Integrative Pain and Wellness Center

New Patient Registration Form

Patient Name:

First_____ MI_____ Last_____

Address: DOB:_____

Street_____ Sex: _____

Apt #_____

City_____ Zip_____ State_____

Phone:

Home_____ Cell_____

Email_____ Marital Status_____ Race_____

Employer_____ Occupation_____

Referred By:_____

Emergency Contact

First_____ Last_____ Relationship_____

Home_____ Cell_____

Insurance Information Please fill out information for Person on Policy

Insurance Company _____

Group # _____ Policy # _____

Name of Policy Holder

First_____ MI_____ Last_____

D.O.B_____ Sex:_____

Preferred Pharmacy

Name:_____

Address:_____

Phone:_____

Medical History

Check all that Apply

- ☐ Allergic Rhinitis/Seasonal Allergies
- ☐ High Blood Pressure
- ☐ Arrhythmia/Murmur
- ☐ Heart Attack/Angina
- ☐ Asthma
- ☐ COPD(lung disease)
- ☐ Reflux (GERD)
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Enlarged Prostate
- ☐ HIV/AIDS
- ☐ Stroke
- ☐ Migraines
- ☐ High Cholesterol
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Skin Cancer
- ☐ Cancer (type) _____
- ☐ Other:
- ☐ _____
- ☐ _____
- ☐ _____

Surgical History

Type of Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

Females Only

Number of pregnancies_____
Number of live births_____
Number of miscarriages_____
Method of birth control_____
Age of onset of menses_____

Date of Last Menstrual Period_____
Flow: ___Light ___ Moderate ___ Heavy
Length of Flow_____
Frequency of Cycle_____

Allergies

Name of Medication/Food	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family Medical History

Please list any chronic medical conditions of your parents, grandparents, or siblings:_____
_____
_____

Current Symptoms (Check all that apply within the last two weeks)

General
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Recent Weight Change

Eyes
- ☐ Decreased Vision
- ☐ Double or Blurred Vision
- ☐ Eye discharge
- ☐ Eye Pain

ENT
- ☐ Decreased Hearing
- ☐ Snoring/Mouth Breathing
- ☐ Ringing/Buzzing in Ears
- ☐ Allergies/Hay Fever/Runny Nose
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Sore Throat

Cardiovascular
- ☐ Shortness of Breath lying Flat
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Swollen Ankles
- ☐ Fainting Spells
- ☐ Leg Pain When Walking

GI
- ☐ Loss of Appetite
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black or Tarry Stools
- ☐ Red Blood in Stools
- ☐ Hemorrhoids

Pulm
- ☐ Wheezing
- ☐ Dry Cough
- ☐ Wet Cough
- ☐ Chronic Cough
- ☐ Shortness of Breath on Excertion

Endo
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Excessive Hunger
- ☐ Heat or cold intolerance
- ☐ Dry Skin
- ☐ Brittle Hair/Nails

HEME
- ☐ Bruise easily
- ☐ Bleeding

Neuro
- ☐ Convulsions/Seizures
- ☐ Tremors
- ☐ Muscle Weakness
- ☐ Numbness/Tingling
- ☐ Headaches
- ☐ Dizzines
- ☐ Pain Radiatin Down Arm/Leg

MS
- ☐ Joint pain
- ☐ Scoliosis
- ☐ Joint Swelling
- ☐ Decreased Range of Motion
- ☐ Muscle Pain
- ☐ Neck Pain
- ☐ Back Pain

Derm
- ☐ Rashes
- ☐ Hives
- ☐ Unusual Moles
- ☐ Skin Lesions
- ☐ Itching

Current Symptoms (Check all that apply within the last two weeks)

PSYCH/EMOTIONAL

- ☐ Difficulty Sleeping
- ☐ Nightmares
- ☐ Nervousness/Anxiety
- ☐ Stress
- ☐ Depression
- ☐ Memory loss

