Office use only: ☐ WC ☐ PI ☐ LOP ☐ Self Pay

Sacred Grove Holistic Healing and Learning Center

1008 Winscott Road; Suite A O: (469) 309-8243
David Peter Armentano LMT, MTI, CE Provider

(Please Print)

Date:						
PATIENT INFORMATION						
Patient's last name: First: Middle:			☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (Check One) ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Widow	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F	
Street address:		Social Security no.:		Home phone no.:		
P.O. box:	City:		State:	ZIP Code:		
Occupation:	Employer:			Employer phone no.:		
Email Address:						
Referred by (please check one box): ❑ Dr._____						
❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other _____						
INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:	Birth date:	Address (if different):		Home phone no.:		
Is this person a patient here? ❑ Yes ❑ No						
Occupation:	Employer:	Employer address:		Employer phone no.:		
Is this patient covered by insurance? ❑ Yes ❑ No						
Please indicate primary insurance ❑						
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-Payment: $	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other						
IN CASE OF EMERGENCY						
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize North Texas Family Care or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

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Chief Complaint: _____

When did the symptoms begin? _____

-Medical History-

☐ Allergies/Hay Fever
☐ Anemia
☐ Alcoholism
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Cancer: Type _____
☐ Emphysema
☐ Epilepsy
☐ Hypertension
☐ Heart Attack
☐ Mental Illness/Suicide
☐ Migraines/Headaches
☐ Rheumatic Fever
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ STD
☐ Anxiety/Depression
☐ Osteoporosis
☐ Glaucoma
☐ Gallstones
☐ Kidney Stones
☐ Diverticulitis
☐ Hepatitis
☐ Pacemaker
☐ Diabetes
☐ Jaundice
☐ High Cholesterol
☐ Pregnancies: Year(s) _____

-Hospitalization-

Year	Hospital	Reason

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-Family History-

Please mark all that apply:

Arthritis	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Asthma	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Cancer	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Diabetes	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Heart Disease	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Hypertension	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Kidney Disease	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Tuberculosis	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Bleeding Disorder	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Heart Attack	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather
Stroke	☐ Mother	☐ Father	☐ Grandmother	☐ Grandfather

Please indicate which substances you use and how much you use:

☐ Caffeine _____
☐ Tobacco _____
☐ Alcohol _____
☐ Drugs _____
☐ Other _____

I certify that the above information is true and correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have had in the completion of this form.

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____

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Medications or Food Allergies/Intolerances: _____
_____
_____
_____

Pharmacy Information:

Name: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip Code: _____

-Medication List (Please list all current medications)-

Name of Medication	Strength	How often taken

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Patient Health Questionnaire (PHQ-9)

Patient Name: _____ Date: _____

Over the last two (2) weeks, how often have you been bothered by any of the following problems? Please check the box that applies.

	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure doing things	☐ 0	☐ 1	☐ 2	☐ 3
Feeling Down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
Feeling bad about yourself, that you are a failure or have let yourself or family down	☐ 0	☐ 1	☐ 2	☐ 3
Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
Thoughts that you would be better off dead, or of hurting yourself	☐ 0	☐ 1	☐ 2	☐ 3
Add Columns	0	+	+	
Total=				

(Healthcare professional: For interpretation of Total, please refer to accompanying scoring card.)

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ **Not difficult at all** ☐ **Somewhat Difficult** ☐ **Very Difficult** ☐ **Extremely Difficult**

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CONSENT TO TREAT

I agree to be treated by David Peter Armentano LMT for the injury/condition I have consulted him/her for. I consent and authorize Range of Motion testing and treatment as ordered by my doctor and/or their associates. I further authorize David Peter Armentano LMT to carry out his instructions with respect to the procedures and treatment ordered by my treating chiropractor/physician. I understand that David Peter Armentano LMT will develop an individualized treatment plan for my care, and in order to recover in the shortest possible time this treatment plan must be followed.

I hereby further agree to maintain and cooperate with the above-named massage therapist's recommendations for the care of this injury/condition provided they are in accordance with my treating physician/chiropractor. In the event of excessive missed appointments without notification or authorization of the above-named providers, it will be assumed that I have reached a point of stabilization and that I am dismissing myself form their care. In this event, I authorize the providers to notify my insurance carrier, legal representation, and/or employer that I am no longer being treated and I have released myself from care. I acknowledge that no guarantees or warranties have been made with me with respect to treatment to be provided at this office. I understand that all services or other goods sold or furnished to me by the clinic are sold or furnished on an "AS IS" basis and Sacred Grove Holistic Healing and Learning Center disclaims any expressed or implied warranties with respect to them.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Legal Guardian/Representative if Under age eighteen (18): _____

Reviewed By: _____ Date: _____

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HIPPA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You affirm, by your signature below, that you have reviewed our notice before signing this consent.

