CellGenuity REGENERATIVE SCIENCE

MCKENNA ORTHOPEDICS & BIOLOGICS

RECLAIM PHYSICIANS MEDICAL GROUP

R. Wade McKenna, D.O. Russell Phillips, D.O. Troy B. Chandler PA-C

Patient Name: (last): _____ (First) _____ (Middle) _____ DOB: _____ / _____ / _____

Welcome to **McKenna Orthopedics**, the following information is needed for your upcoming appointment. Please have your insurance card and drivers' license available for the check-in process. ***If you have had an MRI or X-Rays please be sure and bring your images on a disc.*** Your appointment time is reserved exclusively for you, if you are unable to make your appointment please call within 24 hours to cancel. If you arrive more than 15 minutes late to your appointment please be aware that it will be rescheduled. Not having this information completed in full could result in a delay at the time of your appointment.

It is the Patients Responsibility to know and understand their insurance they have signed up for as well as deductibles and co-pays. Please call your insurance company if you have any questions regarding your policy or coverage. Is the doctor you are seeing a **CONTRACTED PROVIDER** with your insurance? Do you need **PRIOR AUTHORIZATION** for procedures or visits? Are X-Rays and Supplies included I your COPAY? How much is your **COPAY** for a Specialist? Do you have a **YEARLY DEDUCTIBLE** and if so how much _____, and has it been met? Is there a **Co-Pay** and if so what is it? _____

Private pay patients – For patients with no insurance please be aware that our office requires a **$400** deposit for your initial visit. If there are additional charges be prepared to make payment arrangements at check-out.

Photo Consent I consent for a photograph to be made of me or my child (or person for whom I am a legal guardian). I understand that the information will only be used for identification purposes and will be stored securely on the medical record. Refusal to photograph will not affect my medical care. If I prefer not to be photographed, I will be asked to provide photo identification at each visit.

(Initial)_____ I agree for a photograph to be made of me for identification purposes.
(Initial)_____ I agree to use of my or my child's picture for identification purposes.
(Initial)_____ I prefer not to have a photo made of me, my child or dependent.

Prescriptions. Please Allow 48-72 hours on **Prescription** refill requests. Notify your Pharmacy directly on **REFILLS.**

Medical Record Request Please Allow 7 to 10 days to process and a 25.00 fee for *each* request

HIPPA Exceptions (please initial all that apply)
Health Insurance Portability and Accountability ACT

(Initial)_____ Ok to have a message left on my answering machine
(Initial)_____ Ok to leave a message with spouse
(Initial)_____ Ok to leave a message with any adult who answers my phone
(Initial)_____ Ok to leave a message regarding appointments only
(Initial)_____ I Understand appointment reminders are sent via Text or Email

CONSENT FOR TREATMENT I authorize the physicians at McKenna Orthopedics & Biologics to examine me (or the patient for I am legally responsible) and to do any x-rays or other tests that may be needed to make a diagnosis and to provide treatment. I consent to necessary office or other outpatient treatment after being properly informed of alternatives, benefits, and risks.

PHYSICIAN OWNERSHIP DISCLOSURE STSTEMENT The Centers for Medicare & Medicaid Services (CMS) requires any physician – owned hospital to provide written notice disclosing the following information to you the patient.

CONSENT TO OBTAIN PATIENT MEDICATION HISTORY Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical records. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

