Apex Physical Medicine

Dr. Preston Clay Alexander, MD **MizianaAbiad, RN, FNP**
Dr. Jade Malay, DC, DABCO **Dr. SamerHamed, DC**

Dear Patient:

This office is a multidisciplinary doctor 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 an 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 Apex Physical Medicine. As such, when you receive your explanation of benefits from your health insurance company, it will indicate the date of services and procedure codes and payments made to Apex Physical Medicine.

Phone 972-378-0383
Apex Physical Medicine
2800 N. Dallas Parkway, Suite 150 ● Plano, TX 75093

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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:

Preferred Language: Race: Ethnicity:

Marital Status: S M W Spouse's Name:

Your Employer: Occupation:

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

Referred By: Primary Care Physician:

PCP Phone Number:_________________________________ Name of Clinic:____

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto Worker'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:

Person responsible for account:

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:**

____ ____________________________

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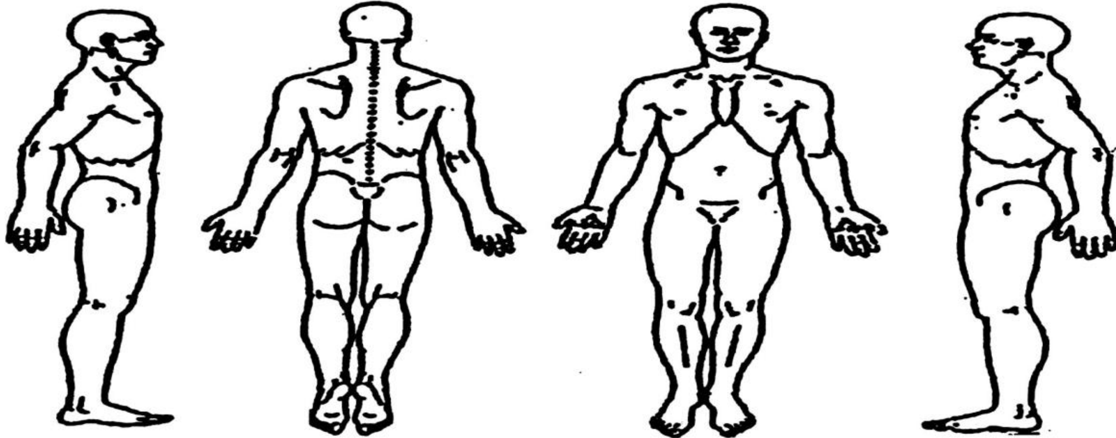
PATIENT INTAKE FORM

Patient Name: ______________________________ Date: ______________

1. Today's problem will be filed as: □ Insurance/ Self Pay □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms:



3. How would you describe the type of pain?

- □ Sharp
- □ Dull
- □ Diffuse
- □ Achy
- □ Burning
- □ Shooting
- □ Stiff
- □ Numb
- □ Tingly
- □ Sharp with motion
- □ Shooting with motion
- □ Stabbing with motion
- □ Electric-like with motion
- □ Other: ______________

On a scale of 1-10 my pain level is a:

0 1 2 3 4 5 6 7 8 9 10

0: No Pain 10: Severe Pain

4. How do you think your problem began? ______________________________

5. How often do you experience your symptoms?

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

6. Rate your level of exercise activity:

□ Strenuous □ Moderate □ Light □ None

7. How would you rate your overall health:

□ Good □ Fair □ Excellent □ Poor

8. Have you had past trauma such as car accidents, Falls, Sport injury?

If yes, What and When? ______________________________

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9. List all prescription and over-the-counter medications and nutritional supplements you are currently taking:

____

____

10. Do you have any food or drug allergies?　　YES　　NO

If **YES**, please describe what you are allergic to**:**

____

11. List all surgical procedures you have undergone:

____

____

12. Place of employment/ Title: ____

What activities do you do at work?

