Patient Name____ Date: _______________________

Email: ____

SS #/SIN____________________ DOB _________________ ☐ Male ☐ Female

Cell Phone___________________________ Secondary Phone __________________________

Check appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's Address __________________________________City _______________ State______ Zip_______________

Employer Name:
____

Spouse or Patient's Guardian name____

Spouse's Employer____

Whom may we thank for referring you?
____

Person to contact in case of an emergency____

Phone______________________________

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

____________________________ ____________________

Parent or Guardian Date

Responsible Party
Name of The Person responsible for this account ______________________________

Relationship to Patient _____________________

Address ____

Home Phone _____________________________

Cell Phone _______________________________

E-Mail ____

Driver's License # _________________ SSN# __________________ Date of Birth: ___________________
Is the person currently a patient at our office? □ Yes □ No

Do you have any medical insurance? □ Yes □ No if yes, complete the following:

Name of the insured____

Relationship to patient__________________________

Birthdate___________________ SS#/SIN_________________________

Name of Employer____

Address of Employer________________________ State _______Zip____________________

Insurance Company______________________________

Group #__________________ ID # ___________________________

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Midlothian Medical and Sports Center** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this ______ day of _________________, 20 ____.

X____________________________ (SEAL)
(patient signature)

X______________________________(SEAL)
(signature of Guardian if applicable)

X_____________________________
(please print patient name)

MIDLOTHIAN MEDICAL & SPORTS CENTER

Health History

Patient Name: ___________________________________ DOB: _________________ Date: ____________

Chief Complaint: ____

History of Present illness:

Location: _______________________________
(Where is the pain/problem?)

Quality: ________________________________
(Example: normal vs abnormal color, activity, etc.)

Severity: _______________________________
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: _______________________________
(How long have you had this pain/ problem? When did it start?)

Timing: ________________________________
(Does the pain/problem occur at a specific time?)

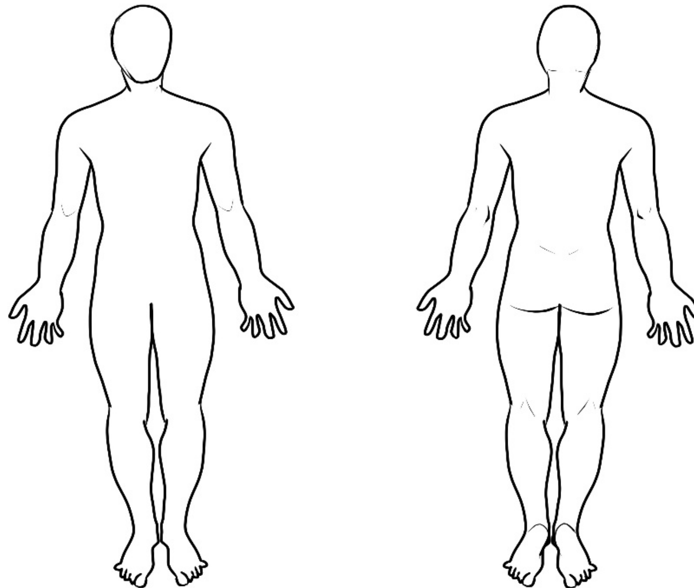
Context: ________________________________
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms ____________________
____
(What other associated problems have you been having?)

Modifying Factors __________________________
____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Pain Diagram

Please use the chart below to mark the area of discomfort:



Use the space below to descibe your pain:
____
____
____

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles..............NO YES
Mumps...............NO YES
Chicken Pox........NO YES
Whooping Cough..NO YES
Scarlet Fever.......NO YES
Diphtheria...........NO YES
Small pox.............NO YES
Pneumonia..........NO YES
Rheumatic Fever..NO YES
Arthritis................NO YES
Venereal Disease..NO YES

Anemia.....................NO YES
Bladder Infection.....NO YES
Epilepsy....................NO YES
Migraine Headaches..NO YES
Tuberculosis..............NO YES
Diabetes.....................NO YES
Cancer........................NO YES
Polio...........................NO YES
Glaucoma..................NO YES
Hernia........................NO YES
Blood or Plasma
Transfusion................NO YES