CellGenuity
REGENERATIVE SCIENCE

MCKENNA
ORTHOPEDICS
& BIOLOGICS

RECLAIM
PHYSICIANS MEDICAL GROUP

R. Wade McKenna, D.O. Russell Phillips, D.O. Troy B. Chandler PA-C

WORKER'S COMPENSATION PATIENTS: It is extremely important to notify our office if this is a worker's compensation injury prior to your visit. Please have all relevant information available in order to quickly complete the screening process. Patient care is our primary concern. It should be noted that on all worker's compensation patients, urine drug screening is carried out to check for therapeutic levels of prescribed medications and to protect patients from combination drug therapy and limit our surgical risks to the patient. Testing is carried out on the initial visit, prior to surgery, and at three months or as needed to follow prescription narcotic usage. The urine drug screen is carried out on the prescription narcotics with which we prescribe as well as the illicit drugs that increase your surgical risks such as methamphetamines, amphetamines, cocaine, and diet pills. Marijuana is not part of the urine drug screen. Please notify us ahead of time if any of these may show up positive so we can provide the appropriate screening. The narcotic usage and the medical risks associated with that will be gone over with you at the time of urine drug screening if there are any positives. (Initial)_____

OTHER TESTING. As part of normal treatment or protocol, patients may be subject to in-office radiographs, random urinary toxicology screening, and other testing and treatments recommended or deemed appropriate. The reasons for urine toxicology screening are to check on therapeutic levels of prescribed narcotic medications and to limit the risks of combination drug therapy and limit surgical risks. Narcotic usage on the urine toxicology screening this office performs does not include marijuana. It only includes the prescribed narcotics that this office uses as well as medications and illicit drugs that would increase your surgical risks or adverse outcomes such as methamphetamines, amphetamines, cocaine, and prescription narcotics.

FINANCIAL AGREEMENT I agree to pay all professional fees charged by Dr. McKenna for my (the patient's) care, irrespective of any insurance benefits to which I may be entitled, except if Dr. McKenna has agreed to accept insurance benefits as full payment for covered services in accordance with federal or state law (e.g., Medicare, Medicaid) or by contract with a prepaid health plan or managed-care plan, and provided such insurance benefits are paid within 60 days of claims submission, and provided there is no recovery from a third-party negligence lawsuit (see Injuries and Third-Party Negligence, below). Ultimately it is your responsibility to understand the coverage that you pay for in a monthly premium to your carrier. If an employer or its carrier denies a claim for payment for a work-related injury, or if a prepaid health plans, managed-care health plan, or Medicare considers certain services ineligible or uncovered services, then I shall pay for those services. I understand that claims for services remaining unpaid 60 days after claims submission shall be presumed ineligible for insurance reimbursement, and I shall pay for those services. If patient is a minor-the parent/guardian who requests treatment for a child will be responsible for all fees. (Initial)_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION I authorize McKenna Orthopedics & Biologics o release to any insurance company, health plan, or governmental agency such medical information that may be required to process my claim of the medical bill. I also authorize McKenna Orthopedics & Biologics to release appropriate information to any doctor, hospital, or other health care facility that has or will participate in my (the patient's) care. I authorize a photocopy, facsimile, or other electronic transmission of the above Assignments, Authorizations, and Releases to be used in place of the original until and unless I send written notice to the contrary to the office of McKenna Orthopedics & Biologics .
I further authorize any other doctor, hospital, or health care facility to release to McKenna Orthopedics & Biologics any medical information concerning my (the patient's) illness or injury.

INJURIES AND THIRD-PARTY NEGLIGANCE. I understand and agree that Dr. McKenna has granted discounts from its usual fees for any reason, including its participation in prepaid or managed-care health plans, and if I (the patient) recover(s) any monies as the result of any judgment, award, or settlement of any lawsuit arising from treated injuries or illness, then I shall give a lien to Dr. McKenna against such monetary recovery in the full amount of such discounts.
Delinquency. If my (the patient's) account becomes delinquent I understand that Dr. McKenna, at its sole discretion, may refer to a collection agency or an attorney as allowed by law.

INSURANCE ASSIGNMENT I authorize any insurance company or third-party payer to whom a claim for payment has been submitted to pay any eligible benefits directly to Dr. McKenna I hereby authorize payment go directly to Dr. McKenna of medical benefits payable by my insurance company and understand that I am responsible for any charge not covered by the terms of my insurance policy. I hereby assign Dr. McKenna full rights to represent my (the patient's) interests in any complaints of appeals of denial of benefits or reimbursement to the Texas Department of Insurance (State Insurance Commissioner). I hereby authorize said assignee Dr. McKenna to furnish these agencies such information as may be necessary to support such complaints or appeals.

