CURIS FUNCTIONAL HEALTH
JERROD EDWARDS, D.C.

CURIS FUNCTIONAL HEALTH INTAKE FORM

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell: ( ) _____Home: ( ) _____Work: ( ) _____
E-mail: _____
Birth Date: _____ Age: _____ Male: ____ Female: ____ Marital Status: _____
Social Security Number: _____ How were you referred? _____
Have you seen a Chiropractor before? YES NO If yes, When? _____

YOUR HEALTH HISTORY

Please **CHECK** all symptoms you have problems with, even if they do not seem related to your primary problem.

☐ Neck Pain	☐ Headaches	☐ Dizziness	☐ Indigestion
☐ Mid Back Pain	☐ Tingling into arm/hand	☐ Ringing in Ears	☐ Heart Burn
☐ Low Back Pain	☐ Tingling into leg/foot	☐ Loss of taste	☐ Diarrhea
☐ Jaw Pain	☐ Tension	☐ Loss of smell	☐ Problem urinating
☐ Hip Pain	☐ Sleeping problems	☐ Fever	☐ Constipation
☐ Shoulder Pain	☐ Cold Sweats	☐ Hot Flashes	☐ Stomach upset
☐ Foot Pain	☐ Cold hands/feet	☐ Depression	☐ Nervousness
☐ Bursitis	☐ Loss of Balance	☐ Mood Swings	☐ High blood pressure
☐ Pregnant	☐ Arthritis	☐ Low blood pressure	☐ An infectious disease
☐ Diabetes	☐ Skin Problems	☐ Epilepsy	☐ Blood clots
☐ Heart trouble	☐ Varicose veins	☐ Cancer	☐ Other_____

Do you smoke? Yes/ No If yes: How many years/ packs per day? _____
List any medications you are taking: _____
_____N/A or None.
Do you have any medically diagnosed conditions? _____ N/A or None.

Does anyone in your family have any medically diagnosed conditions (If so, whom)? _____
_____N/A or None.

MASSAGE PATIENTS ONLY

Please **CHECK** the following of which apply to you:
☐ I have contacts in my eyes I have allergies to: ☐ Lotions ☐ Fragrances ☐ Oils
I consent to massage of (mark all that apply): ☐ gluteal region ☐ face ☐ pectorals (not breast tissue)

I know and understand the following:

- Proper client draping procedures protect the modesty of each the client and therapist.
- Massage therapists are prohibited from prescribing, diagnosing or treating any medical condition. It is recommended that I see a physician for any medical problems I might have.
- I have submitted correct information regarding my state of health medical history, injuries, and/or surgeries undergone.
- I understand that Texas massage law prohibits massage or manipulation of the breast tissue of female without prior written consent.

Signed: _____ **Date**_____

2907 Medlin Dr #101 • Arlington, Texas • 76015 • 817.467.9233 • Fax 817.468.4777
www.gocuris.com

CURIS FUNCTIONAL HEALTH
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HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) CONSENT FORM

Release of Information: Your Protected Health Information (PHI) will be used by this office and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information: **You may request a restriction on the use or** disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent: You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, _____ **(print)** acknowledge that I have reviewed the above information and I authorize this office to release information concerning my condition and treatment to my insurance company, attorney, insurance adjuster and/or other health care providers deemed necessary for treatment purposes, processing my claim, benefits and payment of services rendered to me as well as coordinated treatment. I do understand that if I choose to refuse release of this information, that my **PHI** will be used **within** the office for purposes of my care, to those individuals designated by the doctor.

