

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.
VALERIE FLETCHER, D.C.
KEVIN SYKES, D.C.
CATHERINE STEPHENS, APRN, FNP-C
PAUL C. HARRIS, M.D. — MEDICAL DIRECTOR

RIVER OAKS LOCATION:
1141 LONG AVENUE
FORT WORTH, TX 76114
PHONE: (817) 625-1165
FAX: (817) 740-1701

WATERSIDE LOCATION:
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

City State Zip Code D.O.B. _____

Email Address: _____ Number of Children: _____

Social Security #: _____ Driver's License #: _____

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

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Employer/Occupation: _____ Employer Phone #: _____

Does work involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

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

Spouse's Name: _____ Spouse's D.O.B. _____

Spouse's Occupation/Employer: _____

Name of Primary Care Physician: _____ Phone #: _____

How did you hear about our clinic? _____

Contact Information

Preferred Contact Method? _____ Time of Day: _____

Cell #: _____ Work #: _____ Ext. _____

Other Phone Numbers: _____ May We Leave a Voicemail? ☐ Yes ☐ No

In Case of Emergency

Name: _____ Relationship: _____

Cell #: _____ Work #: _____ Ext. _____

History of Present Injury/Illness

- | | | |
|---|--|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Tension | <input type="checkbox"/> Night Pain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Headaches | <input type="checkbox"/> Erectile Dysfunction |
| <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Vaginal Dryness |
| <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Constipation | <input type="checkbox"/> Bowel/Bladder Changes |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Decreased Libido |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fever | <input type="checkbox"/> Decreased Sexual |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fainting | Performance |

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: _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Bleeding Ulcers |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Peyronie's Disease |
| <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Osteoporosis | |

Approximate Date of Last Vaccine: _____ Type of Vaccine: _____

Any Adverse Reaction(s)? ☐ No ☐ Yes If yes, please explain: _____

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

- | | |
|--|--|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ |

Medical History (Continued)

Intake of the following:

Cigarettes ____ packs/day Alcohol ____ drinks/week Caffeine: ____ cups/day

Exercise Frequency: ☐ Never ☐ Daily ☐ Weekly ☐ Other: _____

Have you ever had Chiropractic Care? ☐ No ☐ Yes If yes, when? _____

Current Injury/Illness

Is this condition due to an accident? ☐ Yes ☐ No (If no, skip to the next section)

Type of Accident: ☐ Automobile ☐ Work ☐ Other: _____

Women Only

Date of Last Well Woman Exam: _____ Date of Last Mammogram: _____

Date of Last Menstrual Period: _____ Any Possibility of Pregnancy: ☐ Yes ☐ No

Signature: _____ Date: _____

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____

Address: _____

Insurance Information

Insurance Company Name: _____

Group # _____ Policy/ID # _____

I understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this medical office will prepare any necessary reports and forms to assist me in making collections from the insurance company. I understand that any amount authorized to be paid directly to this medical office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me, and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient 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, PLLC**; 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.

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

Printed Name of Parent or Legal Guardian, on Behalf of Patient: _____

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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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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

White Integrated Health Clinics, PLLC
Waterside
5925 Convair Drive, Suite 509
Ft. Worth, TX 76109
Phone: 817-349-7541 | Fax: 817-349-7549

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 unless revoked or terminated in writing 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 the above policies, please sign your name below.

Patient or Legally Authorized Individual Signature

Date

Print Patient's Full Name

Time

Witness Signature

Date