Back Trouble..................NO YES
High Blood Pressure......NO YES
Low Blood Pressure.......NO YES
Hemorrhoids..................NO YES
Date of Last Chest X-Ray___________
Asthma.............................NO YES
Hives of Eczema...............NO YES
AIDS & HIV........................NO YES
Infectious Mono.............NO YES
Bronchitis..........................NO YES
Mitral Valve Prolepses....NO YES
Stroke...............................NO YES

Hepatitis........................NO YES
Ulcer..............................NO YES
Kidney Disease.............NO YES
Thyroid Disease............NO YES
Bleeding Tendency........NO YES
Any Other Disease.......NO YES
(Please List):

____

____

List any known allergies: ____

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

____________________________________ ________________ ____________________
____________________________________ ________________ ____________________
____________________________________ ________________ ____________________

Medication: (include nonprescription)

____
____

Have you ever taken Fen-Phen/Redux? NO YES
Are you taking any medications (prescription or over the counter) for acid indigestion?
O yes O no if yes what type: ____

Patient Social History:

Marital Status Single: ______ Married: ______ Separated: _______ Divorced: _______ Widowed: _______
Use of Alcohol Never: ______ Rarely: _______ Moderate: _______ Daily: ________
Use of Tobacco Never: ______ Rarely: _______ Moderate: _______ Daily: _________
Use of Drugs Never: ______ Type/Frequency: ____
Excessive Exposure
At home or at work to: Fumes: ______ Dust: ______ Solvents: ______ Airborne Particles: _______ Noise: _______

CLINICIAN SIGNATURE: ____ **DATE REVIEWED:** ________________________________

PATIENT NAME: ____ **DATE:**____

Name:____ DOB ___________________
Date:____________________

Family Medical History:

	Age	Disease	If Deceased, Cause of Death
Father:	_________	______________________	______________________
Mother:	_________	______________________	______________________
Siblings:	_________	______________________	______________________
	_________	______________________	______________________
	_________	______________________	______________________
Spouse:	_________	______________________	______________________
Children:	_________	______________________	______________________
	_________	______________________	______________________
	_________	______________________	______________________

Indicate which of the below you have experienced in the last 1-2 months.
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5

Continue to next page.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____ ____________________

Signature of the Patient, Parent or Guardian Date

Practitioners Review

____ ____________________

Signature of Practitioner Date

PATIENT CONSENT TO TREAT:

I hereby authorize the Doctor's/Nurse Practitioners of Midlothian Medical and Sports Center to treat my case as they deem appropriate through the use of **lab testing, traction, durable medical equipment, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, and diagnostic testing.** I realize the goal of holistic health care is to strengthen the patient's body in order to heal themselves. It is understood and agreed the amount paid the clinic for x-rays is for interpretation and only the x-ray negatives will remain the property of this office, being on file. The patient also agrees that he/she is responsible for all bills incurred at this office.

Signature: ____ Date: ______________

PATIENT CONSENT FOR COMMUNICATION:

We can call or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign. Patients in our office may be contacted via phone/text messages to be reminded of an appointment, to obtain feedback on an experience within our office, and to provide general health reminders/information.

1. I consent to receiving appointment reminders and other healthcare communications via telephone from Midlothian Medical and Sports Center _______(initial)
2. I consent to receive text messages from Midlothian Medical and Sports Center at my cell phone and any number forwarded or transferred to that number. The cell phone number that I authorize to receive text messages for appointment reminders, feedback and general health reminders/information is: (_____) ________-______________ Carrier: ____________. ________ (initial)
3. I consent to emails, to receive communications as stated above. The email that I authorize to receive email messages for general health reminders/feedback/information is: __________________________________. _______(initial)

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. ______(initial)