I agree I cannot revoke the FINANCIAL AGREEMENT or the INSURANCE ASSIGNMENT at any time while any portion of the medical bill remains unpaid.

I have read, understand, and do hereby agree to the terms of the forgoing Assignments, Authorizations, and Releases. I also certify that the PATIENT INFORMATION I have provided is true and accurate to the best of my knowledge.

_____ _____
Patient, Parent, or Legal Guardian **Date**

CellGenuity REGENERATIVE SCIENCE

MCKENNA ORTHOPEDICS & BIOLOGICS

RECLAIM PHYSICIANS MEDICAL GROUP

R. Wade McKenna, D.O. Russell Phillips, D.O. Troy B. Chandler PA-C

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU THAT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

The Health Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individual identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. You may request a copy of the notice at any time.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose the information.

We may use and disclose your medical records for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more providers. For example, if your provider refers you to a specialist, we will provide the appropriate medical information to that physician to facilitate your care.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health Care Operations include the business aspect of running our practice, such as conducting quality a assessment and improvement activities, auditing functions, cost-management analysis, and customer services. An example would be internal quality assessment review.

Disclosures That Can Be Made Without Your Authorization There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization in writing to stop future uses and disclosers. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Heath, Abuse, or Neglect, and Health Oversight We may disclose your medical information for public health activities as authorized.

Legal proceedings and Law Enforcement We may disclose your medical information in the course of judicial or administrative proceedings, in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

Workers Compensation We may disclose your medical information as required by the Texas Worker's Compensation Law.

Inmates If you are a inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official.

Military, National Security, Intelligence Activities, Protection of the President We may disclose your medical information to authorized government functions.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors We may release medical information to researchers for research purposes if authorized; to organ procurement organizations for the purpose of facilitating organ eye or tissue donation; to a coroner or medical examiner to identify a deceased or cause of death; or to a funeral director where such a discloser is necessary for the director to carry out his duties.

Required by Law We may release your medical information where the disclosure is required by law.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Your Rights Under Federal Privacy Regulations

Requested Restrictions You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do not have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances. To request a restriction, submit the following in writing: a) the information to be restricted, b) what kind of restriction you are requesting, and c) to whom the limits apply. You may also request that we limit disclosure to family members, other relatives, or personal friends that may or may not be involved in your care.

Right to Inspect and Copy You have the right to inspect and request copies of health information that is within the designated record set, which is information that is used to make decision about your care. You must submit your request in writing to the Privacy Officer, HIPAA permits us to charge a fee for copies of medical records. We can refuse to provide access to or copies of some information for certain reasons, when we provide a review of our decision on your request. Another licensed health care provider who was not involved in the provider to deny access will make any such review. We are required to respond or provide copies within fifteen (15) days of your request.

Right to Amend Your Protected Health Information You may request an amendment of your medical information in the designated record set. Request must be in writing using the designated McKenna Orthopedics & Biologics form, and presented to the Privacy Officer of McKenna Orthopedics & Biologics. You must provide a reason that supports your request for amendment. We will respond within sixty (60) days of your request. We may refuse to allow the amendment in the following circumstances: a) is not a part of the designated record set, b) information was not created by health care providers in this practice, c) is not available for inspection because of an inappropriate denial, or d) if the information is accurate and complete. Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing. If we approve the amendment, we will also inform you in writing, allow the amendment to be made, and notify others involved in your health care.

Right to an Accounting of Disclosures The HIPAA privacy regulations permit you to request, and us to provide an accounting of disclosures that are other than for treatment, payment, healthcare operations, or made via an authorization signed by you or your representative. Request must be submitted in writing on the designated McKenna Orthopedics & Biologics form, and presented to the Privacy Officer. Your first request of accounting within a twelve (12) month period is free. For additional request within that period we may charge you for providing the list. We will notify you of the charge, and you may withdraw or modify your request before any costs are incurred.

