Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility. I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility. I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits. Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay.
2. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
5. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy.
6. A service charge is computed by a 'periodic rate' of 1½ % per month – 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee's. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge.
7. Patients are eligible for a maximum $250 personal credit limit when approved. For your convenience we accept most major credit & debit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original. I have made my decision voluntarily and freely to submit for healthcare services in this facility.

____

Print Name of Patient

X ____

Signature of Patient (if minor parent, or legal guardian must sign) Date:

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Consent to use PHI

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Integrity Health Centers, PLLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _______Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

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Informed Consent

I ______________________________[name of patient or legal guardian] do hereby give my full and informed consent to _________________________ & _______________________ [name of office & name of provider] to perform conservative, noninvasive spinal manipulations, adjustments, treatment(s) and/or procedures to my neck, back, joints and soft tissues.

Although spinal manipulation and/or adjustments may be considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications which may be associated including but not limited to: **Soreness:** similar to what may follow exercise; **Dizziness:** with symptoms like dizziness and nausea; **Fractures/Joint Injury:** this is in isolated cases usually with underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution; **Stroke:** although strokes from manipulations and/or adjustments are rare, I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments; **Physical Therapy Burns:** some of the therapies used may generate heat and may rarely cause a burn; **All side effects** should be reported to the doctor immediately.

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery and/or but not limited to: **Medications:** as prescribed and directed by a licensed physician can be used to reduce pain or inflammation; **Rest/Exercise:** may temporarily reduce inflammation and pain. **Surgery:** may be necessary for joint stability or serious disk rupture. **Non-treatment:** risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor’s choosing.

I have read or have had read to me the above explanation of manipulations and/or adjustment procedures and treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

X______________________________**Signature of patient** ______________________ **Date and time**

Based on my personal observation while the above named patient read and signed the above Informed Consent, I conclude that the patient is of legal age or accompanied by a parent or legal guardian; oriented x 3; coherent and lucid; proficient in understanding the English language or accompanied by translator; freely signed this consent and had all questions answered as well as a photocopy of this document if desired.

____________________________________ **Signature of witness** _______________________ **Date and time**