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of Chiropractic procedures, various forms of physio-therapy, physical examination, x-ray studies, and/or any clinical services that are deemed necessary in my case to be administered by the doctor and/or any support staff employed or contracted by this office or clinic. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and include, but are not limited to, muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fracture, disc injury, stroke, dislocations and sprains. The Journal of Alternative and Complementary Medicine, Vol. 16, No. 2, 2010 in a study entitled "**Unanticipated Benefits of CAM (Complementary/Alternative Medicine) Therapies for Back Pain: An Exploration of Patient Experiences"** concludes, "*Positive outcome themes included increased options and hope, increased ability to relax, positive changes in emotional states, increased body awareness, changes in thinking that increased the ability to cope with back pain, increased sense of well-being, improvement in physical conditions unrelated to back pain, increased energy, increased patient activation, and dramatic improvements in health or well-being. The first five of these themes were mentioned for all of the CAM treatments, while others tended to be more treatment specific. A small fraction of these effects were considered life transforming.*"

I understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also be used to alleviate other symptoms through a conservative approach with hopes to avoid more invasive procedures. I further understand that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has the right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I further understand that there are other treatment options available for my condition, and that I have the right to a second opinion should I have concerns as to the nature of my symptoms and/or treatment options. If during the course of my care my insurance company requires me to take an examination from any other doctor, I will notify this facility/physician immediately. I understand that failure to do so may jeopardize my case.

I, _____ **(print)** have read the above consent and I have had an opportunity to ask questions regarding its content. By signing below, I agree to the above-named procedures and intend this consent to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with this office.

Patient or Guardian Signature: _____ Date: _____

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CURIS FUNCTIONAL HEALTH
JERROD EDWARDS, D.C.

OFFICE POLICIES

Welcome to our family. Our goal is to serve this community with exceptionally friendly and prompt service. We want to provide the best health care available for your family. It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.

Office Hours:

Monday	9:00am to 1:00pm	3:00pm to 6:00pm
Tuesday	3:00pm to 6:00pm	
Wednesday	9:00am to 1:00pm	3:00pm to 6:00pm
Thursday	9:00am to 1:00pm	3:00pm to 6:00pm
Friday	9:00am to 1:00pm	

Initials _____

Appointment Schedule:
For your convenience and to ensure prompt, reliable service, we request that you pre-schedule all your appointments. We have a specific course of care that requires a number of adjustments in a set amount of time. Please provide a 24 hour notice when rescheduling an appointment so that we may serve others during your appointment time. Please refrain from repeatedly rescheduling. Keeping your appointments is *your* part in the correction of *your* problem and the restoration of *your* health. Therefore, more than three consecutive missed appointments is grounds for dismissal from care. If you are more than 15 minutes late, we reserve the right to reschedule your appointment. As there are only a few massage appointments available each day, a missed hour long appointment is seriously detrimental to our schedule, not to mention to our massage therapist's pocketbooks. After your first missed massage, a charge of $20 will be assessed to your account when a 24 hour notice is not provided if we are unable to fill your reserved time.

Initials _____

Children & Family:
Once you understand how the nervous system controls and coordinates all functions in the body and that subluxations interfere with nerve flow, we would expect that you would want everyone in your family checked for subluxation. We have a cost effective family program for you. We will be happy to schedule an appointment for their check-up today. We don't know if they need care, we do know they need to be checked.

Initials_____

Interruption of Care:
In the unlikely event that it is necessary to discontinue care, for any reason, any outstanding fees become due **immediately**. If you, the patient, discontinue care at any time, all fees become payable at the retail fee. If we find the need to dismiss you from care, all fees will be payable at any discounted rate agreed upon. If the care was prepaid, you are entitled to a refund of any unused portion, after all visits are paid at the retail rate.

Initials_____

Chiropractic Excellence:
In order to continue providing the best Chiropractic Care available, our doctors and staff occasionally need to be away from the office to attend conferences and continuing education seminars. So that you may continue your recommended adjustment schedule, another highly qualified doctor may be here to care for you in their absence.

Initials_____

Remember…
Healing and correction takes time. If at any time during your care you do not feel that you are responding as well as you expected, please discuss it with us. We want you to get the most from your Chiropractic care!

Initials_____

Treatment Plans
Your treatment plan's discounted price is based off of you completing it. If you choose not to complete the treatment all the way through the refunded charges are the full charge amount not at a discounted rate. All refunds are up to Crowne Chiropractic's discretion.