Appointment Reminder, Treatment alternatives, and Other Health Related Benefits
We may contact you by telephone, mail, or both to provide appointment reminders, Information about treatment alternatives, or health related benefits and services that may be of interest to you.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of the Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make a new notice provision effective for all protected health information that we maintain. We will post it, and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You the right to file a written complaint with our office, or with the Department of Health and Human Services; Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPPA or to file a complaint:

The U.S. Department of Health and Human Services

Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Privacy Officer
1713 S FM F1 Ste 103
Decatur, Texas 76234
(940) 627-697
Fax: (940) 627-349

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have reviewed the **Notice of Privacy Practices**, which explains how my medical information will be used and disclosed

_____ _____
Patient's Printed Name Date of Birth

_____ _____
Signature of Patient/Legal Representative Date

_____
If Legal Representative, Relationship

CellGenuity REGENERATIVE SCIENCE

MCKENNA ORTHOPEDICS & BIOLOGICS

RECLAIM PHYSICIANS MEDICAL GROUP

R. Wade McKenna, D.O. Russell Phillips, D.O. Troy B. Chandler PA-C

PATIENT INFO

Name: (LAST) (MI) (FIRST)

Address: (STREET) (CITY) (STATE) (ZIP)

Home Phone: Work Phone: Cell Phone:

Email Address:

DOB: / / Soc. Sec #: - -

Driver's License #: State:

Marital Status: S M W Spouse's Name: Phone:

Your Employer: Occupation:

Employer Address: (STREET) (CITY) (STATE) (ZIP)

Referred By: Primary Care Physician:

INSURANCE INFORMATION

Insurance Type: Health Personal PayPal/Autoworker's Comp Medicare

Insurance Name:

Member #: Group #:

Insurer's Name (If Different from Patient): Relationship to Patient:

Insurer's DOB: / / Insurer's Soc. Sec #: - -

Insurer's Employer:

Secondary Insurance:

Member #: Group #:

Insurer's Name (If Different from Patient): Relationship to Patient:

I clearly understand and agree that all services rendered to me are charged directly to me and that 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/Guardian Signature: _____ **Date** _____

CellGenuity
REGENERATIVE SCIENCE

MCKENNA
ORTHOPEDICS
& BIOLOGICS

RECLAIM
PHYSICIANS MEDICAL GROUP

R. Wade McKenna, D.O. Russell Phillips, D.O. Troy B. Chandler PA-C

PATIENT INTAKE FORM

Patient Name: _____ Date: _____ Date of Birth: _____

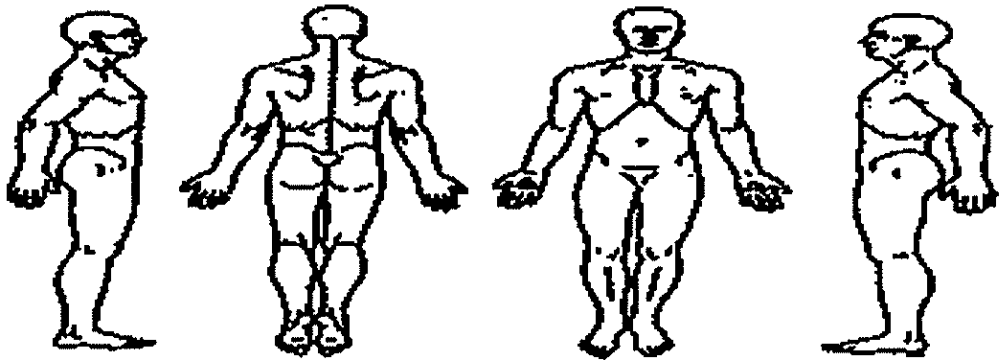
Height: _____Weight: _____ Substance Abuse: ☐Y ☐No / Current Smoker: ☐Y ☐No / Alcohol Use: ☐Y ☐No / Drug Use: ☐Y ☐No

