Dr. Ali Yasin, MD
Dr. Azmaira Rashid, DC
Dr. Richard Hare, DC
Dr. Todd Molski, DC
Andrea Miksits, FNP
Katie Goodman, FNP

PHONE: 972-945-5674
FAX: 972-430-1230
EMAIL: info@integrativecaretx.com

Please bring the following to your first appointment:

- Medication list
- ANY imaging report (X-ray, CT, MRI)
- ANY records pertinent to your treatment

DIRECTIONS TO OUR FRISCO CLINIC:
Google or Apple Maps will take you to the correct area however, incorrect location. Follow your GPS until "Arrived" then follow the bottom instructions.
We are in Mateo Park, 2 buildings in from Wade. Our clinic is adjacent to Spanish Schoolhouse and Fingerprint Preschool. We are behind DocuNav and neighbors with Spangler Chiropractor. We are West of the big clock.

REGISTRATION FORM

Last Name:		First Name:	
Date of Birth:	Sex:	Race/Ethnicity:	
Mailing Address:		City/State/Zip:	
Primary Phone:	Alternative Phone:		Okay to text: __Yes __No
Employer:	Occupation:	Work Phone:	
Referred by:			
Primary Care Physician:			
Pharmacy Name:	Pharmacy Address:		
Pharmacy Phone:			
Insurance Information			
Primary Insurance Carrier:		ID/Policy#:	
Group number:	Policy Holder Name:		
Policy Holder Date of Birth:	Relationship to patient:		
Emergency Contacts			
Name:	Relationship:	Phone:	
Name:	Relationship:	Phone:	

By signing below patient is agreeing above information is correct.

Printed Name:	Signature:
Date:	Relationship to patient if not self:

PAIN PROFILE

Patient Name: _______________________________ ______Date of Birth: ___________________
Where is your pain: ____
Does your pain radiate: ____
What is your pain level today: ________ What is your best pain level: ________ Worst? ______
Pain Scale 10(go to ER) ....0(no pain)
When did your pain begin: _____________ How did pain begin: ___________________________
What makes your pain worse (ex: bending, lifting, walking, standing):
____
____
____

What makes your pain better:
____
____

Medications taken for this pain or in the past that have helped:
____
____

Medications taken for this pain or in the past that have NOT helped:
____
____

Any associates symptoms with your pain: (please circle)

Loss of bowel or bladder control Weakness in arms or legs Fevers or chills
Numbness or tingling in arms or legs

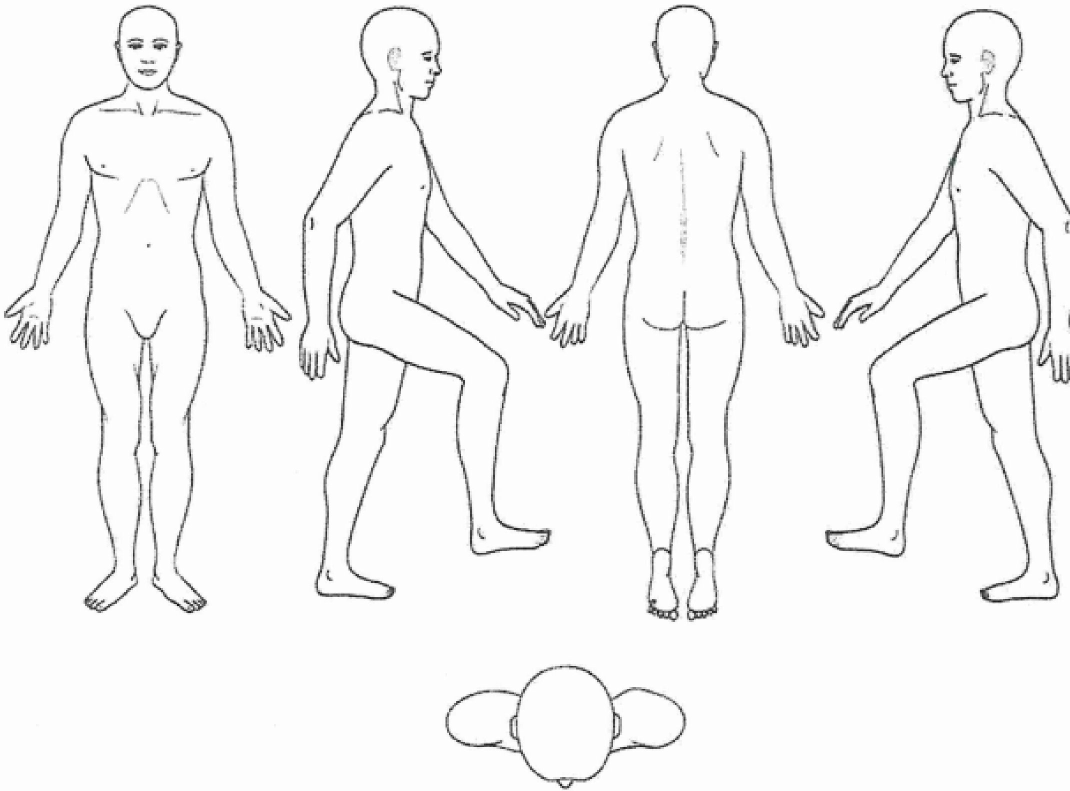
Past Treatments:

