curis
FUNCTIONAL HEALTH

Patient (Child) Information:

Name: _____ Date: _____

Address: _____

Sex: Male___ Female___ Date Of Birth _____ Height: _____ Weight: _____

Patient SSN: _____ Name of Parents/Guardian: _____

Home phone: _____ Cell phone: _____ Work Phone: _____

Email: _____

Whom may we thank for referring you? _____

Authorized Parent/Guardian: _____ Phone: _____

Present Complaint: _____

When did this begin? _____ Was there an accident or injury involved? Yes___ No ____

Has there been past treatment for this complaint? Yes____ No ____ If yes, describe _____

Current medications: _____

General questions/Prenatal History:

Any complications during pregnancy? _____

Medications taken during pregnancy: _____ Cigarettes or alcohol? Yes ____ No ____

Birth Intervention: Forceps ____ Vacuum ____ C-Section ____

Complications during delivery? Yes___ No ___ If yes, Explain _____

Genetic disorders or disabilities: _____

How many times has this patient been prescribed antibiotics in the past 6 months? _____ Total Life____

Has patient received vaccinations? Yes ____ No ____

Feeding history:

Breast Fed: Yes ____ No ____

Formula Fed: Yes ____ No ____

Introduced to: Solids at ___ Months

Cow Milk ___ Months

Food Allergies/ intolerances: Yes___ No ____

List: _____

Childhood diseases:

Chicken Pox: Yes ___ No ____ Age ____

Rubella: Yes ___ No ____ Age _____

Rubeola: Yes ___ No ____ Age _____

Mumps: Yes ____ No _____ Age

Whooping Cough: Yes ___ No___ Age_____

Other: _____ Age _____

Developmental History:

During the following times your child's spine is the most vulnerable to stress and should routinely be checked by a doctor pf chiropractic for prevention and early detection of vertebral subluxation. At what age was your child able to:

_____ Respond to Sound

_____ Respond to Visual Stimuli

_____ Hold Head up Alone

_____ Sit up Alone

_____ Cross Crawl

_____ Stand Alone

_____ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (a bed, changing table, stairs, ect). Was this the case with your child?

Yes___ No ___ If Yes, Explain _____

Is/ has your child been involved in any high impact or contact type of sports (Soccer, football, gymnastics, baseball, cheerleading, martial arts, ect)? Yes_____ No_____ Other _____

Curis
FUNCTIONAL HEALTH

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Curis Functional Health, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all insurance submissions.
Curis Functional Health may use my health care information and may disclose such information to the above-named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

_____
Signature of patient or guardian Date

X-Ray Consent: I hereby give my consent to Curis Functional Health and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge; I am not pregnant. I have read and understood all the above information.

_____ _____
Patient Signature Date

Financial Disclosure: Curis Functional Health provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. If we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account.
I have read and understood all the above information.

_____ _____
Patient Signature Date

curis
FUNCTIONAL HEALTH

Approved HIPAA Contacts

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's Billing Account and Medical Conditions to the patient or legal guardian.

If you would like to add additional contacts (other than the patient or legal guardian) that Curis Functional Health can disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like Curis Functional Health to list as your Emergency Contact in the event of an emergency was to take place at our office.

Contact Name	Relationship to Patient	Phone Number
___ Billing Information	___ Medical Information	___ Emergency Contact

Contact Name	Relationship to Patient	Phone Number
___ Billing Information	___ Medical Information	___ Emergency Contact

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information

curis
FUNCTIONAL HEALTH

Electronic Health Records Intake Form

First Name: _____ Last Name: _____
Email address: _____
Preferred Method of Communication: Email___ Phone___ Mail ___ Text ____
DOB: __/___/___ Gender: Male___ Female____ Preferred Language: _____

Race: American Indian or Alaska Native___ Asian___ Black or African___

White (Caucasian)___ Native___ Hawaiian or Pacific Islander___ I Decline to answer___

Ethnicity: Hispanic or Latino____ Not Hispanic or Latino_____ I Decline to Answer____

Are you currently taking any medications, herbs, or supplements? (Please include regularly used over the counter medications or supplements)

Medication/Supplement Name	Dosage and Frequency (i.e., 5mg once a day)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional comments

__ I choose to decline receipt of my clinical summary after every visit (*These summaries are often blank because of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

curis
FUNCTIONAL HEALTH

NOTICE OF APPOINTMENT CANCELLATION/NO-SHOW POLICY

We would like to inform you of our policy regarding missed appointments and same-day cancellations effective immediately, this refers to all appointments made in the office: Chiropractic, Mental Health, Massage, and Nutrition. We require a 24-hour notice of cancellations BY **PHONE** during business hours. Any patient who misses a scheduled appointment without notifying the office will be subject to a no-show fee.

Due to an increased number of no-show visits, there will be a charge to you (not your insurance company) for a missed appointment. A $30 fee will be assessed for routine office visits and $40 for missed massage appointments. These fees are subject to change without prior notice. At this time, patients who provide advanced notice for missed appointments will **not** be assessed a fee. A no call/no show to your scheduled appointment **WILL** result in a 100% fee, out of which our staff is paid.

After 3 no call/no show visits, you will be dismissed from the practice.

If you have any questions regarding this policy, please do not hesitate to contact our office at 940-668-8755. It is our hope that this policy will reduce wait times and increase efficiency at our office so that we can better serve you with safe, quality healthcare.

Please sign and date below:

_____

Signature Date

_____

Printed Name

CURIS FUNCTIONAL HEALTH
Informed Consent

Please read this entire document prior to signing. Ask questions before you sign if there is anything that is unclear.

Based on my complaints and the history I have provided, I hereby authorize Curis Functional Health ("the Practice") and its licensed doctors and assistants to undertake an examination and provide an evaluation and treatment plan that may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I understand that state law entitles me to receive information concerning my condition and proposed treatment and refuse any treatment to the extent permitted by law. With that knowledge and with my consent, I wish to rely on the Curis Functional Health doctors to make those decisions about my care, based on the facts that they believe are in my best interest.

As a part of the analysis, examination, and treatment, I am consenting to services that may include: Chiropractic adjustment, palpation, massage therapy, spinal decompression, intersegmental traction, vital signs, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, hot/cold therapy, EMS, radiographic studies and other procedures as necessary. The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments, and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

Based on current findings, I understand that the Practice doctors will discuss my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment, and the reasonable alternatives to the proposed treatment. They will also explain the cost of my proposed care (or provided me with a current fee schedule).

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those that relate to physical aberrations unknown or reasonably undetectable by the doctor. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if I have a condition that would otherwise not come to the Doctor's attention, I understand that it is my responsibility to inform the Doctor before treatment.

The availability and nature of other treatment options may include self-administered, over-the-counter analgesics and rest, medical care and drugs such as anti-inflammatory, muscle relaxants, and pain-killers, hospitalization or surgery. If one chooses to use one of the above noted "other treatment" options, one should be aware that there are risks and benefits of such options, and I understand that I may wish to discuss these with my primary medical physician.

The risks and dangers to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility, setting up a pain reaction and further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

This document is intended as a general, broad-based consent applies to any and all contemplated procedures. I have discussed all of the above risks and benefits with the Practice, and, if applicable, have made an informed decision that the potential benefits outweigh the risks in my case.

I understand and accept that:

1. I have the right to withdraw from or discontinue any treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve making judgments based upon the facts known to the doctor during my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent {or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the Practice's examination, evaluation, and proposed course of care and treatments.

_____ _____

Witness Patient's Printed Name

_____

Patient's Signature

_____

Signature of Doctor