WELCOME

Date: _____

Patient Information

Name: _____
Last **First** **MI**

Email Address: _____

Mailing Address: _____

_____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female SS#: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Cell Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY INSURANCE BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, David B. Bradley, D.C., P.C., and/or Active Healthcare & Physical Medicine, L.L.C. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

Health History

Name: _____
Last **First** **MI**

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness		❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss ❑ Nausea
❑ Back Pain/Stiffness		❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste ❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders		❑ Glaucoma	❑ Migraines	❑ Psychiatric Care ❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	
	❑ Heart Disease	❑ Mumps	❑ Other _____	

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any medications you are currently taking: _____

_____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

_____

_____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

❑ Heart Disease __ ❑ Diabetes _____
❑ Cancer __ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

What is your daily/weekly intake of the following:

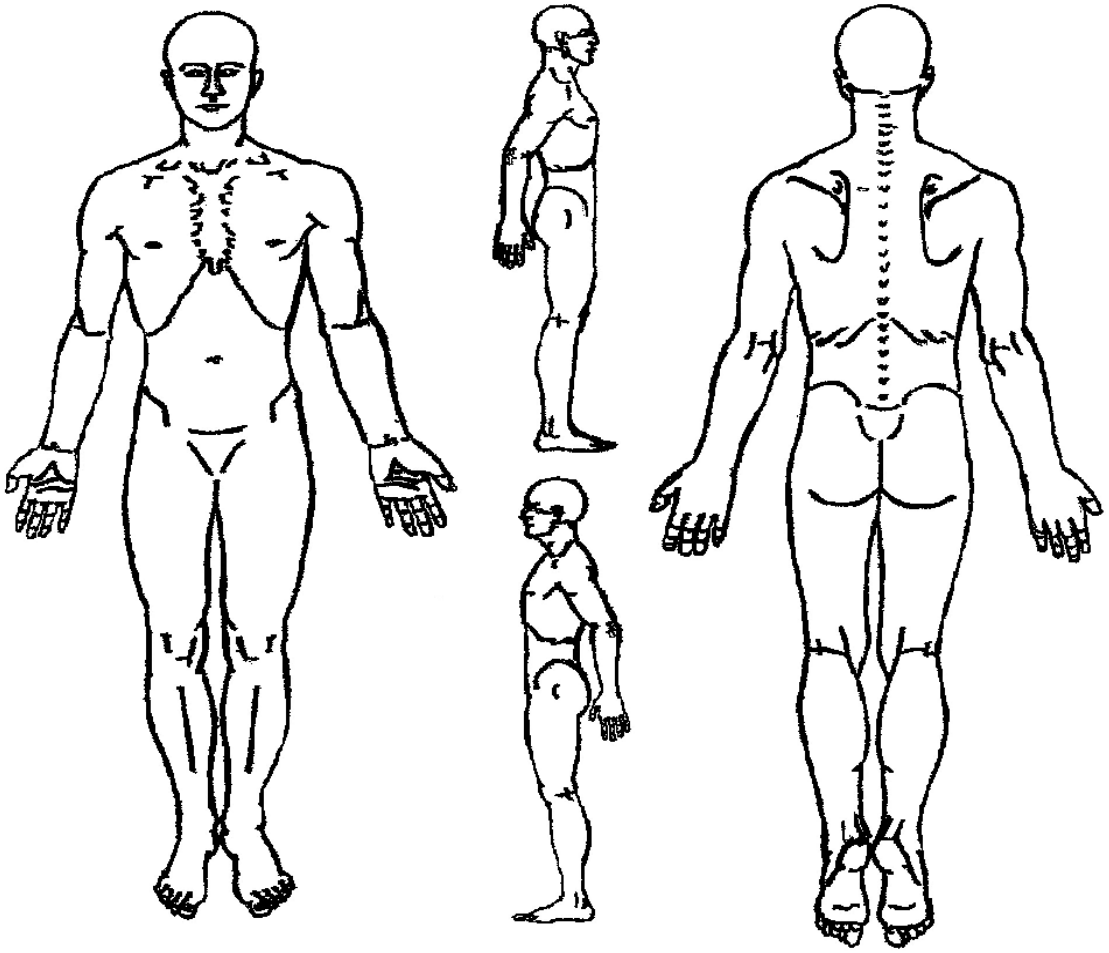
Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.
- **SIGNATURE:** _____ **DATE:** _____

Patient: _____ **Date:** _____

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW.

