



## 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:

Your Employer:

Occupation:

Employer Address:

(STREET)

(CITY)

(STATE)

(ZIP)

Referred By:

Primary Care Physician:

PHARMACY NAME, LOCATION AND PHONE NUMBER

## 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 Name (Printed) \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

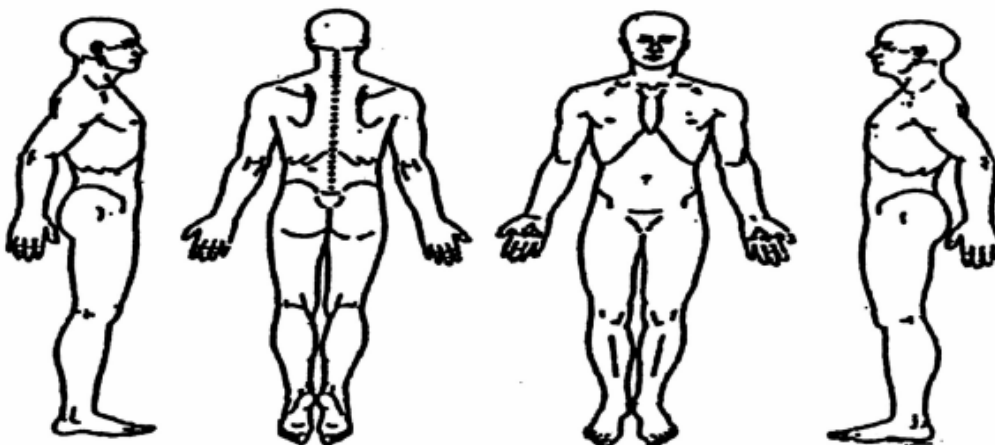
## PATIENT INTAKE FORM

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

2. Chief Complaint/Reason for the visit: \_\_\_\_\_

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



4. How would you describe the type of pain?

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Numb                      |
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Tingly                    |
| <input type="checkbox"/> Diffuse  | <input type="checkbox"/> Sharp with motion         |
| <input type="checkbox"/> Achy     | <input type="checkbox"/> Shooting with motion      |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Stabbing with motion      |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff    | <input type="checkbox"/> Other: _____              |

5. How often do you experience your symptoms?

- |   |   |
|---|---|
| <input type="checkbox"/> Constantly (76-100% of the time) | <input type="checkbox"/> Occasionally (26-50% of the time)  |
| <input type="checkbox"/> Frequently (51-75% of the time)  | <input type="checkbox"/> Intermittently (1-25% of the time) |

6. How are your symptoms changing with time?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Getting Worse | <input type="checkbox"/> Staying the Same | <input type="checkbox"/> Getting Better |
|--|---|---|

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

8. How much has the problem interfered with your work?

- |                                     |                                       |                                     |                                      |                                    |
|-------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Not at all | <input type="checkbox"/> A little bit | <input type="checkbox"/> Moderately | <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Extremely |
|-------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|------------------------------------|

9. How much has the problem interfered with your social activities?

- |                                     |                                       |                                     |                                      |                                    |
|-------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Not at all | <input type="checkbox"/> A little bit | <input type="checkbox"/> Moderately | <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Extremely |
|-------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|------------------------------------|

10. Who else have you seen for your problem?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Chiropractor      | <input type="checkbox"/> Neurologist        | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER physician      | <input type="checkbox"/> Orthopedist        | <input type="checkbox"/> Other: _____           |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> No one                 |



11. Have you had labs done recently (within last 6 months)?  Yes  No  
 If "Yes", when and where? \_\_\_\_\_

12. How long have you had this problem? \_\_\_\_\_

13. How do you think your problem began? \_\_\_\_\_

14. Do you consider this problem to be severe?  Yes  Yes, at times  No

15. 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

16. What aggravates your problem?  
 \_\_\_\_\_

17. What alleviates your problem?  
 \_\_\_\_\_

18. What concerns you the most about your problem; what does it prevent you from doing?  
 \_\_\_\_\_

19. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Occupation \_\_\_\_\_

20. How would you rate your overall Health?  
 Excellent  Very Good  Good  Fair  Poor

21. What type of exercise do you do?  
 Strenuous  Moderate  Light  None

22. Indicate if you have any immediate family members with any of the following (Please indicate the relationship to you):  
 Rheumatoid Arthritis  Diabetes  Lupus  Multiple Sclerosis (MS)  
 Heart Problems  Cancer (see add. Forms)  ALS  Other: \_\_\_\_\_



23. For each of the conditions listed below, place a check in the "Past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "Present" column.