Please select if you have had any of the following treatments:

Type of Treatment	Effective? Yes or No	Type of Treatment	Effective? Yes or No Date? Levels?
Physical Therapy		Spinal Surgery	
Chiropractor		Facet Injections	
Acupuncture		Epidural Injections	
Tens Units		Trigger Points	
Aquatherapy		Rhizotomies	
Decompression		Spinal Cord Stimulators	
Other:			

Integrative Care of North Texas

Pain Profile part 2



Have you had any diagnostic studies (mri's ,x-rays, ct's), if so, name the facility: ____
____

Please list all medical providers who have treated your pain or who have prescribed pain medications in the past: ____
____

Is your pain affecting your mood, if so how: ____

Circle ways the pain is affecting your daily living: job children sex marriage household finances sports exercise walking standing bowels urinary fatigue loss of sleep
poor attention loss of productivity

Where do you see yourself in 1-3 yrs if you don't get this problem taken care of? ____

Do you view your health as an investment or expense? Circle one

What would improving your health mean to you? _________________________________

Integrative Care of North Texas

Health History 1

Patient Name:				DOB:		Date:	
Medical Conditions-Check all that apply							
	AIDS/HIV		Chicken Pox		High Blood Pressure		Depression
	Alcoholism		Diabetes		Kidney Disease		
	Anemia		Eating Disorder		Liver Disease		
	Appendicitis		Emphysema		Migraine/Headaches		
	Arthritis		Epilepsy		Multiple Sclerosis		
	Asthma		Glaucoma		Prostate problems:		
	Anxiety		GERD		STD:		
	Bleeding disorders		Heart Disease		Stroke:		
	Cancer		Hepatitis		Thyroid Problems:		
	Cataracts		Hernia		Ulcers:		
	Chemical dependent		High Cholesterol		Pacemakers:		
Auto immune:					Other:		

Current Medications			
Medication Name	Strength	Frequency	Side effect?
Allergies:			
Medication/Substance	Type of Reaction	Medication/Substance	Type of Reaction

Social History			**Sexual History**
Y N	Substance	How much/often	Sexually active: _____ Yes ______ No
	Caffeine		Type of birth control used:
	Alcohol		
	Marijuana		Sexual orientation:
	Recreational Drugs		STD History:

For Women Only		
Last Menstrual period:	Duration of periods:	Heavy? Y N
# of pregnancies: # of miscarriages: # of abortions: Other:		

