TEXAS MEDICAL INSTITUTE

Dear New Patient

Tarrant County Medical Institute values its patients and is committed to providing them with the highest of quality care.

You have made us aware that you will be the responsible party for all the treatment provided to you at our facility. We accommodate our cash patients by billing them the minimal charges available for our services. The charges are as follows:

Initial Exam Fee **$120 w/out x-ray $180 w/x-ray**
This exam will include all the necessary treatment to determine the best available medical and rehabilitation program for you. This fee will be collected at the time of visit.

Follow-Up Medical Office Visit **$75**
This fee will be collected at the time of visit.

Rehabilitation program **$50/day**
This fee is for a 30 minute session of physical rehabilitation and will be collected at the time of visit.

Please be advised that Texas Medical Institute does not accept Medicare or any of its subsidies. If you are a Medicare beneficiary, or become a beneficiary while receiving treatment at Texas Medical Institute, please notify our office immediately.

Kindly notify us prior to your appointment if you will be unable to make your payment so further arrangements can be made.

Sincerely,

Dr. Greg Gardner D.O

PATIENT INFORMATION

DATE:_____

NAME:_____

ADDRESS: _____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____CELL:_____

EMAIL ADDRESS: _____

SOCIAL SECURITY#: _____D.O.B:_____

EMPLOYER:_____ OCCUPATION:_____

ADDRESS: _____

CITY:_____STATE:_____ZIP:_____

PHONE:_____FAX:_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

INCASE OF EMERGENCY
Nearest relative (this information will be used when we are unable to contact you in the event of emergency or to cancel/reschedule appointments

NAME:_____

ADDRESS: _____

CITY:_____STATE:_____ZIP:_____

PHONE:_____

How is he/she related to you? ☐ Spouse ☐ Parent ☐ Sibling ☐ Other Relative ☐ Friend

MEDICAL HISTORY

What treatment have you already received for your condition?

□ Surgery: Was your surgery ____Successful ____Unsuccessful/who preformed this surgery? _____

□ Physical Therapy: Was your therapy ____Successful ____Unsuccessful/ where was it? _____

□ Chiropractic Services: Was your treatment ____Successful ____Unsuccessful/ where was it_____

□ Other _____ □ None

Name and address of the other Doctor(s) who treated you for your condition:_____

_____

_____

Date of Last: Physical Exam_____ Spinal X-Ray _____ Blood Test_____

Spinal Exam _____ Chest X-Ray _____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____ _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	□ Yes □ No	Chicken Pox	□ Yes □ No	Liver Disease	□ Yes □ No	Rheumatoid Arthritis	□ Yes □ No
Alcoholism	□ Yes □ No	Diabetes	□ Yes □ No	Measles	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Allergy Shots	□ Yes □ No	Emphysema	□ Yes □ No	Migraine Headaches	□ Yes □ No	Scarlet Fever	□ Yes □ No
Anemia	□ Yes □ No	Epilepsy	□ Yes □ No	Miscarriage	□ Yes □ No	Stroke	□ Yes □ No
Anorexia	□ Yes □ No	Fractures	□ Yes □ No	Mononucleosis	□ Yes □ No	Suicide Attempt	□ Yes □ No
Appendicitis	□ Yes □ No	Glaucoma	□ Yes □ No	Multiple Sclerosis	□ Yes □ No	Thyroid Problems	□ Yes □ No
Arthritis	□ Yes □ No	Goiter	□ Yes □ No	Mumps	□ Yes □ No	Tonsillitis	□ Yes □ No
Asthma	□ Yes □ No	Gonorrhea	□ Yes □ No	Osteoporosis	□ Yes □ No	Tuberculosis	□ Yes □ No
Bleeding Disorders	□ Yes □ No	Gout	□ Yes □ No	Pacemaker	□ Yes □ No	Tumors, Growths	□ Yes □ No
Breast Lump	□ Yes □ No	Heart Disease	□ Yes □ No	Parkinson's Disease	□ Yes □ No	Typhoid Fever	□ Yes □ No
Bronchitis	□ Yes □ No	Hepatitis	□ Yes □ No	Pinched Nerve	□ Yes □ No	Ulcers	□ Yes □ No
Bulimia	□ Yes □ No	Hernia	□ Yes □ No	Pneumonia	□ Yes □ No	Vaginal Infections	□ Yes □ No
Cancer	□ Yes □ No	Herniated Disk	□ Yes □ No	Polio	□ Yes □ No	Venereal Disease	□ Yes □ No
Cataracts	□ Yes □ No	Herpes	□ Yes □ No	Prostate Problem	□ Yes □ No	Whooping Cough	□ Yes □ No
Chemical Dependency	□ Yes □ No	High Cholesterol	□ Yes □ No	Prosthesis	□ Yes □ No	Other: _____	
_____		Kidney Disease	□ Yes □ No	Have you ever had any nervous or mental illnesses?		□ Yes □ No	
Have you had psychiatric care?	□ Yes □ No	Have you received a medical discharge from the Armed Forces				□ Yes □ No	

