Dear Patient:

Welcome to Regenerate Health!

Regenerate Health is a multidisciplinary healthcare group. We have done this for various reasons, with the most important one being that our facility can enjoy a more comprehensive approach to your health by utilizing a integrative health care model. This means the incorporation of Medical and Chiropractic personnel, who are directly involved in your healthcare, into our scope of various services. As such, certain services and diagnostics will be administered, when clinically warranted, and billed under Regenerate Health. When you receive our explanation of benefits from your health insurance company, it will indicate the date of services and procedure codes and payments made to Regenerate Health.

REGENERATE HEALTH

Patient Information

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip

Please check Primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

Other Name(s) Used	E-mail Address

Gender ☐ M ☐ F	SSN	Preferred Language	Driver's License

Marital Status

☐ Married ☐ Seperated
☐ Single ☐ Widowed
☐ Divorced ☐ Life Partner

Preferred Contact

☐ Mail
☐ Home Phone
☐ Day Phone
☐ Cell Phone

Primary Care Provider	Referring Provider

Responsible Party (Guarantor) ☐ Same as patient

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip

Please check insurance type	Commercial Insurance ☐	Personal Injury/Auto ☐	Medicare ☐

Member #	Group #	SSN	Relationship to patient

Emergency Contact (for minor child, this section may be used for other parent)

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. 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.

Signature of Patient/Guardian _____ Date _____

Name of Patient/Guardian (Please Print) _____ Relationship to Patient _____

REGENERATE HEALTH

Hospitalizations-List all hospitalizations	
☐ I have never been hospitalized	

Medications – List all medications you take, prescription and non-prescription	
☐ I do not take any medications	

Medication and Food Allergies – List all known allergies (drugs, food)	
☐ No Known Allergies	

Medical History – Check if you have ever experienced the following conditions, and year of onset.

Condition	Year	Condition	Year
☐ None		☐ Gallbladder Disease	
☐ Allergies		☐ GERD (Reflux)	
☐ Anemia		☐ Hepatitis C	
☐ Angina		☐ Hyperlipidemia	
☐ Anxiety		☐ Hypertension	
☐ Arthritis		☐ Irritable Bowel Disease	
☐ Asthma		☐ Liver Disease	
☐ Atrial Fibrillation		☐ Migraine Headaches	
☐ Benign Prostatic Hypertrophy		☐ Myocardial Infarction	
☐ Blood Clots		☐ Osteoarthritis	
☐ Cancer – Type		☐ Osteoporosis	
☐ Cerebrovascular Accident		☐ Peptic Ulcer Disease	
☐ Coronary Artery Disease		☐ Renal Disease	
☐ COPD (Emphysema)		☐ Seizure Disorder	
☐ Crohn's Disease		☐ Thyroid Disease	
☐ Depression		☐ Other	
☐ Diabetes		☐ Other	

REGENERATE HEALTH

Surgical History – Check if you have received the following procedures, and year performed.			
Surgical Procedure	Year	Surgical Procedures	Year
☐ None		Male Only	
☐ Angioplasty		☐ Prostate Biopsy	
☐ Angioplasty w/Stent		☐ TURP (Trans-urethral resection of Prostate)	
☐ Appendectomy			
☐ Arthroscopy Knee		☐ Vasectomy	
☐ Back Surgery		☐ Other	
☐ CABG (heart bypass)		☐ Other	
☐ Carpal Tunnel Release			
☐ Cataract Extraction		Female Only	
☐ Cholecystectomy		☐ Augmentation Mammoplasty	
☐ Colectomy		☐ Bilateral Tubal Ligation	
☐ Colostomy		☐ Breast Biopsy	
☐ Gastric Bypass		☐ Cesarean Section	
☐ Hernia Repair		☐ D and C	
☐ Hip Replacement		☐ Hysterectomy	
☐ Knee Replacement		☐ Mastectomy	
☐ LASIK		☐ Myomectomy	
☐ Liver Biopsy		☐ Reduction Mammoplasty	
☐ Pacemaker		☐ TAH/BSO	
☐ Small Bowel Resection		☐ Vaginal Hysterectomy	
☐ Thyroidectomy		☐ Other	
☐ Tonsillectomy		☐ Other	

Health Maintenance – Check if you have received the following, and date of most recent exam.			
Exam	Date	Exam	Date
☐ None		☐ GYN Exam	
☐ Breast Exam		☐ Influenza Vaccine	
☐ Cardiac Stress Test		☐ Lipid Panel	
☐ Colonoscopy		☐ Mammogram	
☐ DEXA Scan		☐ PAP Test	
☐ Echocardiogram		☐ Physical Exam	
☐ EKG		☐ Pneumococcal Vaccine	
☐ Eye Exam		☐ Pulmonary Function Test	
☐ FOBT (stool card for hidden blood)		☐ Sigmoidoscopy	
☐ Foot Exam		☐ Tetanus Vaccine	

Family History – Check if any family member(s) has had any of the following conditions.