Initials_____

Referrals:
The greatest honor a patient can give to us is a referral of their family and friends. We promise to give your loved ones the same quality, love and attention that you receive. We also want to tell you in advance…..***THANK YOU FOR TRUSTING US!***

I have read and understand the above policies and agree to abide by them.

Signed: _____ **Date**_____

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Personal Insurance Information

Patient Name: _____ Date:_____

Your auto insurance company will only release this information to you, the policy holder.
Please call your auto insurance provider to obtain this important information.

Questions to ask when you're on the phone:

- Do I have Personal Injury Protection (PIP)? YES NO

  If so, how much? $2,500 $5,000 $10,000 Other:_____

- Do I have uninsured motorist policy on my insurance? YES NO

  If so, what is the limit? _____

- Do I have underinsured motorist policy on my insurance? YES NO

  If so, what is the limit? _____

- Patient Name: _____
- Name of your Insurance Company: _____
- Claim Number: _____
- Adjuster's Name: _____
- Adjuster's Phone #: _____
- Date of Injury: _____

** USING YOUR PERSONAL INJURY PROTECTION WILL NOT RAISE YOUR INSURANCE RATES **

Curis Functional Health
2907 Medlin Dr Sutie 101
Arlington, TX 76015

SYSTEM REVIEW

Please check all conditions you currently have or have had

General Questions

- ☐ Weight loss
- ☐ Weight gain
- ☐ Change in sleep patterns
- ☐ Change in activity capacity

Neurologic and Psychiatric

- ☐ Anxiety
- ☐ Headaches
- ☐ Depression
- ☐ Meningitis
- ☐ Paralysis
- ☐ Seizure
- ☐ Stroke
- ☐ Tingling
- ☐ Tremors
- ☐ Memory Loss
- ☐ Fainting spells, dizziness
- ☐ Head injuries
- ☐ Blackouts or near blackouts
- ☐ Change in sensation anywhere on your body
- ☐ Localized weakness or numbness

Ears, Eyes, Nose & Throat

- ☐ Hay fever
- ☐ Glaucoma
- ☐ Polyps
- ☐ Allergy
- ☐ Cataracts
- ☐ Goiter
- ☐ Hoarseness
- ☐ Double vision
- ☐ Gum problems
- ☐ Eye problems
- ☐ Ear Infections
- ☐ Glasses/contacts
- ☐ Hearing Loss
- ☐ Ear discharge/pain
- ☐ Frequent nosebleeds
- ☐ Ringing in your ears
- ☐ Sinus infections
- ☐ Swollen glands

Cardiovascular

- ☐ Angina
- ☐ Chest Pain
- ☐ Leg cramps
- ☐ Murmurs
- ☐ Ankle swelling
- ☐ Awakening short of breath
- ☐ Cardiac catheterization
- ☐ Cold hands or feet
- ☐ Congenital heart defects
- ☐ Dizziness when standing quickly
- ☐ Heart attacks
- ☐ Heart failure
- ☐ High or low blood pressure
- ☐ Irregular heart rate
- ☐ Purple fingers or lips
- ☐ Leg pain that resolves with rest
- ☐ Heart palpitations
- ☐ Varicose veins

Respiratory

- ☐ Pleurisy
- ☐ Wheezing
- ☐ Asthma
- ☐ Breathlessness when lying flat
- ☐ Prolonged cough
- ☐ Coughing up blood
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Frequent infections (bronchitis)

Skin

- ☐ Abscess
- ☐ Dandruff
- ☐ Acne
- ☐ Oily skin
- ☐ Boils
- ☐ Rashes
- ☐ Hives
- ☐ Dry skin
- ☐ Lumps
- ☐ Jaundice
- ☐ Psoriasis
- ☐ Athlete's foot
- ☐ Excessive body odor
- ☐ Excessive sweating
- ☐ Fungal infections
- ☐ Nail problems
- ☐ Moles- irregular
- ☐ Moles - change/new

