WHITE INTEGRATED HEALTH CLINICS, PLLC

DALE L. WHITE JR., D.C.,
D.C.C.T., F.I.C.C.
DONALD WHITE, D.C., F.I.C.C.
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FAX: (817) 740-1701

5925 CONVAIR DRIVE
SUITE 509
FORT WORTH, TX 76109
PHONE: (817) 349-7541
FAX: (817) 349-7549

Confidential Patient Information

Date:______________

Patient Name: ____ Age:____
Last First M.I.

Address: ____ Sex: [ ] Male [ ] Female

____ D.O.B. ________________
City State Zip Code

Email Address: ____ Number of Children: _______

Patient Social Security #:______________________ Patient Driver's License #: ____________________

Employer/Occupation: ____________________________________ Employer Phone #: ___________________

Does work involve: [ ] Sitting [ ] Standing [ ] Light Labor [ ] Heavy Labor

Marital Status: [ ] Single [ ] Married [ ] Windowed [ ] Separated [ ] Divorced

Spouse's Name: ____ Spouse's D.O.B. ________________

Spouse's Occupation/Employer: ____

Name of Primary Care Physician: _________________________________ Phone #: _________________

Whom may we thank for referring you? ____

Contact Information

Cell #: _________________________ Work #: _______________________ Ext._______________

Other Phone Numbers: ____

In Case of Emergency

Name: ____ Relationship: _________________________

Cell #: ____ Work #: ______________________________

History of Present Injury/Illness

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[ ] Neck Pain
[ ] Nausea
[ ] Cold Feet
[ ] Fatigue
[ ] Chest Pain
[ ] Headaches
[ ] Fever
[ ] Stomach Problems
[ ] Night Pain

[ ] Pins/Needles in Arms
[ ] Back Pain/Stiffness
[ ] Loss of Taste
[ ] Loss of Memory
[ ] Jaw Problems
[ ] Cold Sweats
[ ] Fainting
[ ] Asthma
[ ] Erectile Dysfunction
[ ] Decreased Libido

[ ] Light Bothers Eyes
[ ] Pins/Needles in Legs
[ ] Arm/Hand Pain
[ ] Leg/Knee Pain
[ ] Loss of Smell
[ ] Constipation
[ ] Dizziness
[ ] Shortness of Breath
[ ] Vaginal Dryness
[ ] Decreased Sexual Performance

[ ] Sudden Weight Loss
[ ] Depression
[ ] Nervousness
[ ] Sleeping Difficulties
[ ] Tension
[ ] Cold Sweats
[ ] Allergies
[ ] Blurred Vision
[ ] Bowel/Bladder Changes

Medical History

Please list any medications you are currently taking (be sure to include dosage): ____________________________
____
____

Please list any surgeries and/or hospitalizations with dates: ____
____
____

Please list any allergies: ____

[ ] Hypertension
[ ] Diabetes
[ ] Cancer
[ ] Ulcers
[ ] Stroke

[ ] Heart Disease
[ ] Rheumatoid Arthritis
[ ] Fibromyalgia
[ ] Osteoporosis
[ ] Arthritis

[ ] Migraines
[ ] Pinched Nerve
[ ] High Cholesterol
[ ] Thyroid Problems
[ ] Bleeding Ulcers

[ ] Liver Disease
[ ] Kidney Disease
[ ] Herniated Disc
[ ] Pacemaker
[ ] Peyronie's Disease

Approximate Date of Last Flu Vaccine:_______________________

WOMEN ONLY: Date of LMP: _____________ Any Possibility of Pregnancy: __________________

Is there a family history of the following conditions? Please indicate which family member.

[ ] Heart Disease _______________________ [ ] Diabetes _____________________
[ ] Cancer _____________________________ [ ] Arthritis _____________________

Intake of the following: Cigarettes ___ packs/day Alcohol _____drinks/week Caffeine: ____ cups/day

Exercise Frequency: [ ] Never [ ] Daily [ ] Weekly [ ] Walks [ ] Runs [ ] Swims

Signature: ____ Date: ____________________

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Consent to use PHI

Acknowledgement 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 **White Integrated Health Clinics, 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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Electronic Health Information

Patient Name: ________________________Co# ___________

Smoking Status: (choose one)

- ☐ Never
- ☐ Former
- ☐ Current (Everyday)
- ☐ Current (Occasional)

Which method do you prefer the clinic contact you at? (Please choose all that apply, and number them in order of preference, eg. #1, 2, 3)

- ☐ Phone ____________________ Can we leave a detailed message? Y / N
- ☐ Email ____________________
- ☐ Mail

Ethnicity: (choose one)

- ☐ Hispanic
- ☐ Not Hispanic

Race: (choose one)

- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/ Pacific Islander
- ☐ White

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HIPPA STATEMENT

White Integrated Health Clinics, PLLC (WIHC) will identify and evaluate the likelihood and consequences of threats to the security of Protected Health Information and implement reasonable and appropriate measures to safeguard the confidentiality, availability, and integrity of that information. WIHC will adopt and implement HIPAA security practices outlined in the approved HIPAA Security Procedures.

This policy applies to all members of the WIHC workforce, along with all independent contractors who provide services that require access to clinic buildings or the PCC computer network. They will be required to adhere to the policies and procedures in the HIPAA Security Procedures, as well as any procedures established to support this policy.

