ELEVATE Neurology

f 214.377.5022
p 855.435.3828

712 N Washington Ave
Dallas, Texas 75246

713 Grainger St
Fort Worth, TX 76104

New Patient Intake Packet

Patient Last Name/*Apellido del paciente* | First Name/*Primer nombre* | Middle Initial/*Inicial del segundo nombre*

Date of Birth/*Fecha de nacimiento* | Date of Injury/*Fecha de herida* | Attorney/*Abogado*

Address/*Dirección*

City/*Ciudad* | State/*Estado* | ZIP Code/*Código Postal*

Home Phone/*Teléfono de casa* | Cell Phone/*Teléfono móvil*

Email Address/*Correo electrónico*

ELEVATE Neurology

The Rivermead Post-Concussion Symptoms Questionnaire

Form A: *State of Symptoms for the First 7 Days Following the Injury*

Patient Name/*Nombre del paciente* _____ Date/*Fecha* _____ Date of Injury/*Fecha de herida* _____

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

0 = Not experienced at all 1 = No more of a problem 2 = A mild problem
3 = A moderate problem 4 = A severe problem

Compared with before the accident, did you **immediately following the accident (i.e., over the next 7 days)** suffer from:

Headaches.....	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance.....	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, easily upset by bright light.....	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

1. _____	0	1	2	3	4
2. _____	0	1	2	3	4

King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592

ELEVATE Neurology

The Rivermead Post-Concussion Symptoms Questionnaire

Form B: *Current State of Symptoms*

Patient Name/*Nombre del paciente* _____ Date/*Fecha* _____ Date of Injury/*Fecha de herida* _____

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

0 = Not experienced at all 1 = No more of a problem 2 = A mild problem
3 = A moderate problem 4 = A severe problem

Compared with before the accident, do you **now (i.e., over the last 24 hours)** suffer from:

Headaches.....	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance.....	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, easily upset by bright light.....	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

1. _____	0	1	2	3	4
2. _____	0	1	2	3	4

King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592

Assignment of Benefits: Assignment of Cause on Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants, and conveys, to Elevate HC Texas, PLLC, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred 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. I hereby give my permission to elevate health clinics to release my information to a new attorney of their choosing in the event my representing attorney drops my case.

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 Elevate Health Clinics, LLC and to 712 N Washington Ave Ste 200, Dallas, TX 75246.

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 Elevate HC Texas, PLLC and to send any and all checks to 712 N Washington Ave Ste 200, Dallas, TX 75246.

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.

Premises Liability Release: I hereby release Elevate HC TX, PLLC and its subsidiaries and affiliates from any liability assumed in the event I sustain any injury while on premises, including any injury sustained due to dizziness, headache or other symptoms brought on by testing or examination performed by or at the Elevate facilities. I hereby indemnify, defend and hold harmless Elevate HC TX, PLLC and its affiliates and subsidiaries from any and all claims, actions, damages, liabilities, costs and expenses, including without limitation reasonable attorney's fees and expenses, arising out of (a) the death or bodily injury of any agent, employee customer or business invitee of the indemnitor, and (b) the damage, loss or destruction of any property of the indemnitor.

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.

Continuation of Care: I hereby acknowledge and understand that Elevate Health Clinics provides service specific to traumatic brain injury. At the conclusion of treatment at Elevate Health Clinics, it is the patient's responsibility to seek ongoing care with a health care provider not affiliated with Elevate Health Clinics to continue to address health issues both related and not related to the patient's care at Elevate Health Clinics. I understand the failure to do so may jeopardize my medical care.

Signature of Patient and/or Responsible Parties/*Firma de paciente o parte responsable* Date/*Fecha*

Financial Disclosure Notice Acknowledgement

I have read the **Financial Disclosure Notice** provided to me and understand my financial obligations. I agree to pay the amounts required of me for any fees or services incurred at ***Elevate*** (Elevate HC Texas, PLLC). I am over 18 years of age or I am the parent or guardian of the patient. I give permission for ***Elevate*** (Elevate HC Texas, PLLC) to bill my insurance (if applicable) and release information to my insurance, if necessary, for payment of claims.

Signature of Patient and/or Responsible Parties *Firma de paciente o parte responsable*	Date *Fecha*	Relationship to Patient if Minor *Relacion con el paciente si es menor*

Notice of Privacy Practices Acknowledgement

By signing below, you acknowledge that you have received the **Notice of Privacy Practices** and you consent to the use and disclosure of your medical information except as expressly stated below. You understand that ***Elevate*** (Elevate HC Texas, PLLC) has the right to change its **Notice of Privacy Practices** and that you may contact ***Elevate*** (Elevate HC Texas, PLLC) at any time if you have any questions.

I hereby request the following restrictions on the use and/or disclosure of my information. I understand that you are not required to agree to my requested restrictions and will notify me, in writing, if my request(s) is denied.

_____

_____

Patient Confidentiality and Treatment of Private Medical Information

1. Please list people (and their relation to you) to whom we may release information about your medical condition and/or treatment. Please include anyone who may pick up prescriptions, reports, x-rays, etc. for you. ***Please note: for minors, the parents &/or legal guardians must be listed below, even if completed by a parent or legal guardian.***

   _____ _____
   _____ _____
   _____ _____
   _____ _____

2. How can we communicate confidential information (e.g., lab results, referrals, diagnostic test results, billing inquiries)?