Health History 2

Surgical History

Year	Name of procedure/Surgery	Performing Doctor	Reason

Hospitalizations

Year	Reason	Year	Reason

Family History
Check all that apply

	Alcohol abuse	Alzheimer's	Asthma	Auto immune	Breast Cancer	Cancer	Depression	Diabetes	Heart Disease	Cholesterol
Mother										
Father										
Mat GMA										
Mat GPA										
Pat GMA										
Pat GPA										
	Blood Pressure	**Kidney Disease**	**Stroke**	**Osteoporosis**	**Seizures**	**Thyroid Disease**	**Drug abuse**	**Colon Cancer**	**COPD**	**Melanoma**
Mother										
Father										
Mat GMA										
Mat GPA										
Pat GMA										
Pat GPA										

Preventative Care-Indicate last date

	Colonoscopy		Mammogram		Flu Shot
	Eye exam		Pap smear		TDAP/Tetanus
	Hepatitis A/B Vaccine		Prostate exam		Meningitis

Integrative Care of North Texas

Patient Consent to Treatment

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, medical services, or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my physician(s), and I acknowledge and consent to the following:

1. **INDEPENDENT CONTRACTORS:** Integrative Care of North Texas may utilize independent contractors for office, outpatient, or inpatient treatment/procedures. These include, but are not limited to, surgical assistants, physical therapists, and consulting and referral physicians. Healthcare professionals that are independent contractors are not agents of Integrative Care of North Texas and are responsible for their own actions. I understand that Integrative Care of North Texas shall not be reliable for the acts or omissions of independent contractors. This consent to treatment also applies to any independent contractor utilized by my physician(s).
2. **VALUABLES**: Integrative Care of North Texas assumes no responsibility for, and I hereby release Integrative Care of North Texas from liability for, loss or damage to any of my personal property while on the premises and/or receiving treatment
3. **AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THRID PARTY PAYMENTS**: I hereby expressly authorize Integrative Care of North Texas and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to Integrative Care of North Texas and all professionals (including independent contractors) providing such care, and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to Integrative Care of North Texas and the third-party payor signed and dated by me; however, such revocation shall not be effective as to information released and or charges incurred prior to such revocation.
4. **AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS**: I authorize and release Integrative Care of North Texas and its employees and agents to take photographs, videos, x-rays, and/or other photographic, electronic, or other images of me and to use them as may be medically appropriate. Such images may be used for educational or other purposes as necessary and appropriate. These images may be maintained as a permanent part of my medical record. I understand and acknowledge that Integrative Care of North Texas may use cameras for security and patient monitoring, and patient confidentiality will be maintained for all such images.
5. **NO GUARENTEE OF RESULTS**: Integrative Care of North Texas physicians and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, procedure, or medical care. I release Integrative Care of North Texas physicians and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of Integrative Care of North Texas, or its employees, agents, representatives.
6. During my care and treatment, I understand that various types of examinations, tests, diagnostic, or treatment procedures (“procedures”) may be necessary. These procedures may be performed by physicians(s), nurses, technicians, physician’s assistants, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional informed consent documents relating to specific procedures.
7. I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

By signing this document, I certify that I have read and understand its contents and the information provided by me is accurate and complete (including insurance information and current eligibility for benefits)

Printed Name:	Signature:
Date:	Relationship to patient if not self:

Integrative Care of North Texas

Disclosure of Physician Ownership and Financial Interest

State and federal guidelines may require that physicians who may have an affiliation or ownership interest in or with in and out of network facilities/services to which the physician refers we must disclose this information. In the interest of providing our patients with complete information, we are providing the names of the out of network facilities where Integrative Care of North Texas, PA may have an ownership interest/affiliation with Latera Anesthesia, Wexford Anesthesia, Memorial Pain Management, Tadlock Pain Management, Plano Infusions, North Plano Infusions, Premier Center of Surgical Arts, Mckinney Center of Surgical Arts, Maus Pain Management. During your course of treatment at Integrative Care of North Texas, PA, you may be referred to one of these facilities for medical services. You have the right to choose the facility where you receive medical treatment/services, including the right to choose a facility/service other than the ones listed above.