Chief Complaint/Reason for the visit: _____

Date of onset/How long have you had this problem? _____

Was your complaint a result of: ☐ Car Accident ☐ Fall ☐ Work Injury ☐ Other, please explain_____

Indicate on the drawings below **where you have pain/symptoms**



How would you describe the type of pain? ☐ Sharp ☐ Numbness ☐ Dull ☐ Tingling ☐ Swelling ☐ Catching ☐ Shock ☐ Weakness ☐ Burning ☐ Knots ☐ Throbbing ☐ Stabbing ☐ Stiffness ☐ Other Please Explain:_____

Using a scale from 0-10 (10 being the worst), how would you rate your problem? (*Please circle*) 0 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

What alleviates your problem? ☐ Rest ☐ Therapy ☐Heat ☐ Cold ☐Brace ☐Exercise
☐ Medication: _____

☐ Other, please explain:_____

What aggravates your problem? ☐Sitting ☐Standing ☐Bending ☐Lifting ☐Walking ☐Resting ☐Other

Please explain: _____

Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than ½ the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

Other Medical History Please List: _____

_____

2800 E Hwy 114 Ste 130 Trophy Club, TX 76262 - 469-916-4435 Office - 469-916-4437 Office Fax - 855-959-1785 Primary Fax
1713 S FM 51 Ste 103, Decatur, TX 76234 - 940-627-6976 Office - 940-627-3491 Office Fax - 855-959-1785 Primary Fax

CellGenuity
REGENERATIVE SCIENCE

MCKENNA
ORTHOPEDICS
& BIOLOGICS

RECLAIM
PHYSICIANS MEDICAL GROUP

R. Wade McKenna, D.O. Russell Phillips, D.O. Troy B. Chandler PA-C

Have you ever had general anesthesia? □ Yes □ No
Have you ever had problems with anesthesia? □ Yes □ No, If Yes, Describe_____

Family History – Indicate if you have any immediate family members with any of the following (Please indicate the relationship to you):

	Mother	Father	Brother	Sister
Heart Disease				
Stroke				
Diabetes				
Neurologic Problems				
Autoimmune Disease				
Rheumatoid Arthritis				
Cancer				
High Blood Pressure				
Asthma				
Other:				

Preferred Pharmacy: _____

List all Allergies (medications, food, seasonal, etc.) you may have: _____

_____

Have you had your Influenza (flu) Immunization within the active flu months of October-March?
□ Yes □ No

Have you had your Pneumococcal (Pneumonia) Vaccine within the 12 months?
□ Yes □ No

Please List All Medications

Medication:	Dosage:	Reason for Taking:

Patient Signature_____ Date: _____

2800 E Hwy 114 Ste 130 Trophy Club, TX 76262 - 469-916-4435 Office - 469-916-4437 Office Fax - 855-959-1785 Primary Fax
1713 S FM 51 Ste 103, Decatur, TX 76234 - 940-627-6976 Office - 940-627-3491 Office Fax - 855-959-1785 Primary Fax

CellGenuity
REGENERATIVE SCIENCE

MCKENNA
ORTHOPEDICS
& BIOLOGICS

RECLAIM
PHYSICIANS MEDICAL GROUP

R. Wade McKenna, D.O. Russell Phillips, D.O. Troy B. Chandler PA-C

Past Medical History

Check all that apply

Patient: _____ Date: _____ Date of Birth: _____

Pulmonary
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Pulmonary Embolism
- ☐ Pulmonary Hypertension
- ☐ Sleep Apnea
- ☐ Interstitial Pulmonary Fibrosis

Women's Issues
- ☐ Fibrocystic Breast
- ☐ Heavy Menstrual Periods
- ☐ PMS
- ☐ Fibroids
- ☐ Ovarian Cysts
- ☐ Endometriosis
- ☐ Abnormal PAP smear
- ☐ Tubal Pregnancy