Past	Present		Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Mid-Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis (MS)
<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain/Loss			
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite			
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<b>For Females Only</b> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Rheum. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder			
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue			
<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination			
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances			
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness			
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash						
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____						

24. List all prescription medications you are currently taking:

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25. List all of the over-the-counter medications you are currently taking:

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

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27. List all surgical procedures you have had:

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28. What activities do you do at work?

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day

29. What activities do you do outside of work?

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**30. Have you ever been hospitalized?**  Yes  No  
If Yes, why? \_\_\_\_\_

**31. Have you had any past injuries or trauma, such as car accidents (ever?), falls, sports injuries, etc.?**  Yes  No  
If "Yes", please provide details:

\_\_\_\_\_

**32. Is there anything else you wish to let us know about you visit today?**  Yes  No

If "Yes", please provide details:  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Insurance Verification Disclosure/Agreement

As a courtesy, Park Place Health Solutions 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.

Patient Name (Printed) \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Office Manager \_\_\_\_ Signature on file \_\_\_\_\_ Date \_\_\_\_ on file \_\_\_\_\_



## 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.

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Secondary Number: \_\_\_\_\_

Patient Name (Printed) \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Witnessed By \_\_\_\_\_ Date \_\_\_\_\_





## Assignment of Benefits

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, grants and conveys for deferred payment to Park Place Health Solutions, a lien and assignment against the proceeds of the patient's insurance settlement with all the following rights, power, and authority:

**RELEASE OF INFORMATION:** You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me.

**IRREVOCABLE ASSIGNMENT OF RIGHTS:** You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

**DEMAND FOR PAYMENT:** To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Park Place Health Solutions

**THIRD PARTY LIABILITY:** If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Park Place Health Solutions.

**STATUTE OF LIMITATIONS:** I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

**LIMITED POWER OF ATTORNEY:** I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

**REJECTION IN WRITING:** I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

**TERMINATION OF CARE:** I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

**By my signature be it known that I have read and fully understand the above contract.**

Patient Name (Printed) \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Office Manager \_\_\_\_\_ Signature on File \_\_\_\_\_ Date \_\_\_\_ on file \_\_\_\_\_



**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:

Park Place Health Solutions

**Expiration Date of Authorization**

This authorization is effective through 12/31/23 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 Office Manager to use my protected information for the listed reasons.

Patient Name (Printed) \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Office Manager \_\_\_\_\_ Signature on file \_\_\_\_\_ Date \_\_\_\_\_ on file \_\_\_\_\_



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. All services received in this office, are medically billed under Dr. Jason Kouri MD or Park Place Health Solutions. 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 insurance payments made to Dr. Jason Kouri, MD or Park Place Health Solutions, Inc. In addition, all credit and debit card processing will be done on our behalf and will show as a charge **from** Park Place Health Solutions, or Latch-D inc.

Patient Signature \_\_\_\_\_

Date: \_\_\_\_\_

Staff Signature \_\_\_\_\_ On File \_\_\_\_\_



## X-RAY CONSENT FORM

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. In addition, they may be required in order to administer treatment. By signing below, I consent to having the diagnostic x-rays performed, which the doctor determines is clinically necessary.

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

### CONSENT TO X-RAY A MINOR CHILD

I \_\_\_\_\_ authorize the performance of diagnostic x-ray examination of my child or ward which the above doctor or his associate may consider necessary or advisable in the course of examination and treatment.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### **THIS PORTION FOR WOMEN ONLY:**

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I am aware that the ten (10) days following the onset of a menstrual period are generally considered to be safe for x-ray exams. With those factors in mind, I am advising my doctor that:

I am pregnant.  Yes  No

I could be pregnant.  Yes  No

I am late with my menstrual period.  Yes  No

I am taking contraceptives.  Yes  No

I have had a tubal ligation.  Yes  No

I have had a hysterectomy.  Yes  No

I have irregular menstrual periods.  Yes  No

My last menstrual period began on \_\_\_\_\_

With full understanding of the above, and believing that I am currently not as risk, I wish to have an x-ray examination performed today if requested by the doctor.

Signature \_\_\_\_\_ Date: \_\_\_\_\_



## Financial Policy

Welcome to our office and thank you for trusting us with your care. This is a medically integrated office consisting of:

-Primary care including sick visits, physicals and general health.

-Chiropractic care and physical medicine.