Key: **A=Ache** **B=Burning** **N=Numbness**
P=Pins & Needles **S=Stabbing** **O=Other**



Rate your pain on a scale of 1 to 10:

0	1	2	3	4	5	6	7	8	9	10
(No Pain)										(Worst Pain)

Signature **Date**

NAME _____ **DATE** _____

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

For any YES answer, please explain under comment and notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do your legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Have you tried any medications such as anti-inflammatory? NO YES
    If yes, what kind of medication? _____
    _____
12. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
    If yes: When? For how long? What kind? _____
    _____
13. Have you had an MRI? NO YES
    If yes: When? Who ordered it? What was it ordered for? _____
    _____
14. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If yes: When? What kind? Who ordered it? _____
    _____
15. If you have tried any treatment or medications, did this make your problem better? NO YES
    Comment: _____

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

NECK PAIN AND DISABILITY INDEX

Patient Name:_____ Date _____/_____/_____

Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section and then mark the box that most closely describes your problem.

SECTION 1 – PAIN INTENSITY

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is worse than imaginable at the moment.

SECTION 2 – PERSONAL CARE (washing, dressing, etc.)

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally, but it causes extra pain.
- ❑ It is painful to look after myself, and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ❑ I can lift heavy objects without any extra pain.
- ❑ I can lift heavy objects, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned on a table.
- ❑ Pain prevents me from lifting heavy objects, but I can manage light to medium objects if they are conveniently positioned.
- ❑ I can lift very light objects.
- ❑ I cannot lift or carry anything at all.

SECTION 4 – READING

- ❑ I can read as much as I want to with no pain in my neck.
- ❑ I can read as much as I want to with light pain in my neck.
- ❑ I can read as much as I want to with moderate pain in my neck.
- ❑ I can't read as much as I want to because of moderate pain in my neck.
- ❑ I can hardly read at all because of severe pain in my neck.
- ❑ I cannot read at all.

SECTION 5 – HEADACHES

- ❑ I have no headache at all.
- ❑ I have slight headaches, which come infrequently.
- ❑ I have moderate headaches, which come infrequently.
- ❑ I have moderate headaches, which come frequently.
- ❑ I have severe headaches, which come frequently.
- ❑ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- ❑ I can concentrate fully when I want with no difficulty.
- ❑ I can concentrate fully when I want with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want.
- ❑ I have a lot of difficulty in concentrating when I want.
- ❑ I have a great degree of difficulty in concentrating when I want.
- ❑ I cannot concentrate at all.

SECTION 7 – WORK

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I can hardly do any work at all.
- ❑ I cannot do my usual work.
- ❑ I can't do any work at all.

SECTION 8 – DRIVING

- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want with slight pain in my neck.
- ❑ I can drive my car as long as I want with moderate pain.
- ❑ I can't drive my car as long as I want because of moderate pain.
- ❑ I can hardly drive at all because of severe pain in my neck.
- ❑ I can't drive my car at all.

SECTION 9 – SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed. (Less than 1 hr. sleepless)
- ❑ My sleep is mildly disturbed (1-2 hrs sleepless)
- ❑ My sleep is moderately disturbed (2-3 hrs sleepless)
- ❑ My sleep is greatly disturbed (3-5 hrs sleepless)
- ❑ My sleep is completely disturbed (5-7 hrs sleepless)

SECTION 10 – RECREATION

- ❑ I am able to engage in all recreational activities with no neck pain.
- ❑ I am able to engage in all my recreational activities with some pain in my neck.
- ❑ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- ❑ I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ❑ I can hardly do any recreational activities because of pain.
- ❑ I can't do any recreational activities at all.

(For office use only) Score:_____

I understand that the information I have provided above is current and complete to the best of my knowledge. (Neck)

Signature:_____

Active Healthcare & Physical Medicine, L.L.C.

REVISED OSWESTRY LOW BACK PAIN AND DISABILITY

Patient Name: _____ Date: _____/_____/_____

Please read instructions carefully:

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please fill in ONE circle which most closely describes your problem.

SECTION 1 – PAIN INTENSITY

- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain comes and goes and is very severe.
- ❑ The pain is severe and doesn't vary much.

SECTION 2 – PERSONAL CARE

- ❑ I can look after myself without causing extra pain.
- ❑ I can look after myself normally but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but can manage most of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ❑ I can lift heavy weight without extra pain.
- ❑ I can lift heavy weight but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor.
- ❑ Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- ❑ I can only lift very light weights at the most.