Kidneys & Urinary Tract

- ☐ Blood in urine
- ☐ Brown urine
- ☐ Dribbling after urination
- ☐ Painful urination
- ☐ Excessive thirst
- ☐ Involuntary urination/incontinence
- ☐ Urinating frequently (day)
- ☐ Urinating frequently (night)
- ☐ Urine hesitancy
- ☐ Weak flow
- ☐ Frequent bladder infections
- ☐ Kidney disease
- ☐ Kidney stone

Endocrine

- ☐ Diabetes
- ☐ Sickle cell
- ☐ Abnormal body hair
- ☐ Changes in skin texture
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ History of "borderline" diabetes
- ☐ Increased loss of hair
- ☐ Rheumatism
- ☐ Thyroid disease

Male & Female

- ☐ Painful sexual intercourse
- ☐ Loss of sexual interest
- ☐ Unprotected sex
- ☐ Groin itching
- ☐ Sexually transmitted diseases

☐ Males Only

- ☐ Hernia
- ☐ Bloody ejaculation
- ☐ Inability to complete intercourse
- ☐ Lump on testicle
- ☐ Penile discharge
- ☐ Sterility
- ☐ Sores on penis or warts
- ☐ Prostate disease
- ☐ Testicular pain
- ☐ Testicular swelling

Musculoskeletal

- ☐ Anemia
- ☐ Arthritis
- ☐ Back pain
- ☐ Bursitis
- ☐ Gout
- ☐ Joint aches
- ☐ Neck pain
- ☐ Tendonitis
- ☐ Abnormal Blood Counts
- ☐ Blood clots in legs/lungs
- ☐ Bone Marrow Biopsy
- ☐ Easy Bleeding
- ☐ Easy bruising
- ☐ Joint swelling
- ☐ Morning stiffness
- ☐ Muscle aches

Gastrointestinal

- ☐ Diarrhea
- ☐ Gallstones
- ☐ Reflux
- ☐ Vomiting
- ☐ Ulcers
- ☐ Heartburn
- ☐ Hepatitis
- ☐ Indigestion
- ☐ Abdominal pain
- ☐ Anal fissures
- ☐ Black tarry stools
- ☐ Vomiting blood
- ☐ Constipation
- ☐ Nausea
- ☐ Problems swallowing
- ☐ Hiatal Hernia
- ☐ Intestinal obstruction
- ☐ Liver disease
- ☐ Hemorrhoids
- ☐ Red blood after bowel movement

☐ Females Only

- ☐ D + C
- ☐ Hot flashes
- ☐ Hernia
- ☐ Fibroids
- ☐ Endometriosis
- ☐ PMS
- ☐ Abn. bleeding between cycles
- ☐ Abnormal pap smear
- ☐ Bleeding after intercourse
- ☐ Complications with pregnancy
- ☐ Heavy bleeding during cycles
- ☐ Ovarian cysts
- ☐ Pelvic Inflammatory Disease
- ☐ Postmenopausal symptoms

Provider Notes:

Patient Name Age ID#

Patient Signature Date Provider Signature Date

Curis Functional Health
2907 Medlin Dr Suite 101
Arlington, TX 76015
817-467-9233

AUTO INJURY FORM

Name: _____ ☐ Male ☐ Female Age: ____ Date: _____

MOTOR VEHICLE ACCIDENT INFORMATION: Date: _____ Time: _____a.m _____p.m
Were You: [ ] Driver [ ] Passenger [ ] Pedestrian How many passengers in your vehicle? _____

The impact was from [ ] Behind [ ] Right Side [ ] Left Side [ ] Front [ ] Parked

Did your car hit the others involved? [ ] Yes [ ] No Did the other car hit yours? [ ] Yes [ ] No

Did the police come to the scene of the accident? [ ] Yes [ ] No Was a police report filed? [ ] Yes [ ] No

As a result of the accident, were any traffic citations issued to you? [ ] Yes [ ] No

Did you go to the Emergency Room? [ ] Yes [ ] No If so: how did you get there? _____
When did you go? _____ Which hospital? _____

Have you previously consulted any medical professional for this accident? [ ] Yes [ ] No

