FREEDOMHEALTH CENTERS
PHYSICAL MEDICINE & CHIROPRACTIC

Application for Patient Care

PATIENT INFORMATION

First Name: _____ M.I.: _____ Last Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

SS#: _____-_____-_____ Age: _____ DOB: __ __/__ __/__ __ Male / Female

Cell Phone #: _____ Primary Care Physician: _____

Do we have permission to contact your doctor regarding your care in our office? ____Yes ____No

Your preferred method of contact for appointment reminders? Email / Text (Cell Carrier_____)

Occupation: _____ Employer: _____

Type of Tasks Performed/Common Movements: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Spouse's Name: _____ # of Children? _____ Children's Ages: _____

Emergency Contact Name: _____ Relation: _____ Phone #: _____

Smoking Status: Never smoked / Former Smoker / Occasional Smoker / Daily Smoker Preferred Language: _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer **Ethnicity (Circle one)**: Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

ACCIDENTS

Have you had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Had a recent fall/other accident? (X if applies) : ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have You Ever Received Physical Therapy ☐ Chiropractic Care ☐ or Pain Management ☐? Last Visit: _____

REFERRALS

How Did You Hear About This Office?

☐ Existing Patient: _____ ☐ Walk-In/Drive-By

☐ Radio: _____ ☐ Internet: _____ ☐ Gym: _____

☐ Ad: _____ ☐ Community Event: _____ ☐ Group: _____

☐ Physician: _____ ☐ Other: _____ ☐ Insurance Comp.

INSURANCE

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release **Method of payment for today's charges: ___Cash ___Check ___Visa / MC / Amex / Disc**

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, FREEDOM HEALTH CENTERS, PLLC, and/or MOLSKI CHIROPRACTIC, PA, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

Patient Name: _____ Date: ___/___/___ Date of Birth: ___/___/___

PRIMARY COMPLAINTS: Please list body part / symptom in order of most severe (#1) to least severe (#4).

Sample complaints: Low Back, Left Knee, Right Shoulder, Neck, etc.

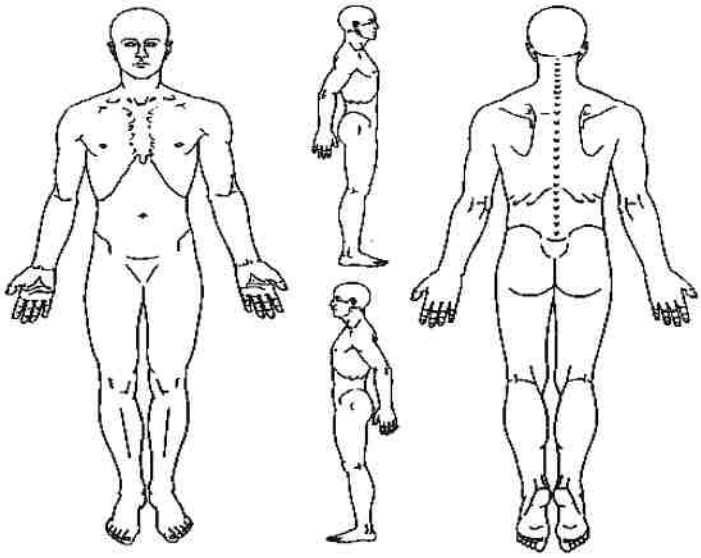
MOST SEVERE ◄——————————► **LEAST SEVERE**

Body Part / Symptoms WRITE-IN ⇨	1.	2.	3.	4.
Circle the word that best describes this complaint.	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other
How often do you feel this complaint?	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"
How long have you had this complaint?	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years
Is it getting better, worse, or staying the same?	Better Worse Same	Better Worse Same	Better Worse Same	Better Worse Same
What makes it better, if anything?				
What makes it worse, if anything?				
On a scale of 0 – 10, rate your discomfort. *(0 = no pain, 10 = excruciating)*	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10
How have you taken care of this in the past? Has that worked for you?				
Circle the ways this issue is affecting your life. *(all that apply)*	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity
Improving this issue in my life would improve my quality of life by: *(Circle best response)*	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%