EXERCISE	**WORK ACTIVITY**	**HABITS**	
□ None	□ Sitting	□ Smoking	Packs/day_____
□ Moderate	□ Standing	□ Alcohol	Drinks/week_____
□ Daily	□ Light Labor	□Caffeine Drinks	Cups/Daily _____
□ Heavy	□ Heavy Labor	□ High Stress Level	Reason _____
			_____

Women Only: Are you pregnant? □Yes □No If yes Due Date: _____ # of Pregnancies: _____

Method of delivery: C-Section #_____Vaginal #_____Miscarriages #_____Other Female

Surgeries:_____

Injuries/Surgeries you have had	Descriptions	Date
Falls		
Head Injuries		
Broken bones		
Dislocations		
Surgeries		

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**

Pharmacy Name:_____Phone #:_____

X-RAY Release Form

I have been advised by the doctor or staff member of this office that x-rays can be HAZARDOUS to an unborn child. At this time, and to the best of my knowledge, I am not pregnant. I consent to having life size, digital x-ray pictures taken.

Patient Signature:_____

Date:_____

Witness:_____

Date:_____

FOR WOMEN ONLY

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination test, diagnostic x-rays, and chiropractic modalities on myself (or on the patient names below for which I am legally responsible). All by which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for, or associated with, or serving as back-up for the doctors of chiropractic named below.

Names and Addresses of Offices and Clinics

Texas Medical Institute
6789 Camp Bowie Blvd.
Fort Worth, TX 76116

Texas Medical Institute
3304 SE Loop 820
Fort Worth TX 76140

Texas Medical Institute
8100 John W. Carpenter Fwy Ste 100
Dallas, TX 75247

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Signature of Patient Date

Printed Name of Patient

Signature of Patient Representative (If minor or physically incapacitated)

Witness Date

PATIENT COMFORT ASSESSMENT GUIDE

Name: _____
Where is your pain: _____

Circle the words that describe your pain;

aching	sharp	penetrating	throbbing	tender
nagging	shooting	burning	numb	stabbing
exhausting	miserable	gnawing	tiring	unbearable

Circle ONE - occasional continuous

What time of day is your pain the worst? morning afternoon evening nighttime

Rate your pain by circling the number that best describes your pain at its **worst** in the last month.

1 2 3 4 5 6 7 8 9 10
(1 being the least 10 being the worst/extreme pain)

Rate your pain by circling the number that best describes your pain at its **least** in the last month.

1 2 3 4 5 6 7 8 9 10
(1 being the least 10 being the worst/extreme pain)

Rate your pain by circling the number that best describes your pain on average in the last month.

1 2 3 4 5 6 7 8 9 10
(1 being the least 10 being the worst/extreme pain)

Rate your pain by circling the number that best describes your pain right now.

1 2 3 4 5 6 7 8 9 10
(1 being the least 10 being the worst/extreme pain)

What makes you pain **better**?_____

What makes you pain **worse**?_____

What **treatments** or **medicines** are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.

a) _____ No 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) relief relief

b) _____ No 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) relief relief

d) _____ No 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) relief relief

e) _____ No 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) relief relief

PATIENT COMFORT ASSESSMENT GUIDE CONTINUED

What **side effect** or **symptoms** are you having? Circle the number that best describes your experience during the past week.