Signature: ____ Date: ______________

MIDLOTHIAN
MEDICAL & SPORTS CENTER

Provider Statement of Patient/Client Rights and Responsibilities

- Patients/Clients have the **right** to be treated with dignity and respect.
- Patients/Clients have the **right** to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- Patients/Clients have the **right** to have their treatment and other patient information kept private. Only by law may records be released without patient permission.
- Patients/Clients have the **right** to access care easily and in a timely fashion.
- Patients/Clients have the **right** to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- Patients/Clients have the **right** to share in developing their plan of care.
- Patients/Clients have the **right** to the delivery of services in a culturally competent manner.
- Patients/Clients have the **right** to information about the organization, its providers, services, and role in the treatment process.
- Patients/Clients have the **right** to information about provider work history and training.
- Patients/Clients have the **right** to information about clinical guidelines used in providing and managing their care.
- Patients/Clients have a **right** to know about advocacy and community groups and prevention services.
- Patients/Clients have a **right** to freely file a complaint, grievance, or appeal, and to learn how to do so.
- Patients/Clients have the **right** to know about laws that relate to their rights and responsibilities.
- Patients/Clients have the **right** to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities policy.
- Patients/Clients have the ***responsibility*** to treat those giving them care with dignity and respect.
- Patients/Clients have the ***responsibility*** to give providers the information they need, in order to provide the best possible care.
- Patients/Clients have the ***responsibility*** to ask their providers questions about their care.
- Patients/Clients have the ***responsibility*** to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
- Patients/Clients have the ***responsibility*** to let their provider know when the treatment plan no longer works for them.
- Patients/Clients have the ***responsibility*** to tell their provider about medication changes, including medications given to them by others.
- Patients/Clients have the ***responsibility*** to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- Patients/Clients have the ***responsibility*** to let their provider know about their insurance coverage, and any changes to it.
- Patients/Clients have the ***responsibility*** to let their provider know about problems with paying fees.
- Patients/Clients have the ***responsibility*** not to take actions that could harm others.
- Patients/Clients have the ***responsibility*** to report fraud and abuse.
- Patients/Clients have the ***responsibility*** to openly report concerns about quality of care.
- Patients/Clients have the ***responsibility*** to let their provider know about any changes to their contact information (name, address, phone, etc).
- Patients/Clients have the **right** and the ***responsibility*** to understand and help develop plans and goals to improve their health.

I have read and understood my rights and responsibilities.

____________________________________ ________________________

Patient Signature Date

Consent to Treat Minor without Parent Present

In order for us to treat a minor without a parent/legal guardian present, please complete this form and return it with a copy of the parent/legal guardian driver license or state issued identification to Midlothian Medical and Sports Center.

I, ________________________________(printed name) am the parent/legal guardian of _____________________________(printed name of minor), date of birth_______________.

I authorize Midlothian Medical and Sports Center to provide treatment per the signed treatment consent form to my son/daughter as deemed appropriate by the provider.

I further understand once my child reaches the age of eighteen (18) my consent for treatment is no longer needed.

This consent will remain in effect until the patient reaches the age of eighteen (18) unless revoked in writing to Midlothian Medical and Sports Center.

By signing this, I acknowledge I have read and agree to this consent and that any questions I had prior to signing were answered by Midlothian Medical and Sports Center.

Payment is expected the day of the appointment and can be made by cash, check, or credit card during check out.

____

Printed Name of Parent/Legal Guardian

____

Signature of Parent/Legal Guardian

In the event we need to contact you in regards toto please provide your best contact information.

Cell:___________________ Work:_______________ Home:__________________

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how Midlothian Medical & Sports Center may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient (print): ____

Date of Birth: ____________________

I. My Authorization

I authorize ______________________________ to use or disclose the following health information:

- ❑ All of my health information
- ❑ My health information relating to the following treatment or condition:

  ____

- ❑ My health information covering the period of healthcare from ______________(Start Date) to ________________(End Date).
- ❑ Other:____

The above party may disclose this health information to the following recipient:

Name/Organization:

____

Phone: ______________________ Fax: ______________________

Email: _________________________

The purpose of this authorization is (check all that apply):

- ❑ At my request
- ❑ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.
- ❑ To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.
- ❑ Other: ____

This authorization ends:

- ❑ On (Date): ______________________________
- ❑ When I am no longer a patient of the practice.
- ❑ When the following event occurs:

____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: ____

Date: ____

If the patient is a minor or unable to sign please complete the following:

- ❑ Patient is a minor: __________years of age
- ❑ Patient is unable to sign because:

____

Authorized Representative Signature: ____

Date: ____________________

Print Name of Representative:

____

Authority of representative to sign on behalf of patient:

❑ Parent ❑ Legal Guardian ❑ Court Order ❑ Other

III. Notice of Privacy Practice

The signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for the authorized party listed above and have read and understood its content.

Signature of Patient or Authorized Representative: ____

Date: ______________________ Time: ________________________