Genitourinary

- ☐ Pain on Urination
- ☐ Blood in urine
- ☐ Discharge from penis or vagina
- ☐ Pain During Intercourse
- ☐ Increased Urinary Frequency
- ☐ Urinary Urgency
- ☐ Bladder Incontinence
- ☐ Urinary Retention

Other Current Symptoms

_____ _____

_____ _____

Current Medications/Vitamins/Supplements

Name	Dose/Frequency

Siginature of Patient or Legal Guardian:_____ Date: _____

Name of Legal Guardian or Patient (Please Print): _____

Integrative Pain and Wellness Center

Financial Policies

Our goal is to get you back to your optimal health. We are not contracted with any private insurance companies. What that means for all of our patients is that payment is required at the time services are rendered. All patients will be provided with a Superbill (a document indicating the services rendered and showing funds collected) and it will be your responsibility to submit it to your insurance company for possible reimbursement. Each insurance company differs in what percentage they will reimburse you for out of network providers and you would need to contact them directly to obtain that information. Integrative Pain and Wellness Center does not guarantee that your insurance company will reimburse you. Sometimes, your insurance company will request the note from the office visit to verify services prior to reimbursing you. If this does occur, we will make every effort to supply your insurance company with any requested documents. If your insurance company mistakenly sends your reimbursement check to us, we will return it to your insurance company and ask them to reimburse you directly. Please be aware that there will be a $25 charge for any checks that you write to Integrative Pain and Wellness Center which are returned for insufficient funds.

Cancellation Policy

We know that plans change and emergencies happen. If you do need to cancel or reschedule your appointment, we ask that you notify us at least 24 hours prior to your appointment time. If you cancel your appointment with less than 24 hours notice or miss your appointment, then a fee of $100 will be charged to your credit card on file.

By signing below, I acknowledge that I have read and understand the above policies:

Name of Patient/Guardian: _____

Date: _____

Signature of Patient/Guardian: _____

Integrative Pain and Wellness Center

Patient Consent Form for Use and Disclosure of Protected Health Information (PHI)

(The Notice of Privacy Practices provided by **Integrative Pain and Wellness Center** describes such uses and disclosures more completely.)

By initialing below, I give consent to **Integrative Pain and Wellness Center** to disclose and use my protected health information (PHI) for treatment, payment and health care operations (HCO).

Initials:_____

By initialing below, **Integrative Pain and Wellness Center** may contact me at the numbers I have provided and can leave messages via voice mail regarding any information that assists **Integrative Pain and Wellness Center** in carrying out HCO, such as appointment dates and times, insurance information and all calls or communications in regards to my clinical care, including lab test results, imaging results, etc.

Initials: _____

By initialing below, **Integrative Pain and Wellness Center** has my permission to text me on the cell phone number I have provided in regards to any information needed to assist in carrying out HCO, such as appointment times and dates.

Initials: _____

By initialing below, **Integrative Pain and Wellness Center** may e-mail me at the address provided by me any items that assist the practice in carrying out HCO, such as appointment reminder cards and patient statements. I have the 1ight to request that **Integrative Pain and Wellness Center** restrict how it uses or discloses my PHI to carry out HCO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Initials: _____

By initialing below, I understand that I have the right to request that **Integrative Pain and Wellness Center** restrict how it uses or discloses my PHI to carry out HCO. **Integrative Pain and Wellness Center** is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Initials:_____

By initialing below, **Integrative Pain and Wellness Center** can send mail to my home address or other locations I have provided in regards to information needed to assist **Integrative Pain and Wellness Center** in carrying out HCO. I understand that mail sent to my home containing PHI will be marked "Personal and Confidential."

Initials:_____

By initialing below, I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that I may find the most updated copy of the policy on www.IPAWC.com or I may request a copy. **Integrative Pain and Wellness Center** reserves the right to revise its Notice of Privacy Practices at any time. If I wish to obtain a revised Notice of Privacy Practices a written request must be sent to Matthew Barker, DO at 1100 N. Kimball Ave #130 Southlake, TX 76092.

Initials: _____

My signature below indicates that I allow **Integrative Pain and Wellness Center** to use and disclose my PHI to carry out HCO.