Describe any treatment you have received for this accident: _____
_____

Were any x-rays taken? [ ] Yes [ ] No Was any medication prescribed for your injuries? [ ] Yes [ ] No
If so, list them: _____
_____

Have you lost any days from work due to this accident? [ ] Yes [ ] No If so, when? _____

In your words, describe the accident: _____
_____
_____

Check the symptoms you have noticed since the accident:

[ ] Headache	[ ] Sleeping Problems	[ ] Lights Bother Eyes	[ ] Diarrhea	[ ] Loss of Balance
[ ] Neck Pain	[ ] Irritability	[ ] Loss of Memory	[ ] Constipation	[ ] Feet Cold
[ ] Mid Back Pain	[ ] Fatigue	[ ] Ears Ringing	[ ] Shortness of Breath	[ ] Hands Cold
[ ] Low Back Pain	[ ] Numbness to Hands	[ ] Numbness to Toes	[ ] Depression	[ ] Buzzing in Ears
[ ] Radiating Pain	[ ] Dizziness	[ ] Chest Pain	[ ] Other _____	

As a courtesy to you, Curis Functional Health will wait for payment until your case settles.

In return for not demanding payment at the time of visit, I agree to the following:

- I hereby authorize assignment of benefits and instruct my attorney/insurance company to pay the balance of my account to Curis Functional Health directly.
- I will keep Curis Functional Health informed of the status of my case, changes of address, or change of attorney.
- I will not settle my case without informing the office in advance of my intention to do so.
- I promise not to negotiate any settlement payment until I have confirmed that my balance has been paid in full.
- I agree to sign instructions to my attorney to allow direct payment of my balance.
- I agree to pay any costs related to the enforcement of this agreement.

We invite you to discuss with us any questions you have regarding your service. The best results are based on a friendly, mutual understanding between the patient and the doctor. Relax, and let us help you on the journey towards health!

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Curis Functional Health to provide me with care, in accordance with this state's statutes.

Patient or Guardian Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS: ASSIGNMENT OF CAUSE OF ACTION: CONTRACTUAL LIEN

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, assigns to **Dr. Jerrod Edwards/Curis Functional Health** the following rights and power of authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of procession my claim for benefits and payment of 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 Texas Insurance Code §§ 542.051 to 542.061 (formerly known as 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 for treatment rendered by physician/ facility named above, you are hereby tendered demand to pay in full the bill for services rendered by physician/ facility named above within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to Texas Insurance Code §§ 542.051 to 542.061, 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 Curis Functional Health and send all checks to 2907 Medlin Dr, Arlington, TX 76015.**

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable directly to **Curis Functional Health and send all checks to 2907 Medlin Dr, Arlington, TX 76015.**

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 costs of collection, including attorney fees and court cost incurred, and any postal fees.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/ facility named above the power to endorse my facility 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 account or forwarded to my address upon request in writing to the physician/ facility named above.

REJECTION IN WRITING: I hereby authorized the physician/ facility named above to establish a PIP or UM claim on my behalf. I also instruct my insurance carrier to provide upon request to the physician/ facility named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. If my carrier is unable to provide said rejections a timely manner, I acknowledge that I am entitled to minimum levels of coverage, as per section
1952.152 of the Texas Insurance Code, and further instruct my carrier to pay up to available limits directly to physician/ facility named above and to send any and all checks to **Curis Functional Health and send all checks to 2907 Medlin Dr, Arlington, TX 76015.**

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my 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.
I understand that I am directly and fully responsible to said **Dr. Jerrod Edwards/Curis Functional Health**, for all bills and charges for services rendered to me, and that this agreement is made solely for the additional protection of **Dr. Jerrod Edwards/Curis Functional Health** and in consideration of their awaiting payment.
I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict, which I may eventually recover. This agreement and assignment supersedes any prior agreement executed by the undersigned patient relating to the accident / illness referenced above.

Patient Name and/or responsible parties (PRINT): _____ Date: _____

Signature: _____ Date: _____

Office Signature: _____ Date: _____