The terms of the notice may change, in such occurrences, you will be notified at your next visit to update your signature/date of consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) Law allows for the use of the information for treatment, payment, or health care operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in publication. You have the right to revoke this consent in writing, signed by you, however such revocation will not be retroactive.

By signing this form, I understand that:

- Protected Health Information may be disclosed or used for treatment, payment, or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent, in writing, at any time and all full disclosures will then cease.
- The practice may condition a receipt of treatment upon execution of this consent.

May we contact you by phone, email or text for appointment confirmations? ☐ Yes ☐ No
May we leave messages on your answering service/voicemail
at home or on your cell phone? ☐ Yes ☐ No
May we discuss your medical condition with any member of your family? ☐ Yes ☐ No
If Yes, please name the members allowed: _____
_____

This consent was signed by (Printed Name): _____
Signature: _____ Date: _____
Witness: _____ Date: _____

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Assignment of Proceeds, Contractual Lien, and Authorization Agreement

I hereby direct any and all insurance carriers, attorneys, agencies, government agencies, companies, individuals, and/or other legal entities ("payers") which may elect to be obligated to par me for any reason, to pay directly to, and exclusively in the name of Sacred Grove Holistic Healing and Learning Center("SGHHLC"), in the amount of the full charges incurred by me at NTXC&RC, past or future, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at SGHHLC ("my charges"). I further grant a contractual lien to SGHHLC with respect to my charges, however I understand that nothing in this agreement shall be construed as an election by SGHHLC to claim protection under any statutory lien law. For the purposes of this Agreement, proceeds shall include, but shall not be limited to, proceeds form any settlement, judgement, or verdict, as well as proceeds relating to the following- insurance coverage, individual and/or group health, disability, worker's compensation, medical payment benefits, personal injury protection, lost wages benefits, lost services, no fault benefits, uninsured and/or underinsured motorist coverage, liability coverage, and malpractice coverage.

If I retain an attorney(s) to represent me in this matter, I will direct each attorney to issue a letter of protection (LOP) to SGHHLC regarding my charges. Upon issuance, I agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of SGHHLC. I further direct and SGHHLC hereby requests, that each attorney provide immediate notice to SGHHLC regarding any funds received by said attorney(s), relating to my accident, and promptly pay SGHHLC out of said funds and to provide a full accounting to SGHHLC upon request.

I hereby authorize and direct SGHHLC to file my claims with my health insurance carrier. I understand that in the event my charges submitted in their full amount to any other form of insurance or source of payment (EX: Personal Injury Protection, Liability, Med Pay, Attorney(s), etc.), I hereby authorize and direct SGHHLC to collect any write-offs or discounts issued by my health insurance out of the proceeds from any other insurance or source of payment.

I hereby direct all payers to release to SGHHLC any pertinent information regarding any coverage I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize SGHHLC to release any information regarding my treatment or that may be pertinent to my case(s) to all payers as defined above to facilitate collection under this agreement. I hereby direct SGHHLC to file a copy of this agreement together with any applicable charges, with any and/or all payers regardless of whether a claim has been established with said payers. I hereby authorize SGHHLC to endorse and/or sign my name on any and all checks listing me as the payee, which are presented to SGHHLC for payment on an account relating to me, my spouse and/or any of my dependents. I further authorize SGHHLC to apply any credit balances or charges incurred by me or any other outstanding charges still owed by me, my spouse, and/or any of my dependents, regardless of whether those other charges are related to my condition.

I understand that I remain personally responsible and liable for the total amount(s) due SGHHLC for their services rendered to me. This agreement does not constitute any consideration for SGHHLC, at its option, may demand payment immediately upon rendering services to me. If SGHHLC must take action to collect an outstanding balance on my account, I will be responsible for the payment(s) and will reimburse SGHHLC for all costs of such collection efforts including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without mutual written consent of SGHHLC and myself. I hereby revoke any previously signed authorizations, whether executed at SGHHLC, to the extent that the terms of those authorizations conflict with the terms of this agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of SGHHLC however, should any provision of this Agreement be found invalid, illegal, unenforceable, or for any reason cease to be binding upon any part hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Executed On (Date): _____ Date Signed: _____
Patient Printed Name: _____ Signature: _____
Printed Name of Patient Representative or Legal Guardian:
_____ Signature: _____