   Home phone? Yes No **Work phone?** Yes No **Cell Phone?** Yes No **E-Mail?** Yes No

   Email Address (please print clearly): _____

Signature of Patient and/or Responsible Parties *Firma de paciente o parte responsable*	Date *Fecha*	Relationship to Patient if Minor *Relacion con el paciente si es menor*

No-Show/Late Policy

Failing to appear for a scheduled appointment will result in a "no-show" fee of $250, which will be taken out of your settlement. Tardiness of fifteen or more minutes will be considered a no-show and your appointment will be canceled. After three no-shows, you will be discharged from our care due to noncompliance.

Si no se presenta a su cita programada, se le cobrará una tarifa de $250 "por no presentarse", que se le sacara de su compensación. Su tiene una tardanza de quince minutos o mas, sera considerado como no presentarse y se le cancelará su cita. Después de tres ausencias, se le dará de alta de nuestra atención medica, debido a su incumplimiento.

Signature of Patient and/or Responsible Parties/*Firma de paciente o parte responsable*	Date/*Fecha*

Authorization to Use or Disclose Protected Health Information

Patient Name/*Nombre del paciente* _____ Date of Birth/*Fecha de nacimiento* _____

This form will authorize the below facility to provide a copy or summary of my medical records to **Elevate Health Clinics** as indicated on this authorization:

Facility name where records are located: _____

Facility address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Records to be released include:

____ **All Records** for the period of _____ through _____

____ **Lab Results –** Date(s): _____

____ **MRI results/X-ray –** Date(s): _____ Type: _____

____ **Other**: _____

The above information may be released to:

Elevate Health Clinics
712 N Washington Ave
Dallas, TX 75246

Phone: 855.435.3828
Fax: 214.377.5022

Expiration of authorization (if not specified, authorization expires at the end of litigation): _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise required by law. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations. I further understand that information disclosed pursuant to this authorization may be re-disclosed by the parties listed above and no longer protected. I have the right to revoke this authorization in writing except to the point that action has already been taken in reliance upon the authorization. I also understand that treatment or payment cannot be conditioned on the authorization.

Signature of Patient and/or Responsible Parties/*Firma de paciente o parte responsable* _____ Date/*Fete* _____

ELEVATE Neurology

Other Providers

Patient Name/*Nombre del paciente* _____ Date of Birth/*Fecha de nacimiento* _____

Please list below any and all physicians you have seen regarding your injury/symptoms. Include any imaging, ER visits, ambulance rides, family medicine, chiropractic, pain management, neurology, psychology, psychiatry, or other providers who have evaluated you.

Ambulance/EMT
☐ Yes / ☐ No Date(s): _____

ER/Hospital: ☐ Yes / ☐ No
Facility: _____ Date(s): _____

Brain Imaging: ☐ Yes / ☐ No
Facility: _____ Date(s): _____

Primary Care Doctor: ☐ Yes / ☐ No
Physician: _____ Facility: _____ Date(s): _____

Chiropractic: ☐ Yes / ☐ No
Physician: _____ Facility: _____ Date(s): _____

Pain Management: ☐ Yes / ☐ No
Physician: _____ Facility: _____ Date(s): _____

Orthopedic: ☐ Yes / ☐ No
Physician: _____ Facility: _____ Date(s): _____

Neurology: ☐ Yes / ☐ No
Physician: _____ Facility: _____ Date(s): _____

Other – Specialty: _____
Physician: _____ Facility: _____ Date(s): _____

Other – Specialty: _____
Physician: _____ Facility: _____ Date(s): _____

Other – Specialty: _____
Physician: _____ Facility: _____ Date(s): _____

Signature of Patient and/or Responsible Parties/*Firma de paciente o parte responsable* _____ Date/*Fete* _____

Parental Consent of a Minor*

In compliance with the Texas Family Code

This form will be required prior to treating your child.

Please complete this form to detail your wishes regarding treatment of your child.
Por favor complete este formulario para detallar sus deseos con respeto al tratamiento de su hijo.

Child's Name/*Nombre del paciente* _____ Date of Birth/*Fecha de nacimiento* _____

Parent or Guardian's name(s)/*Nombre del padre o parte responsable* _____

Check one:

- ❑ I consent to my child being given treatment with a guardian or other authorized adult present.
  Consiento que mi hijo reciba tratamiento con un tutor o otro adulto presente

  I wish for this consent to be in effect from _____ to _____.
  (If no dates are listed, this consent will automatically expire once the minor turns 18 or is emancipated.)

  Please list the names and phone numbers of any other person(s) who can bring your child in for treatment:
  _____

  _____

  _____

- ❑ I wish to decline consent for treatment
  Deseo rechazar el consentimiento para el tratamiento

Signature of Parent or Guardian/*Firma de paciente o parte responsable* _____ Date Signed/*Fecha* _____

Driver's License Number: _____
(Please verify we have a copy of your license on file, as this form will not be valid without the DL on file in our system. You may include a copy of your license with this form if you are unsure as to whether or not it has been presented to us previously.)

**In the State of Texas, a minor is anyone under the age of 18 years, who is not and has not ever been married, or who has not been emancipated for general purposes by a court of law.*

Treatment for Concussion and/or Mental Health requires a parent or guardian be present regardless of signed consent.