PATIENT HEALTH HISTORY

Please check if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Loss of Taste
- ❑ Nervousness
- ❑ Jaw Problems
- ❑ Loss of Smell
- ❑ Blurred/Double Vision
- ❑ Mood Changes
- ❑ Foot Trouble
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Light Bothers Eyes
- ❑ Recent Weigh Change
- ❑ Loss of Memory
- ❑ Cold Extremities
- ❑ Sleeping Difficulties
- ❑ Bowel/Bladder Changes
- ❑ Constipation/Diarrhea
- ❑ Swollen Joints
- ❑ Trouble Concentrating
- ❑ Loss of Balance
- ❑ Nausea
- ❑ Night Pain
- ❑ Fatigue
- ❑ Fever
- ❑ Tension
- ❑ Chest Pain
- ❑ Asthma
- ❑ Cold Sweats
- ❑ Dizziness
- ❑ Fainting



Patient info:

PATIENT HEALTH HISTORY continued.... *Please check if you have ever had any of the following:*

- ❑ ADD/ADHD
- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma/Wheezing
- ❑ Bad Breath/Taste
- ❑ Bleeding Disorders
- ❑ Blood Pressure: High or Low (circle)
- ❑ Breast Lump
- ❑ Broken Bones
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Colon Trouble
- ❑ Contacts/Glasses
- ❑ Depression
- ❑ Diabetes
- ❑ Dry Skin
- ❑ Ear Infections
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Fractures
- ❑ Gall Bladder
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heartburn
- ❑ Heart Attack
- ❑ Heart Problems
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Hormone/Gland Problems
- ❑ Insomnia
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Measles
- ❑ Menopausal Prob.
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Mouth Sores or Bleeding Gums
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Nosebleeds
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Sexual Difficulty
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ TMJ Pain
- ❑ Tonsillitis
- ❑ Tremors
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other: _____

Please write your current medical conditions from the list above: _____

Please list any and all medications you are currently taking: _____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

ALLERGIES: (Please list any known allergy that you have. Ex. Penicillin, Eggs, Fish, Latex, Pet Dander, Wheat, etc.)

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? *(indicate family member including parents, grandparents & siblings)*

❑ Heart Disease_____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑ 5-7x/week ❑ 3-4x/week ❑ 1-2x/week ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

What is your daily/weekly intake of the following: Caffeine ____ cups/day Alcohol ____ drinks/week Cigarettes _____ pks/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete & accurate information during my exam.

Signature (X) _____ **Date**_____

FINANCIAL POLICY AND AGREEMENT

Freedom Health Centers, PLLC

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Definitions. In this Agreement, "Office" and "Clinic" shall refer to Freedom Health Centers, PLLC located at 2709 Virginia Parkway, Suite 100, McKinney, Texas 75071. "Financial Policy" or "Agreement" shall refer to this document.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office promptly upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that (1) any delay by the Office in making demand for payment, any delay in paying the full amount of my Charges, and any partial payments received by the Office towards my Charges, shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full promptly upon demand, and shall not constitute an "accord and satisfaction" of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments, and (2) any delay in paying the full amount of my Charges beyond fourteen (14) calendar days of demand shall be construed as a "default" of my obligation.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). For example (without limiting this Agreement), I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I further understand that a Payer may Deny Payment stating that the individual provider who actually renders the treatment or procedure is out-of-network. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I also understand that a Payer may require certain Charges to be pre-certified or pre-authorized. I understand that there may be many other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I agree that if I have any questions about the Terms of Non-Coverage, I can ask to see copies of the Office's verification (e.g., eligibility, pre-authorization) forms to gain further understanding. I further agree that should the Office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or the Office may in my opinion not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office responsible or liable in any of the foregoing instances.

Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any and all Payers, including without limit in accident cases my health benefit plan, but not including Medicare. Notwithstanding the foregoing, in the event that the Office determines in its sole discretion that it has any reasonable basis for either submitting or not submitting my Charges and/or other documentation to a Payer, I hereby authorize the Office to take such action without condition or restriction. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said Payers in writing, or (b) law expressly imposes on the Office to accept (collectively, "Mandatory Fee Reductions"). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are imposed on the Office by virtue of laws which regulate or restrict "balance billing," I hereby waive the application of such laws. In the event that no Mandatory Fee Reductions are actually imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase, "by Freedom Health Centers, PLLC," shall serve as a properly authorized endorsement. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Agreement. I have reviewed the Office's "Assignment & Lien" and Health Insurance Election forms and further agree to the terms and definitions set forth in these documents. Said documents are incorporated herein by reference. In the event that my condition is related to an accident, including without limit automobile accident, I understand that there will be an administrative fee necessary to cover the costs of verifying multiple Payers, filing and terminating liens, and submitting notices of same to Payers.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (print): _____

Patient Signature: _____ Date: ____/____/____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: ____/____/____

Patient info:

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

The clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc).

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also understand that the fee paid for treatment x-rays is for analysis only. The file itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There is a fee for copying of the x-rays.

Also, for your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the front desk check-out stations.

I have read and I accept the terms above and understand them fully. I hereby give consent to the clinic to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

I, _____ have read and fully understand the above statements.
(PRINT NAME)

_____ _____
(SIGNATURE) (DATE)

FOR MINORS: I, _____ being the parent or legal guardian of _____,
(Print Guardian Name) *(Print Minor's Name)*
have read and fully understand the above terms of acceptance & grant permission for my child to receive treatment.

X-ray Questionnaire: For women only Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____ Date of last menstrual period: _____

☐ There is a possibility that I may be pregnant at this time
☐ No, I am definitely not pregnant at this time
☐ Yes, I am definitely pregnant
☐ I request that x-ray films not be taken because:

_____ _____
Patient's Signature Date

Patient info:

Allergy, Food & Chemical Sensitivity Survey

Gender: M / F Height: Feet _____Inches _____ Weight: _____lbs.

Please complete the following allergy, food and chemical sensitivity questionnaire. Score each symptom based upon your experiences over the last 90 days. Circle appropriate number 0-5 according to severity.

0=No Problem at All
1=Extremely Mild Symptoms
2=Mild to Moderate Symptoms Occasionally
3=Moderate Symptoms Frequently
4=Moderate to Severe Symptoms
5=Very Severe Symptoms

Digestive Symptoms
0 1 2 3 4 5 Stomach Pains or Cramping
0 1 2 3 4 5 Constipation
0 1 2 3 4 5 Diarrhea
0 1 2 3 4 5 Reflux or Heartburn
0 1 2 3 4 5 Bloating
0 1 2 3 4 5 Gas
0 1 2 3 4 5 Nausea or Vomiting

Weight
0 1 2 3 4 5 Inability to Lose Weight
0 1 2 3 4 5 Food Cravings
0 1 2 3 4 5 Binge Eating
0 1 2 3 4 5 Water Retention

Sinus/Respiratory
0 1 2 3 4 5 Stuffy or Runny Nose
0 1 2 3 4 5 Asthma
0 1 2 3 4 5 Chest Congestion
0 1 2 3 4 5 Chronic Cough
0 1 2 3 4 5 Wheezing
0 1 2 3 4 5 Frequent Sneezing or Nasal Discharge

Head/Ears
0 1 2 3 4 5 Migraines
0 1 2 3 4 5 Headaches
0 1 2 3 4 5 Earaches
0 1 2 3 4 5 Sinus or Ear Infections
0 1 2 3 4 5 Ringing in Ears

Eyes/Throat
0 1 2 3 4 5 Itchy Eyes
0 1 2 3 4 5 Watery Eyes
0 1 2 3 4 5 Sore Throats or Colds
0 1 2 3 4 5 Persistent Canker Sores