SECTION 4 – WALKING

- ❑ I have no pain walking.
- ❑ I cannot walk more than one mile without increasing pain.
- ❑ I cannot walk more than ½ mile without increasing pain.
- ❑ I cannot walk more than ¼ mile without increasing pain.
- ❑ I can walk with crutches.
- ❑ I cannot walk at all without increasing pain.

SECTION 5 – SITTING

- ❑ I can sit in any chair as long as I like.
- ❑ I can only sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting more than one hour.
- ❑ Pain prevents me from sitting more than a half hour.
- ❑ Pain prevents me from sitting more than 10 minutes.
- ❑ I avoid sitting because it increases pain straight away.

SECTION 6 – STANDING

- ❑ I can stand as long as I want without pain.
- ❑ I have some pain on standing but it does not increase with time.
- ❑ I cannot stand for longer than one hour without increasing pain.
- ❑ I cannot stand for longer than ½ hour without increasing pain.
- ❑ I can't stand for longer than 10 minutes without increasing pain.
- ❑ I avoid standing because it increases the pain straight away.

SECTION 7 – SLEEPING

- ❑ I get no pain in bed.
- ❑ I get pain in bed but it doesn't prevent me from sleeping well.
- ❑ Because of pain my normal night's sleep is reduced by < ¼.
- ❑ Because of pain my normal night's sleep is reduced by < ½.
- ❑ Because of pain my normal night's sleep is reduced by < ¾.
- ❑ Pain prevents me from sleeping at all.

SECTION 8 – TRAVELING

- ❑ I get no pain while traveling.
- ❑ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ❑ I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- ❑ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that are done lying down.

SECTION 9 – SOCIAL LIFE

- ❑ My social live is normal and gives me no pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain limits my more energetic interests, e.g. dancing, etc.
- ❑ Pain has restricted my social life and I do not go out very often.
- ❑ Pain has restricted my social life to my home.
- ❑ I have hardly any social life because of the pain.

SECTION 10 – CHANGING DEGREE OF PAIN

- ❑ My pain is rapidly getting better.
- ❑ My pain fluctuates but overall is definitely getting better.
- ❑ My pain seems to be getting better but improvement is slow.
- ❑ My pain is neither getting better nor worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

For office use only – Score:_____(LOW BACK)

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____

Name:_____ Date: _____

HEAVY METAL TOXIN SCREENING

Please complete the following questionnaire. Mark each symptom based on your experience. Some of these symptoms may have been repeated previously in this paperwork.

Symptom Scoring System:
■□□□ = No Symptoms
□■□□ = Experience Mild Symptoms
□□■□ = Experience Moderate Symptoms
□□□■ = Experience Severe Symptoms

A) Psychological, physical and behavioral problems
□□□□ Chronic fatigue
□□□□ Tired in the morning upon waking
□□□□ Excessive sleeping
□□□□ Hypoglycemic (with unexplained energy bursts)
□□□□ Muscular weakness
□□□□ Seasonal depression
□□□□ Memory loss
□□□□ Irritability
□□□□ Difficulty to concentrate
□□□□ Nightmares
□□□□ Sleep disorders, trouble falling asleep, waking too early
□□□□ Suicidal tendencies
□□□□ Difficulty in making decisions

B) Central Nervous System
□□□□ Dizziness
□□□□ Loss of muscle control in hands and/or feet
□□□□ Loss of muscle coordination
□□□□ Muscle paralysis
□□□□ Vision gets more and more limited or troubled
□□□□ Tinnitus
□□□□ Shaking hands and/or arms
□□□□ Loss of hearing
□□□□ Muscle Spasms

C) Immune System
□□□□ Frequent colds
□□□□ Allergies
□□□□ Asthma
□□□□ Sinusitis
□□□□ Multiple Sclerosis
□□□□ Hodgkin Disease
□□□□ Leukemia
□□□□ Auto immune disorders
□□□□ Diagnosed with cytomegalovirus, herpes, Epstein Barr

D) Endocrine System
□□□□ Tendency to diabetes
□□□□ Renal stones
□□□□ Thyroid dysfunction
□□□□ Low sex drive
□□□□ Muscle wasting
□□□□ Cold hands and feet

E) Cardiovascular System
□□□□ High blood pressure
□□□□ Tachycardia
□□□□ Pain in the heart region/angina
□□□□ Low blood pressure
□□□□ Loss of cardiac rhythm

F) Intestine
□□□□ Intestinal spasms (alternates from diarrhea to constipation)
□□□□ Irritable bowel syndrome
□□□□ Stomach pains
□□□□ Stomach ulcers
□□□□ Diverticulitis
□□□□ Colitis