WIHC will safeguard information in a manner consistent with applicable requirements of federal, state and local law and regulations, including the final rule governing the security of health information systems enacted by the Department of Health and Human Services as required by HIPAA.

Please sign and date below that you have read our HIPPA statement. You are always welcome to request a copy of this at any time.

____________________________	____________________________	______________
Printed Name	Signature	Date

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Patient Rights and Responsibilities

Your rights as a patient:

- To be treated with respect and consideration without regard to race, creed, national origin, disability, gender or age.
- To obtain complete and current information concerning all aspects of your care.
- To be seen by the doctor of choice.
- To know the name and professional status of all people who provide your care.
- To refuse care and to be informed of the clinical consequences of this action.
- To expect that communications and records are treated confidentially according to current regulations and/or as required by law.
- To understand why tests and procedures are required.
- To understand and receive an explanation of your bill, regardless of source of payment, and options for available payment plans.
- To be advised of any potential involvement in research projects. The patient has the right to refuse to participate in such projects.
- To expect reasonable continuity of care.
- To receive information to make informed consent prior to the start of any procedure and/or provision of patient care.
- To review your personal healthcare record and to receive an explanation of information contained therein within a reasonable timeframe, in accordance with clinic policy.
- To request an amendment of your personal healthcare record.
- To be free from all forms of abuse or harassment.
- To receive care in a safe and smoke-free environment.
- To receive information about how to submit a complaint or concern, upon request, from White Integrated Health Clinics, PLLC.
- To submit a complaint or concern, verbally or in writing, without compromise to your care or access to care.

Your responsibilities as a patient:

- To arrive on time for appointments and follow-up visits and to phone White Integrated Health Clinics, PLLC if you must cancel or arrive late.
- To provide White Integrated Health Clinics, PLLC with a complete and accurate clinical history.
- To ask questions if any aspect of your care is not clear.
- To follow directions concerning clinical management and to express any concerns about your ability to follow such directions throughout the course of care.
- To treat all those involved in the White Integrated Health Clinics, PLLC community with respect and consideration.
- To take financial responsibility for services provided by White Integrated Health Clinics, PLLC.
- To report changes in health status/condition to the clinician providing care.
- To recognize the effect of lifestyle on personal health.
- To be respectful of the property of White Integrated Health Clinics, PLLC.

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Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

☐ Scheduling of Appointments ☐ Billing ☐ Insurance ☐ Medical Records

☐ Other: ______________________

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

____

Name of Person / Organization

____

Name of Person / Organization

Expiration Date of Authorization

This authorization is effective through December 31, 2020 unless revoked or terminated by the patient or patient's personal representative.

Patient Rights

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

If you understand and agree with all of the above policies, please sign your name below.

______________________ ______________

Patient or Legally Authorized Individual Signature Date

______________________ ______________

Print Patient's Full Name Time

______________________ ______________

Witness Signature Date

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TREATMENT AGREEMENT, PARTIAL ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, AND CONTRACTUAL LIEN

Consideration: In consideration for the Offices services, I, the undersigned, agree to the following:
Definitions: For the purposes of this Agreement, the following terms shall have the following meaning: Office shall refer to **WHITE INTEGRATED HEALTH CLINICS, PPLC**; Payer shall refer to without limit, any insurance carrier, health plan benefit administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for any reason; Proceeds shall include, without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits, plans, or coverages: individual or group health benefits, Medicare, Medicaid, workers compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; Charges shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, depositions, and testimony), any Collection costs incurred by the Office, interest to the extent permitted by law, and any other charges incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Partial Assignment of the Cause of Action, Assignment of Proceeds, and Contractual Lien. I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to the Office, as well as any and all causes of action that I might have now or in the future against any Payer to the extent of my Charges, the right to prosecute such causes of action either in my name or in the Office's name and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further assign my right to receive any Proceeds from any Payer to the Office. I further grant a contractual lien to the Office with respect to my charges, however nothing in this Agreement shall be construed as an election or waiver by the Office to any protection under any statutory lien law. Consistent with these rights, I hereby direct any and all Payers, to pay the Proceeds directly to, and exclusively in the name of, the Office in the amount of my charges.

Other Terms: I understand that I remain personally responsible for my charges and that nothing in this Agreement requires the Office to await payment for my charges. I agree to pay the full amount of my charges to the Office upon its demand. I understand that at any time, I can request a copy of my total charges. I hereby waive any statute of limitations which may apply to the collection of my charges.
In the event that I retain one or more attorneys to assist me in collecting my proceeds, I direct each attorney to issue an irrevocable letter of protection to the Office regarding my charges. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds received by the Office.

I authorize and direct the Office to submit my charges to any and all Payers including, without limit, my health benefit plan. I understand, however, that in the event that my Charges are submitted to more than one Payer, I hereby authorize and direct the Office to apply any Proceeds received from one Payer to any reductions, write-offs, or discounts, issued by another.

I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

This Agreement shall not be modified or revoked without the mutual written consent of the Office and myself. I hereby revoke the terms of any previously signed documents to the extent those terms conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of the Agreement be found to be invalid, illegal, or unenforceable, or for any reason cease to be binding on any part hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patients **Printed** Name: ______________________________
Patients **Signature:** ________________________________ Date**:** ________________
Printed Name of Parent or Legal Guardian, on Behalf of Patient: _________________________