☐ Sit	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Stand	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Computer Work	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ On the Phone	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Drive	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Other Activities	☐ Perform manual labor	☐ Read a lot	☐ Travel frequently

13. What activities do you enjoy outside of work?

____

Excessive exposure at home or at work of the following:
Fumes:_____　Dust:_____　Solvents:_____　Airborne particles:____　Noise:____

14. Have you ever been admitted to the hospital?　☐ Yes　☐ No

If yes, why? ____

15. Is there anything else you wish to let the doctor know about your visit today?　☐ Yes　☐ No

If yes, what? ____

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16. Family History:
Use "x" to indicate your answer for each family member.

Family Member	Diabetes	Blood Pressure	Mental Illness	Other (please List)	Unknown
Father	☐	☐	☐	☐ ________	☐
Mother	☐	☐	☐	☐ ________	☐
Sibling	☐	☐	☐	☐ ________	☐
Sibling	☐	☐	☐	☐ ________	☐
Sibling	☐	☐	☐	☐ ________	☐
Children	☐	☐	☐	☐ ________	☐
Children	☐	☐	☐	☐ ________	☐
Children	☐	☐	☐	☐ ________	☐

17.Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

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18. For the conditions listed below, please check the "past" column if you have had the condition in the past; If you presently have a condition listed below, please check the "present" column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Diabetes	☐	☐	Low Blood Pressure	☐	☐	Allergies
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Systemic Lupus
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Epilepsy
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	HIV/AIDS
☐	☐	Low Back Pain	☐	☐	Kidney Stones			
☐	☐	Shoulder Pain	☐	☐	Kidney Disorder	**Females Only**		
☐	☐	Elbow/Upper Arm Pain	☐	☐	Bladder Infection	☐	☐	Birth Control Pills
☐	☐	Wrist Pain	☐	☐	Painful Urination	☐	☐	Hormonal Replacement
☐	☐	Hand Pain	☐	☐	Loss of Bladder Control	☐	☐	Pregnancy
☐	☐	Hip Pain	☐	☐	Prostate Problems			
☐	☐	Upper Leg Pain	☐	☐	Abnormal Weight gain/loss			
☐	☐	Knee Pain	☐	☐	Loss of Appetite			
☐	☐	Ankle/Foot Pain	☐	☐	Abdominal Pain			
☐	☐	Jaw Pain	☐	☐	Ulcer			
☐	☐	Joint Pain/Stiffness	☐	☐	Hepatitis			
☐	☐	Arthritis	☐	☐	Liver/Gall Bladder Disorder			
☐	☐	Rheumatoid Arthritis	☐	☐	General Fatigue			
☐	☐	Cancer	☐	☐	Muscular Incoordination			
☐	☐	Tumor	☐	☐	Visual Disturbances			
☐	☐	Asthma	☐	☐	Dizziness			
☐	☐	Chronic Sinusitis						

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19. Please check the appropriate box if you are currently experiencing any of these symptoms and/or if you have experienced them in the past 7 to 14 days

	Today	7-14 Days
Blurred Vision	☐	☐
Elevated Blood Sugar	☐	☐
Extreme Thirst	☐	☐
Frequent Urination	☐	☐
Fatigue (Tiredness)	☐	☐
Heartburn	☐	☐
Increased Hunger	☐	☐
Nausea	☐	☐
Numbness & Tingling in Hands/Feet	☐	☐
Vomiting	☐	☐
Painful Contact With Socks or Bed Sheet	☐	☐
Stabbing or Electrical Shock Sensation	☐	☐
Burning Sensation	☐	☐
TIA(mini stroke)	☐	☐
Shortness of Breath	☐	☐
Chest Pain that goes away with rest	☐	☐
Heartburn	☐	☐
Pain in Calves	☐	☐
Stroke	☐	☐
Angina (severe chest pain, spreading shoulder ,arm, back, neck, or jaw)	☐	☐
Pebbles or Sandlike Sensation in Shoes	☐	☐

	Today	7-14 Days
Lack of Energy	☐	☐
Rapid, Shallow Breath	☐	☐
Thirst	☐	☐
Depression	☐	☐
Fainting	☐	☐
Lack of Concentration	☐	☐
Cold, Clammy, Pale Skin	☐	☐
Urinary Problems	☐	☐
Pins and Needles Sensation in Feet	☐	☐
Sweat Abnormalities	☐	☐
Sexual Difficulties	☐	☐
Exercise Intolerance	☐	☐
Dizziness or Fainting	☐	☐
Difficulty Digesting Food	☐	☐
Headaches	☐	☐
Swelling of Ankles	☐	☐
Blood Clog in a Vien (Venous Thrombosis)	☐	☐
Heart Attack	☐	☐
Irregular heartbeat, too fast or slow (atriafibrillation)	☐	☐
Stroke	☐	☐