G) Skin problems
□□□□ Dry skin
□□□□ Rashes
□□□□ Eczema
□□□□ Itchy skin

H) Oral problems
□□□□ Metallic taste in mouth
□□□□ Bleeding gums
□□□□ Periodontal disease
□□□□ Bad breath
□□□□ Charged tongue

CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

_____ _____

Patient's Name (Please Print) **Date**

_____

Patient's Signature

☐ **I request a copy of this signed document.**

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ There is a possibility that I may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because:_____
_____
_____

Date of last menstrual period: _____

_____ _____

Patient's Signature Date

PATIENT MISSED APPOINTMENT POLICY

DEFINITIONS

POLICY- a way of managing affairs so as to achieve some purpose.

APPOINTMENT- a meeting with someone at a certain time and place.

MISSED- fail to keep, do, or be present at.

It is our wish that each and every one of our patients receive the very best care and service possible. **Your Treatment Program** consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all your appointments. Arrange the activities in your life so that this can occur.
2. If you become ill, we still want you to come in, because **Treatments** will help you recover.
3. If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.
4. With the exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.
5. **All cancelled or missed appointments must be rescheduled and made up within one week.**
6. **There is a $40.00 service charge for no call/no show appointments.**

I have read, understand, and agree to follow the above policy.

Patient's Name: _____

Signature: _____

Staff Witness: _____

Financial Office Policies
Active Healthcare and Physical Medicine

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information necessary to process any claims.
11. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care then our standard fees will apply.
15. This office accepts MasterCard, Visa, American Express, Discover Card, personal checks and cash.
16. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
17. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.

Thank you for your cooperation in this matter.
I have read and fully understand the financial office policy and agree to abide by these terms.

_____ _____/_____/_____
Patient Signature or Responsible Party Date

Active Healthcare and Physical Medicine
1228 Precinct Line Rd., Ste. B
Hurst, TX 76053
P: (817) 282-7600 F: (817) 282-7604

Assignment of Insurance Benefits Policy

I have been informed that my insurance company will assign benefits over to this office, meaning that any amount due to the doctor's office that would have been mailed to me, the patient, will be mailed to the doctor's office.

Since my insurance company will assign benefits directly to the office, I am opting to follow the below 'Assignment of Benefits' policy.

Our office will treat you and you will be responsible to pay the deductible, co-payments or co-insurance that are due for each of your allowed visits by the insurance company. To do this, our office will require a valid credit card on file.

If the insurance disburses funds to you, the patient, you are required to bring the payments to this office within seven (7) days. If we have not received the payment from you, the patient, within seven (7) days, our office will charge the amount that you received from the insurance company to the credit card on file. NOTE: We will only charge the credit card if payment of the insurance proceeds are not delivered within seven (7) days.

If unusual circumstances should arise where you cannot bring the payment in, please call the office to let us know so we can take a credit card payment over the phone. (Ex. You're out of town, emergency, etc.)

If the insurance company denies your claim, you will be responsible for services rendered.

I have read the above policy and my signature below indicates that I understand and agree to follow this policy.

_____ _____/_____/_____
Patient's Printed Name Date

_____
Patient's Signature

Instructions:

1. Have the "Insured" person of the policy sign the back of the check
2. Bring the check and EOB (explanation of benefits) to our office within 7 days. **DO NOT DETACH THE CHECK FROM THE EOB.**
3. Give the EOB/Check to the front desk when you arrive to our office. We will make a copy for your records.

Active Healthcare and Physical Medicine
1228 Precinct Line Rd Ste B
Hurst, TX 76053
P: (817) 282-7600 F: (817) 282-7604

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Active Healthcare.

(Please initial one of the following options and sign below.)

_____ I wish to receive a **paper copy** of Privacy Notice.

_____ I wish to receive an **electronic copy** of Privacy Notice.

My email address is: _____@_____

_____ **I do not request a copy of the Privacy Notice** at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that as a normal part of patient care at Active Healthcare, some of the diagnostics and treatments are done in a communal area where other patients and staff will be able to hear and see me. If the open area protocol is not to my liking or I feel it violates my HIPPA rights, I agree to inform Active Healthcare in writing so other arrangements can be made. **If, on a particular visit, I need to talk to the doctor/staff in private, I will inform the Front Desk Assistant so that I can be accommodated.**

_____ I acknowledge that it is the policy of Active Healthcare to leave reminder messages on my answering machine, on my cell phone, or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date