**\*\* All of our Providers are also certified and multi-trained in HRT (Hormone Replacement Therapy) for both men & women. This includes testosterone therapy as well as estrogen & progesterone (as appropriate for females). Our PA/NP also specializes in diagnostic labs and medically supervised weight loss.**

### **Medical office visits and Labs/Diagnostic testing**

For follow up visits and labs, it is imperative that you follow your Providers appointment recommendations and be sure to get labs done as scheduled and attend follow up visits as your Provider instructs. Failure to do so can interrupt your treatment schedule as well as any medication refills needed. Please remember, during busiest times, it can take 3-4 weeks to get back on the Provider's schedule.

### **For Physical Medicine/Chiropractic visits**

**Your schedule is based upon your exam and x-ray findings, as well as Dr. Park's 26 years' experience. All muscles, ligaments, tendons and cartilage must be strengthened and realigned to hold the vertebrae in position. Therefore, you can't expect meaningful changes in just a few visits. Each adjustment builds on the one before. Missing or postponing visits will interfere with the "retraining" of your spine.** Therefore, it is important to understand that your cooperation is crucial in facilitating the healing process. Communication about your progress is very important. If at any time, you and/or we feel you are not progressing in your care as expected, we will discuss further testing, change your therapy and send any necessary referrals.

Please feel free to discuss any concerns about your care or questions you may have. ***Your understanding of your condition and your health is our main concern.***

### **PATIENTS W/O INSURANCE**

We request that your visits be paid at the time that services are rendered. We accept checks, MasterCard or Visa.

### **GROUP OR INDIVIDUAL INSURANCE**

Your insurance policy is an agreement between you and your insurance company, not between your insurance company and our office. The amount they pay varies from one policy to another. We will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge and file them to your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or copays.



### SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help filing.

#### FLEX PLANS/ MEDICAL SAVINGS ACCOUNT

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

### INSURANCE FORMS/ PAYMENT

**MOST BILLING IS UNDER DR. JASON KOURI, M.D., MEDICAL DIRECTOR.**

**However, some services may be billed under Dr. James T. Park.**

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request for more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible.

### PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card or health insurance card and tell us if you have retained an attorney. There are four options available for PI patients:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the PIP/Med Pay portion of your auto insurance.
3. We will accept a Letter of protection Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all copays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement on your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate the case, any fees for services are due immediately.

### MISSED APPOINTMENTS

Please know that we reserve appointment times especially for you. Therefore, we ask that you give 48 hours' notice for appointments changes. However, we REQUIRE you to give us at least 24-hour notice when canceling your appointment. **Appointments canceled/no showed less than 24 hours will be charged at \$35.00 fee.**

*I have read and understand the payment policy of **Park Place Health Solutions**. I understand that my insurance is an agreement between myself and my insurance company, NOT between **Park Place Health Solutions** and my insurance company. I understand this practice has the authorization to charge the credit card on file for any outstanding balance.*

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Patient's signature (or guardian if patient is a minor)

Date

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Witness



**MRS Checklist - BEFORE HRT**

Place an "X" for EACH symptom you are currently experiencing. Please mark only ONE box.

For symptoms that do not apply, please mark NONE.

	None	Mild	Moderate	Severe	Extremely Severe
1. <b>Hot flashes, sweating</b> (episodes of sweating)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. <b>Heart discomfort</b> (unusual awareness of heart beat, heart skipping, heart racing, tightness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. <b>Sleep problems</b> (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. <b>Depressive mood</b> (feeling down, sad, on the verge of tears, lack of drive, mood swings)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. <b>Irritability</b> (feeling nervous, inner tension, feeling aggressive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. <b>Anxiety</b> (inner restlessness, feeling panicky)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. <b>Physical and mental exhaustion</b> (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. <b>Sexual problems</b> (change in sexual desire, in sexual activity and satisfaction)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. <b>Bladder problems</b> (difficulty in urinating, increased need to urinate, bladder incontinence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. <b>Dryness of vagina</b> (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. <b>Joint and muscular discomfort</b> (pain in the joints, rheumatoid complaints)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please share any additional comments about your symptoms you would like to address.

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Do you have cold hands and feet?  Yes  No Do you have daily bowel movements?  Yes  No

Do you have gas, bloating or abdominal pain after eating?  Yes  No

Please select your WEEKLY Activity Level based on these criteria → Physical activity that accelerates heart rate / Breathlessness

0-1 day per week (Low)  2-3 days per week (Average)  More than 3 days per week (High)

Please list any prior hormone therapy? \_\_\_\_\_