By signing below, I acknowledge receipt of the above disclosure information and have a right to a copy of this form.

Patient Signature:	
Date:	Relationship to patient if not self:

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. This form must be completely filled out.

Patient Name	
Social Security Number	
Phone#	
Date of Birth	
Email address	

Section B: Must be completed only if a health plan or health care provider has requested the authorization.

I understand that my health care and the payment for my health will not be affected if I do not sign this form.

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it further, I understand there may be a fee for a copy of this information.

Section C: Must be completed for all authorizations.

What is the purpose of the use or disclosure? _____________________________________

I understand if not specified this release will expire 360 days from the date signed.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any effect on any actions they took before they received the revocation.

I understand that my records are protected under state and federal law. I understand that specific information to be disclosed may include history of drug or alcohol abuse, mental health treatment, AIDS or any other medical information. I understand there may be a fee for a copy of this information.

Patient Signature:	
Date:	Relationship to patient if not self:

Integrative Care of North Texas

Assignment of Benefits/Release of Information/Notice of Privacy Practices/Appt of Authorized Representative

- Integrative Care of North Texas and associated physicians are committed to securing the privacy of your health information. We are supplying you with a copy of our Notice of Privacy Practiced. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.
  Initial: __________
- I request that payment of authorized Medicare and other insurance benefits be made on my behalf to Integrative Care of North Texas for any services furnished to me by any healthcare providers associated with that group. I authorize medical information about me to be released to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits payables for related services.
  Initial: __________
- I appoint Integrative Care of North Texas to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of payment.
  Initial: __________
- Unless I request the contrary, in writing, I will receive appointment reminders and or other information regarding my treatment or invoices by mail to my home address.

Patient Financial Responsibility Statement

To maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through: ________________________

- If you have out-of-network benefits, we will happily file claims on your behalf.
- You must pay any co-payment and applicable deductible amounts at the time of services unless other arrangements have been made with our office.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- If your insurance carrier has not paid our claim within 45 days, we will expect payment from you.
- If, by mistake, your health plan remits payment to you, you will send it to us along with all paperwork which accompanied it. Your health plan may refuse payment of a claim for some of the following reasons:
  - You have not met your deductible for the full calendar year
  - The type of medical service required is not covered by your plan
  - The health plan was not in effect at the time of the service
  - You have other insurance which must be filed first.

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way health care is financed and delivered. Again, we value you as a patient and our priority is to provide you with the best possible care.

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier**. Initial: __________**

Integrative Care of North Texas

HIPPA RELEASE FORM

Patient Name: _____________________
Date of Birth: ______________________

I authorize the release of information including diagnosis, records, rendered to me and billing information.

This information may be released to:

Name	Relationship	Phone Number

Patient Signature:	
Date:	Relationship to patient if not self:

NO SHOW/CANCELLATION POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from receiving much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit due to a seemingly "full" appointment book.

Patients who fail to show for their scheduled appointment or did not notify the office within 24 hours of their scheduled appointment time, will be subject to a "No Show Cancellation" fee of $50.00. If cancelled by the physician as a medical necessity, then the patient is not subject to this charge.

Patient Signature:	
Date:	Relationship to patient if not self:

Integrative Care of North Texas

Massage Therapy Consent Form

Patient Name: ____________________
Date of Birth: _____________________

I, ___________________________, consent to receive medical massage therapy as part of my treatment plan. I understand that medical massage therapy is intended to address specific medical conditions and is not solely for relaxation purposes. I acknowledge and agree to the following:

