



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*

The Rivermead Post-Concussion Symptoms Questionnaire

Form A: *Estado de los síntomas durante los primeros siete días posteriores a la lesión*

Patient Name/*Nombre del paciente*

Date/*Fecha*

Date of Injury/*Fecha de herida*

Después de una lesión cerebral o un accidente, algunas personas sufren de síntomas que pueden causar preocupación o molestias. Nos gustaría saber si ahora experimenta algunos de los síntomas que se detallan a continuación. Dado que muchos de estos síntomas ocurren normalmente, nos gustaría que se compare con antes del accidente. Para cada uno, circule el número que mejor describa la gravedad de sus síntomas.

0 = Nunca fue un problema 1 = Ya no es más un problema 2 = Un problema leve
3 = Un problema moderado 4 = Un problema grave

Comparado con antes del accidente, **¿ha sufrido de estos síntomas en los próximos 7 días?**

Dolores de cabeza.....	0	1	2	3	4
Sensación de mareo.....	0	1	2	3	4
Nauseas o vómitos.....	0	1	2	3	4
Sensibilidad al ruido, se molesta fácilmente					
por el ruido fuerte.....	0	1	2	3	4
Suño alterado, dificultad al dormir.....	0	1	2	3	4
Fatiga, se cansa más fácil.....	0	1	2	3	4
Irritabilidad, se enoja/enfada más fácilmente..	0	1	2	3	4
Depresión, tristeza, o lagrimas.....	0	1	2	3	4
Frustración o impaciencia.....	0	1	2	3	4
Olvido, mala memoria.....	0	1	2	3	4
Mala concentración.....	0	1	2	3	4
Pensamientos lentos, necesita mas tiempo					
para formar ideas.....	0	1	2	3	4
Visión borrosa.....	0	1	2	3	4
Sensibilidad a la luz, se altera fácilmente					
por la luz brillante/fuerte.....	0	1	2	3	4
Visión doble.....	0	1	2	3	4
Inquietud	0	1	2	3	4

¿Esta sufriendo de alguna otra dificultad?

1. _____ 0 1 2 3 4

2. _____ 0 1 2 3 4

The Rivermead Post-Concussion Symptoms Questionnaire

Form B: *Estado actual de los síntomas*

Patient Name/*Nombre del paciente*

Date/*Fecha*

Date of Injury/*Fecha de herida*

Después de una lesión cerebral o un accidente, algunas personas sufren de síntomas que pueden causar preocupación o molestias. Nos gustaría saber si ahora experimenta algunos de los síntomas que se detallan a continuación. Dado que muchos de estos síntomas ocurren normalmente, nos gustaría que se compare con antes del accidente. Para cada uno, circule el número que mejor describa la gravedad de sus síntomas.

0 = Nunca fue un problema 1 = Ya no es más un problema 2 = Un problema leve
3 = Un problema moderado 4 = Un problema grave

Comparado con antes del accidente, **¿ha sufrido de estos síntomas en las últimas 24 horas?**

Dolores de cabeza.....	0	1	2	3	4
Sensación de mareo.....	0	1	2	3	4
Nauseas o vómitos.....	0	1	2	3	4
Sensibilidad al ruido, se molesta fácilmente por el ruido fuerte.....	0	1	2	3	4
Sueno alterado, dificultad al dormir.....	0	1	2	3	4
Fatiga, se cansa más fácil.....	0	1	2	3	4
Irritabilidad, se enoja/enfada más fácilmente..	0	1	2	3	4
Depresión, tristeza, o lagrimas.....	0	1	2	3	4
Frustración o impaciencia.....	0	1	2	3	4
Olvido, mala memoria.....	0	1	2	3	4
Mala concentración.....	0	1	2	3	4
Pensamientos lentos, necesita mas tiempo para formar ideas.....	0	1	2	3	4
Visión borrosa.....	0	1	2	3	4
Sensibilidad a la luz, se altera fácilmente por la luz brillante/fuerte.....	0	1	2	3	4
Visión doble.....	0	1	2	3	4
Inquietud	0	1	2	3	4

¿Esta sufriendo de alguna otra dificultad?

1. _____ 0 1 2 3 4

2. _____ 0 1 2 3 4

Assignment of Benefits: Assignment of Cause of 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 sacará 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 health-care 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/*Fecha*

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): _____