Gastrointestinal
- ☐ Peptic Ulcer Disease
- ☐ Gastro esophageal Disease (GERD)
- ☐ Esophagitis
- ☐Gastritis
- ☐ Irritable Bowel Syndrome
- ☐ Inflammatory Bowel Disease
- ☐ Esophageal Strictures
- ☐ Colon Polyps
- ☐ Pancreatitis
- ☐ Diverticulitis
- ☐ GI Bleeding

Allergy & Skin
- ☐ Allergic Rhinitis (hay fever)
- ☐ Latex Allergy
- ☐ Eczema
- ☐ Chronic Sinusitis
- ☐ Ear Infections
- ☐ Psoriasis
- ☐ Anaphylaxis
- ☐ Iodine Allergy

Cardiovascular
- ☐ High Blood Pressure
- ☐ Coronary Heart Disease
- ☐ Atherosclerosis
- ☐ Arrhythmia
- ☐ Angina (chest pains)
- ☐ Heart Attack
- ☐ Peripheral Vascular Disease
- ☐ Cardiomyopathy
- ☐ Valvar Disease
- ☐ Endocarditis
- ☐ Congestive Heart Failure

Rheumatology
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Gout
- ☐ Lupus
- ☐ Fibromyalgia
- ☐ Polymyalgia Rheumatic
- ☐ Temporal Arteritis
- ☐ Reynaud's

Psychiatric
- ☐ Depression
- ☐ Manic-Depressive (Bipolar Disorder)
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Psychosis
- ☐ Anorexia or Bulimia
- ☐ Schizophrenia
- ☐ Delusional Thought Disorder

Infectious Disease
- ☐ HIV or AIDS
- ☐ Tuberculosis PPD
- ☐ Hepatitis A, B, or C
- ☐ Cellulitis Other (Please Specify)

Endocrine
- ☐ Diabetes Mellitus
- ☐ Thyroid Disease
- ☐ Osteoporosis
- ☐ Adrenal Insufficiency
- ☐ Cushing's Disease
- ☐ Pituitary Tumor
- ☐ Menopause

Cancer or Blood Disorders
- ☐ Breast
- ☐ Prostate
- ☐ Colon
- ☐ Lymphoma
- ☐ Leukemia
- ☐ Melanoma
- ☐ Lung
- ☐ Thyroid
- ☐ Ovarian
- ☐ Cervical
- ☐ Brain
- ☐ Anemia
- ☐ Bleeding Disorder

Renal
- ☐ Kidney or Ureter Stones
- ☐ Pyelonephritis
- ☐ Bladder Infection
- ☐ Cystitis
- ☐ Polycystic Kidneys
- ☐ Incontinence
- ☐ BPH (large prostate)
- ☐ Erectile Dysfunction

Neurological
- ☐ Stroke TIA's (small stroke)
- ☐ Problems swallowing
- ☐ Headaches
- ☐ Neuropathy
- ☐ Seizure Disorder
- ☐ Carpal Tunnel Syndrome
- ☐ Dizziness
- ☐ Cerebellar Dysfunction

Surgeries

☐ Tonsils	☐ Cataract	☐ Gallbladder	☐ Colon
☐ Appendix	☐ Sinuses	☐ Ear	☐ Thyroid
☐ Lung	☐ Breast	☐ Hysterectomy	
☐ Hernia	☐ Prostate	☐ Brain	
☐ Back	☐ Joints	☐ Bypass Surgery of Heart Valves	

2800 E Hwy 114 Ste 130 Trophy Club, TX 76262 - 469-916-4435 Office - 469-916-4437 Office Fax - 855-959-1785 Primary Fax
1713 S FM 51 Ste 103, Decatur, TX 76234 - 940-627-6976 Office - 940-627-3491 Office Fax - 855-959-1785 Primary Fax