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20. Past Medical History (have you ever had the following: (circle "yes" or "no" leave blank if uncertain **)**

Measles No Yes
Small pox No Yes
Diphtheria No Yes
Polio No Yes
Glaucoma No Yes
Venereal disease No Yes
Hernia No Yes
Infectious mono No Yes

Mumps No Yes
Scarlet fever No Yes
Pneumonia No Yes
Bronchitis No Yes
Tuberculosis No Yes
Hemorrhoids No Yes
Thyroid disease No Yes

chicken pox No Yes
Whooping cough No Yes
Rheumatic fever No Yes
Bleeding Tendency No Yes
Mitral valves prolepses No Yes
Blood or plasma transfusion No Yes
Date of last chest x-ray___________

21. Social History(Please X all that apply)
Are you a?

- ☐ current smoker
- ☐ former smoker
- ☐ nonsmoker
- ☐ current every day smoker
- ☐ current some day smoker
- ☐ Smoker current status unknown
- ☐ unknown if ever smoked
- ☐ light tobacco smoker
- ☐ heavy tobacco smoker
- ☐ Uses tobacco in other forms

Did you have a drink containing alcohol in the past year?

- ☐ Yes
- ☐ No

If 'Yes' : How often did you have a drink containing alcohol in the past year?

- ☐ Never
- ☐ Monthly or less
- ☐ 2 to 4 times a month
- ☐ 2 to 3 times a week
- ☐ 4 or more times a week

If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?

- ☐ 1 or 2 drinks
- ☐ 3 or 4 drinks
- ☐ 5 or 6 drinks
- ☐ 7 to 9 drinks
- ☐ 10 or more drinks

If 'Yes' : How often did you have 6 or more drinks on one occasion in the past year?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

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Insurance Verification Disclosure/Agreement

As a courtesy, Apex Physical Medicine will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

HIPAA Disclosure

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

All Patient Medical Records

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

Apex Physical Medicine

Expiration Date of Authorization
This authorization is effective through __12/2017__unless revoked or terminated by the patient or patient's personal representative.

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.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize Apex Physical Medicine Office Managertouse my protected information for the listed reasons.

Patient
Name (Printed) ____

Patient
Signature ____ Date ____________________

Parent/Guardian
Signature ____Date______________________

Office Manager ____ Date ____________________

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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.

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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.

Emergency Contact Name: ____

Emergency Contact Phone Number: ____________________________________

Secondary Number: ____________________________________

Patient Name (Printed) ______________________________ Date ____________

Patient Signature ____

Parent/Guardian Signature ____

Witnessed By______________________________ Date ____________

Release of Medical Records

I, ______________________________, hereby authorize the release of my medical records

From:____

To: **Apex Physical Medicine**
□ Mail to: 2800 Dallas PKWY #150 Dallas TX, 75093
□ Fax to: (972) 403-3434

____
Print Name

____
Signature

____
Date of Birth

____
Date

TESTIMONIAL/PHOTO/VIDEO RELEASE AUTHORIZATION

Permission to Use Testimonial/Photograph/Video

I grant Apex Physical Medicine, its representatives and employees the right t o take photographs of me and my property in connection with the above identified subject. I authorize Apex Physical Medicine, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that Apex Physical Medicine may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, social media, and Web content.

I have read and understand the above:

Signature____
Printed Name______________________________________
Address____
Date____
Signature, parent or guardian___________________________
(If under age 18)

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ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Apex Physical Medicine- MizianaAbiad, APRN, FNP-C, Jade Malay, DC, Preston Alexander, MD, SamerHamedDCas well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this ______ day of ________________, 20 ____. X____________________________________
(patient signature)

X_________________________________ X_____________________________________
(signature of Guardian if applicable) (please print patient name)

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