Emotional/Mental
0 1 2 3 4 5 Depression
0 1 2 3 4 5 Anxiety
0 1 2 3 4 5 Mood Swings
0 1 2 3 4 5 Irritability
0 1 2 3 4 5 Poor Concentration/Memory

Energy
0 1 2 3 4 5 Fatigue
0 1 2 3 4 5 Hyperactivity
0 1 2 3 4 5 Lethargy
0 1 2 3 4 5 Restlessness
0 1 2 3 4 5 Insomnia

Skin Disorders
0 1 2 3 4 5 Eczema
0 1 2 3 4 5 Dermatitis
0 1 2 3 4 5 Excessive Sweating
0 1 2 3 4 5 Rashes
0 1 2 3 4 5 Hives

Other Symptoms:
0 1 2 3 4 5 Joint Pain
0 1 2 3 4 5 Arthritis
0 1 2 3 4 5 Irregular Heartbeat
0 1 2 3 4 5 Chest Pains
0 1 2 3 4 5 Muscle Aches

Please list any symptoms not mentioned above:

_____

_____

TOTAL SCORE: _____

Patient info:

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient FREEDOM HEALTH CENTERS, PLLC, and/or MOLSKI CHIROPRACTIC, PA we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or discloser of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the Information that we use or disclose based on this privacy notice may be subject to re-discloser by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: DR. TODD MOLSKI. If you would like further information about our privacy policies and practices please contact: DR. TODD MOLSKI.

This notice is effective as of December 1, 2011. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Print)	*Signature*	*Date*

FREEDOM HEALTH
PHYSICAL MEDICINE & CHIROPRACTIC CENTERS

Communications Disclosure

We communicate with our patients to remind them of appointments, office closures due to weather, and various other reasons. These communications are essential to getting you well and helping to keep you on track. Email and text messages are the primary way we communicate with you outside of the office. We do not over-burden you with communications, but we want to help you to achieve your goals and have a great experience in our office. So we need the best contact information from you. Please fill in the information for the best cell phone number and best email to contact you at.

Cell Phone #: _____

Cell Phone Carrier (circle one): AT&T Verizon T-Mobile Sprint Metro PCS Other:_____

Email Address: _____

Signing below authorizes us to communicate with you on these formats (a HIPPA requirement):

_____

Printed Name

_____

Signature

_____

Date

FREEDOM HEALTH
PHYSICAL MEDICINE & CHIROPRACTIC CENTERS

(place sticker here)

X-Ray Specialist Fee Form

I, the above mentioned patient of Freedom Health Centers and/or Molski Chiropractic, understand that I may have problems on my x-rays that I need a specialist to evaluate. If this is the case, the x-rays will be sent to the specialist for that evaluation. These specialists do not contract with insurance companies, so no insurance can be submitted for this charge. Therefore, there is a charge of $35.00 to cover the specialist's fee for reviewing the x-ray. I understand that I will be charged for this fee once the report is received.

Signed: _____ Date: _____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____ _____

Signature **Date**

"THE LOWER EXTREMITY FUNCTIONAL SCALE"

Name:_____ Date:_____

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you, or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework or school activities	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3	Getting into or out of the bath	0	1	2	3	4
4	Walking between rooms	0	1	2	3	4
5	Putting on your shoes or socks	0	1	2	3	4
6	Squatting	0	1	2	3	4
7	Lifting an object, like a bag of groceries, from the floor	0	1	2	3	4
8	Performing light activities around your home	0	1	2	3	4
9	Performing heavy activities around your home	0	1	2	3	4
10	Getting into or out of a car	0	1	2	3	4
11	Walking 2 blocks	0	1	2	3	4
12	Walking a mile	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14	Standing for 1 hour	0	1	2	3	4
15	Sitting for 1 hour	0	1	2	3	4
16	Running on even ground	0	1	2	3	4
17	Running on uneven ground	0	1	2	3	4
18	Making sharp turns while running fast	0	1	2	3	4
19	Hopping	0	1	2	3	4
20	Rolling over in bed	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE: _____/80**

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Signature:_____