I understand that I can revoke my consent in writing as long as **Integrative Pain and Wellness Center** has not already made disclosures in reliance upon my prior consent. **Integrative Pain and Wellness Center** can
decline to provide treatment to me if I chose to revoke or decline to provide my signature below.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient's Name Date

_____

Print Name of Patient or Legal Guardian, if applicable

Integrative Pain and Wellness Center

OMT Consent Form

By signing below, I agree to the following:

- I understand that osteopathic manipulative treatment (OMT) is considered a medical procedure and the risks and benefits have been explained to me.
- I understand that at the beginning of each visit, my doctor will evaluate me for the indications and contraindications for OMT and that there is no guarantee that OMT will be performed. If OMT is not performed, I am still responsible for the encounter portion of the visit.
- I understand that I may be evaluated and treated in all areas of the body as medically indicated and that I may verbally refuse any portion of the exam or treatment at any time.
- I understand that if I would like a chaperone present during my appointment, that I would need to provide one myself.
- I understand that any patient under the age of 18 will require a parent or guardian to be present during the entire appointment.

Patient Name (print):_____

Patient or Legal Guardian (signature):_____ Date:_____

Medicare Patients Only

By signing below, I agree to the following:

- I understand that neither Dr. Barker/Dr. Gray nor Integrative Pain and Wellness Center are contracted as providers with Medicare.
- I understand that neither Dr. Barker/Dr. Gray nor Integrative Pain and Wellness Center may submit any charges to medicare for reimbursement and that I am solely responsible for any payments for services rendered by Integrative Pain and Wellness Center.

Patient Name (print):_____

Patient or Legal Guardian
(signature):_____Date:_____

Integrative Pain and Wellness Center

Complementary and Alternative Medicine (CAM) Informed Consent Form

Definitions:

CAM refers to a broad range of healing philosophies, approaches and therapies that mainstream Western (conventional) medicine does not commonly use, accept, study, understand, or make available. A few of the many CAM practices include acupuncture, herbs, homeopathy, meditation, energy medicine, therapeutic massage, intravenous vitamin infusions and traditional Oriental medicine to promote well-being or treat health conditions. CAM therapies may be used alone, as an alternative to conventional therapies, or in addition to conventional, mainstream therapies, in what is referred to as complementary or an integrative approach.

Conventional medical practices refer to those medical interventions that are taught extensively at U.S. medical schools, generally provided at U.S. hospitals, or meet requirements of the generally accepted standard of care.

By signing below, I agree to the following:

- I understand that Integrative Pain and Wellness Center combines conventional medicine with a variety of CAM therapies in an integrative approach to medical practice. Integrative Pain and Wellness Center's goal is to optimize patient health while minimizing risks associated with treatment or non-treatment of medical conditions.
- After assessing you, your doctor will discuss your condition and may recommend integrated medical treatments. They will discuss with you the goals, risk and benefits, possible interference with conventional treatments, and the therapeutic basis of any recommended treatment. Refusal to choose an alternative treatment will not affect your right to future care or treatment.
- Integrative Pain and Wellness Center may refer you to another healthcare provider who practices conventional medicine, CAM, or a combination of the two. I understand that Integrative Pain and Wellness Center is not responsible for any outcome that may result from

a treatment or recommendation provided by another healthcare provider.

- I understand that Dr. Barker is not my primary care provider. I understand and accept full responsibility to communicate my treatment choices with my primary care and other health providers.
- I understand that emergency care and hospital treatment are not included in this agreement.
- I understand that I may purchase nutritional supplements, medical supplies, and other items, which Integrative Pain and Wellness Center may receive financial benefit.
- No warranty or guarantee will be made to you regarding the outcome of the care and treatments I may receive. I realize that risks and hazards persist with conventional medical treatment, alternative care, or no treatment at all. I certify that this form has been fully explained to me; I have read it or have had it read to me and I understand its contents.

Patient Name (print):_____

Patient or Legal Guardian (signature):_____ Date:_____