1. **Treatment Purpose & Scope:**
   a. Medical massage therapy is a therapeutic treatment aimed at addressing specific medical conditions such as pain management, injury recovery, and musculoskeletal dysfunction.
   b. This treatment is not a substitute for medical care and does not diagnose conditions.
2. **Risks & Side Effects:**
   a. Possible temporary discomfort, soreness, bruising, or minor skin irritation may occur.
   b. Any pre-existing medical conditions, including but not limited to fractures, deep vein thrombosis, severe osteoporosis, or open wounds, should be disclosed prior to treatment.
3. **Medical History Disclosure:**
   a. I have disclosed all relevant medical conditions, injuries, medications, and allergies to my provider.
   b. I understand that failure to provide accurate health information may result in complications or ineffective treatment.
4. **Treatment Expectations:**
   a. Results vary based on individual conditions and compliance with the treatment plan.
   b. Multiple sessions may be required for optimal results.
5. **Comfort & Privacy:**
   a. I understand that I may dress down to my comfort level during the massage therapy session.
   b. Proper draping techniques will be used to ensure my privacy and comfort at all times.
6. **Consent to Treatment & Release of Liability:**
   a. I voluntarily consent to medical massage therapy and understand I may stop treatment at any time.
   b. I release the massage therapist and the facility from any claims, damages, or liabilities arising from my participation in the treatment, except in cases of gross negligence or misconduct.
7. **Financial Responsibility & Insurance:**
   a. I understand that medical massage therapy may or may not be covered by insurance, and I am responsible for any associated costs.
   b. If applicable, I will comply with the requirements of my insurance provider for reimbursement.
8. **Appointment Policy:**
   a. I agree to provide at least 24 hours' notice for cancellations or reschedules. Failure to do so may result in a cancellation fee.

By signing below, I confirm that I have read, understand, and agree to the terms outlined in this consent form. I have had the opportunity to ask questions and have received satisfactory answers.

Patient Signature: ____________________________ **Date:** ______________

Integrative Care of North Texas

OFFICE AND FINANCIAL POLICIES

We would like to thank you for choosing Integrative Care of North Texas as your medical provider. We want to keep you informed of our current office and financial policies prior to any treatment.
All payments and expected at the time of service: Payment is required at the time of services are rendered. This includes your applicable copayment, coinsurance and deductible for participating insurance companies. If your coverage is currently under the pre-existing condition clause, payment in full as expected at the time of your visit. If you have not met your deductible, the full amount of the visit is due on the day of service. It is also expected that you will pay any remaining balances at the time of service. The copayment, coinsurance requirement cannot be waived by our practice as it is a requirement placed on you by your insurance carrier.

High deductible health plans: if you have a high deductible plan be prepared to pay for all your services in full. If a procedure is required, you'll be asked to pay in advance.

Statements: Itemize statements of charges can be requested by the patient and will be mailed or provided by front desk

Insurance card: You must present a current and active insurance card on your new patient visit. Insurance must be active at time of visit, or you will be responsible for payment in full at the time of your visit

Worker's Compensation: If your injury is due to an accident in your workplace, please be sure to contact your employer and inform them of your injury. We will need to receive authorization from your employer before we can process your medical claims. Failure to properly report this injury to your employer may result in your claim being denied. Denied claims will be your responsibility in full.

No insurance: Payment in full is expected at the time of your visit for an uninsured patient

Estimates: an estimate of cost will be provided if requested by an uninsured patient, a patient not covered by a government program, or an insured patient seeking out of network services.

Missed appointments/Cancellations: If you are unable to keep your appointment, please give 24-hour notice to avoid being charged. If you miss your scheduled appointment, you will receive a $50 charge on your next scheduled visit. Excessive abuse of scheduled appointments may result in discharge from the practice.

Return check/rejected ACH withdrawals: a $30 charge will be added to your account for any checks returned or ACH withdrawals rejected by your bank for any reason in addition to any fees that your financial institution may charge you. These balances must be paid in full prior to your next appointment.

Disability or insurance forms: there will be a charge of $25 for the completion of medical forms. Payment is due at the time that you pick up the forms. Please allow 7 to 14 business days for the completion of these forms.

Prompt payment: As we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. If your account becomes delinquent and you have not established or set up payment options with our billing office, your account will be turned over to a collection agency and we will ask you to seek your medical care from another medical office. Please contact our billing department to discuss payment or any concerns.

Thank you for allowing us to service you.
Integrative Care of North Texas