a.	Nausea	Barely Noticeable	1	2	3	4	5	6	7	8	9	10	Sever Enough to Stop Medicine
b.	Vomiting	Barely Noticeable	1	2	3	4	5	6	7	8	9	10	Sever Enough to Stop Medicine
c.	Constipation	Barely Noticeable	1	2	3	4	5	6	7	8	9	10	Sever Enough to Stop Medicine
d.	Lack of Appetite	Barely Noticeable	1	2	3	4	5	6	7	8	9	10	Sever Enough to Stop Medicine
e.	Tired	Barely Noticeable	1	2	3	4	5	6	7	8	9	10	Sever Enough to Stop Medicine
f.	Itching	Barely Noticeable	1	2	3	4	5	6	7	8	9	10	Sever Enough to Stop Medicine
g.	Nightmares	Barely Noticeable	1	2	3	4	5	6	7	8	9	10	Sever Enough to Stop Medicine
h.	Sweating	Barely Noticeable	1	2	3	4	5	6	7	8	9	10	Sever Enough to Stop Medicine
i.	Difficulty Thinking	Barely Noticeable	1	2	3	4	5	6	7	8	9	10	Sever Enough to Stop Medicine
j.	Insomnia	Barely Noticeable	1	2	3	4	5	6	7	8	9	10	Sever Enough to Stop Medicine

Circle the one number that describes how during the past week **pain has interfered** with your:

a.	General Activity	Does not	1	2	3	4	5	6	7	8	9	10	Completely
b.	Mood	Does not	1	2	3	4	5	6	7	8	9	10	Completely
c.	Normal Work	Does not	1	2	3	4	5	6	7	8	9	10	Completely
d.	Sleep	Does not	1	2	3	4	5	6	7	8	9	10	Completely
e.	Enjoyment of Life	Does not	1	2	3	4	5	6	7	8	9	10	Completely
f.	Ability to Concentrate	Does not	1	2	3	4	5	6	7	8	9	10	Completely
g.	Relations with Other People	Does not	1	2	3	4	5	6	7	8	9	10	Completely

Patient Record of Disclosures

HIPPA Privacy rule: **III. Other Uses and Disclosures of Health Information** We will not use or disclose your health information for any purpose other than those identified in this written Authorization. We cannot take back any uses or disclosures already made with your permission.

I wish to be contacted in the following manner (check all that apply):

☐ Home telephone #: _____
- ☐ O.K to leave messages with detailed information
- ☐ Leave message with call-back number only
- ☐ Fax to this number#: _____

☐ Work telephone #: _____
- ☐ O.K to leave messages with detailed information
- ☐ Leave message with call-back number only
- ☐ Fax to this number#: _____

☐ **Written Communication**
- ☐ Mail to my home address
- ☐ Mail to my work/office

☐ Other _____
_____

_____ _____ _____
Patient Signature Date Print Name

Healthcare entities must keep records of PHI disclosures; information provided below, if completed properly, will constitute an adequate record.
NOTE: Uses and disclosure for PHI may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to	1	Purpose	By Whom	2	3

1. Check this box if the disclosure is authorized
2. Print: T = Treatment Record; P = Payment Information; O = Other Healthcare provider
3. How was disclose made: F = Fax; P = Phone; E = E-mail; O = Other

Standard Authorization Form
To Use or Disclose Protected Health Information (PHI)

Patient Name:_____ Date: _____
Address: _____ SS#:xxx-xx- __ __ __ __
_____ D.O.B: _____

Receive Records From:
_____
_____
_____
_____

Release Records To:
Texas Medical Institute
6789 Camp Bowie Blvd
Fort Worth TX 76116
P: 817-731-2102 Fax: 817-731-2157

Please send a copy of my records as indicated for date(s) of Treatment: _____

Specifically:
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ MD Progress Notes
- ☐ Nursing Notes
- ☐ Social Serv. Notes
- ☐ Laboratory
- ☐ Radiology
- ☐ EEG/EKG/CAT Scan
- ☐ MD Orders
- ☐ other please specify: _____

Purpose for releasing medical information_____
_____

_____ _____
Signature of Patient, Parent or Legal Guardian **Witness**

_____
Date

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems and this special consent also will apply to HIV/AIDS related diagnoses, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

_____ _____
Signature of Patient, Parent or Legal Guardian **Witness**

_____
Date