☐ Adopted

Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Blood Disease	☐	☐	☐	☐	☐	☐	☐
CAD (Heart Attack)	☐	☐	☐	☐	☐	☐	☐
Cancer – Type:	☐	☐	☐	☐	☐	☐	☐
CVA (Stroke)	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Developmental Delay	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐

REGENERATE HEALTH

Family History – continued							
Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Eczema	☐	☐	☐	☐	☐	☐	☐
Hearing Deficiency	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Disease	☐	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
PVD	☐	☐	☐	☐	☐	☐	☐
Renal Disease	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

Social History for Adult Patient					
Occupation	Activities performed at work (sitting, standing, computer work, etc.)				
Do you have children? ☐ Yes ☐ No	How many?		Female(s)	Male(s)	
Tobacco Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:		☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette ☐ Smokeless Brand:		
Alcohol Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:		☐ Beer ☐ Wine ☐ Liquor ☐ Other		
Exercise Activity	☐ Moderate ☐ Vigorous ☐ Sedentary Days/Week:		Sleep Pattern: ☐ Other_____ ☐ Regular ☐ Irregular		

Chief Complaint 1					
Chief Complaint 1 (Main Concern)/Location:	Rate pain severity on a scale of 1-10; 10 being most severe pain:				
Describe Pain:	☐ Sharp	☐ Achy	☐ Shooting	☐ Numb	☐ Sharp/Shooting w/motion
	☐ Dull	☐ Burning	☐ Stiff	☐ Tingling	☐ Other
Cause of Injury:	☐ Auto Accident		☐ Work Accident		☐ N/A
	☐ Other:				
Date of Injury-When did the pain start	How often do you experience symptoms ☐ Constantly 76-100% of time ☐ Frequently 51-75% of time ☐ Occasionally 26-50% of time ☐ Intermittently 1-25% of time				
Aggravators of pain (computer work, walking, etc.):	Alleviators of pain (massage, medication, Etc.):				

REGENERATE HEALTH

Chief Complaint 2					
Chief Complaint 2/Location:			Rate pain severity on a scale of 1-10; 10 being most severe pain:		
Describe Pain:	☐ Sharp	☐ Achy	☐ Shooting	☐ Numb	☐ Sharp/Shooting w/motion
	☐ Dull	☐ Burning	☐ Stiff	☐ Tingling	☐ Other
Cause of Injury:	☐ Auto Accident		☐ Work Accident		☐ N/A
	☐ Other:				
Date of Injury-When did the pain start	How often do you experience symptoms ☐ Constantly 76-100% of time ☐ Frequently 51-75% of time ☐ Occasionally 26-50% of time ☐ Intermittently 1-25% of time				
Aggravators of pain (activity, mornings, driving, Etc.)			Alleviators of pain (massage, medication, Etc.):		

Chief Complaint 3					
Chief Complaint 3/Location:			Rate pain severity on a scale of 1-10; 10 being most severe pain:		
Describe Pain:	☐ Sharp	☐ Achy	☐ Shooting	☐ Numb	☐ Sharp/Shooting w/motion
	☐ Dull	☐ Burning	☐ Stiff	☐ Tingling	☐ Other
Cause of Injury:	☐ Auto Accident		☐ Work Accident		☐ N/A
	☐ Other:				
Date of Injury-When did the pain start	How often do you experience symptoms ☐ Constantly 76-100% of time ☐ Frequently 51-75% of time ☐ Occasionally 26-50% of time ☐ Intermittently 1-25% of time				
Aggravators of pain (activity, mornings, driving, Etc.)			Alleviators of pain (massage, medication, Etc.):		

REGENERATE HEALTH

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I request that payment of Medicare, Medicaid, Medicare supplement or other insurance benefits be made on my behalf to Regenerate Health. I authorize any holder of medical information to release to Regenerate Health, my physician, CMS, caregiver, its agents and to my primary and other medical insurer. I agree that I am responsible for all amounts not covered by Medicare and/ or my insurer for which I am responsible including but not limited to any unmet portion of Medicare's annual deductible.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Name: _____

Patient Signature: _____

Date: _____

REGENERATE HEALTH

Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the physician's hands or with the use of a machine. Frequently, adjustments create a "popping" or "clicking" sound/sensation in the areas being treated.

In this office, we use trained assistants who may assist the physician with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. On the occasion when your physician is unavailable, your care may be handled by another physician or trained assistant.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The chiropractic adjustment that is related to the vertebral artery stroke is called Extension-Rotation-Thrust Atlas Adjustment. We DO NOT use this type of adjustments on our patients. Other type of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractic would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disk Herniations: Disk herniations that create pressure on a spinal nerve or the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustment, traction, etc. This includes both in the neck and back. Yet, occasionally, chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely, surgery may cause a disk problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment (or treatment) may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or mid-back. They extend from your back to your front chest area. Rarely, a chiropractic adjustment will crack a rib bone and this is referred to as a fracture. This occurs only on patients who have weakened bones from conditions such as osteoporosis. Osteoporosis can be detected on your x-rays. We adjust all patients very carefully, and especially with those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform your physician.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always provide you with the best care and if results are not acceptable, we will refer you to another health care provider who we feel may assist your condition.

If you have any questions on the above information, please ask your physician. Once you have a full understanding, please sign and date below.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Witnessed By_____ Date _____

Patient Signature: _____Date: _____

Notice of Privacy Practices
Patient Summary

We understand that medical information about you is personal. We are committed to protecting medical information about you and your loved ones.

Regenerate Health employees are committed to protecting your personal health information and privacy. We will use your information to provide you care and treatment, create a record of the care and services you receive, bill your insurance in a timely fashion and operate our facility in a diligent manner. We will safeguard your information and share it only with those who need or are entitled to know. We will obtain your permission for other use or disclosure. You may ask to see, change, restrict or obtain a copy of your information and file a formal complaint if we fail to assure your privacy or information confidentiality.

For more details, please read this Notice of Privacy Practices.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to:

- Keep medical information about you private.
- Provide you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the most stringent state and federal law.

How we may use and disclose medical information about you:

- We may use and disclose medical information about you to treatment (example, sending medial information about you to a specialist as part of a referral); to obtain payment for treatment (example, sending billing information to your insurance company or Medicare); and to support our care operations (example, using patient information to improve quality care).

- We may use and disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, funeral arrangements, organ donation, workers compensation purposes and emergencies. We also disclose medical information when required by law, such as in response to valid judicial or administrative orders.

We may also contact you for appointment reminders, or to tell you about or recommend possible treatment options, alternatives, health-related benefits, or services that may be of interest to you.

Other uses of medical information

In any other situation not involving routine care, financial and insurance matters we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding your medical information:

- In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, after you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or related supplies. If we deny you request to review or obtain a copy, you may submit a written request for a review of that decision.

- If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if we did not create the information; if it is not part of the medical information maintained by us; or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend the record.

- You have the right to a list of the instances where we have disclosed medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003. You will the request in paper form. We will inform you of the cost before you incur any costs.

All written requests or appeals should be submitted to our Privacy Officer listed at the bottom of this notice.

Complaints

If you wish to file a complaint because you feel that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Officer (listed below).

Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights.

Under no circumstance will you be penalized or retaliated against for filing a complaint.

Brenda Van Ackeren
Case Manager
8821 Davis Blvd Ste 210
Keller, TX 76248

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave. S.W.
Washington, D.C.20201

REGENERATE HEALTH

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

I _____, hereby acknowledge that I have been given the opportunity to review and receive a copy of this office's Notice of Privacy Practices explaining:

How this office will use and disclose protected health information
My privacy rights with regard to my protected health information
This offices obligation concerning the use and disclosure of my protected health information

I understand that the Notice of Privacy Practices may be revised from time to time and I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.
If you have any questions about our Notice, please contact: Brenda Van Ackeren (682) 593-0500

Brenda@regeneratehealth.com

You may also contact the Secretary of the U.S. Dept. of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Dept. of Health and Human Services.

Patient or Personal Representative

Signature: _____ Date: _____

Name: _____

Relationship to Patient: _____

For Office Use Only

We made a good faith effort to obtain an acknowledgment of _____'s
Receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reason (check all that apply):

- ☐ Patient refused to sign (date of refusal _____)
- ☐ Communication barriers prohibited obtaining an acknowledgement.
- ☐ An emergency situation prevented us from obtaining an acknowledgment
- ☐ Other _____

Attempt was made by: _____ Date: _____