ADVANCED NERVE & HEALTH CENTER INTAKE FORM

Date:_____/_____/_____

Name:_____ Birthday: _____/_____/_____ Age: _____

Preferred to be called: _____ Spouse's Name: _____

E-Mail:_____ SS#: _____-_____-_____

Address: _____ City: _____ State: _____

Zip Code: _____ Home #: _____ Cell #: _____

Occupation: _____ Employer: _____ Retired: ☐ Y ☐ N

How Did You Hear About Us? _____

EMERGENCY NOTIFICATION INFORMATION

In the event of an emergency, whom should we contact?

Name: _____ Relation to patient: _____

Home #: _____ Cell #: _____ Work #: _____

PREFERRED PAYMENT METHOD

❑ Care Credit ❑ Credit Card ❑ Other ❑ Cash/Check ❑ Apply For Financing

TRANSPORTATION/APPOINTMENTS

- **Are you able to drive yourself to and from your scheduled appointment times? ☐ Y ☐ N**
- **If No, do you have someone that can bring you to your appointments? ☐ Y ☐ N**
- **Which TWO days works best for you to attend your appointments?**

  ☐ **Monday**
  ☐ **Tuesday**
  ☐ **Wednesday**
  ☐ **Thursday**

  What time of Day?

  ☐ **Early Morning**
  ☐ **Mid-Morning**
  ☐ **Noon**
  ☐ **Afternoon**

DOCTOR(S) YOU'VE SEEN FOR THIS CONDITION

Names of All Doctors & Facilities You Have Seen for CURRENT CONDITION and Treatment Received.

Doctor & Facility Name:	Treatment:	Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS

Name:	Dose (MG or IU):	Purpose (ex: high blood pressure):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List of Medications Attached: ☐

Are You Currently Using:

- ☐ **Pain Creams: _____**
- ☐ **Pain Killers: _____**
- ☐ **Blood Thinners: _____**
- ☐ **Neurontin: (_____mg/times per day _____)**
- ☐ **Gabapentin: (_____mg/ times per day _____)**
- ☐ **Lyrica**
- ☐ **Cymbalta**

ALLERGIES

List ALL Allergies (or Sensitivities) to Medicines, Foods, and other items.

Item you react to:	**Reaction:**
_____	_____ _____
_____	_____ _____
_____	_____ _____

PERSONAL HEALTH HISTORY

CHECK ALL THAT APPLIES:

- ☐ **Do You Smoke? Packs Per Day: _____**
- ☐ **Do You Drink?**
  - ☐ **_____ Drinks per Day / Week / Month**
  - ☐ **Exercise Regularly:**
    Type: _____
- ☐ **Unable to Walk For 30 Minutes Without Symptoms**
- ☐ **Sit to Stand with Difficulty**
- ☐ **Able to Work**
- ☐ **Deemed Disabled: Year _____**

On A Scale of 0 To 10, How Would You Rate Your Pain Level: 0 = No Pain 10 = Worse Pain
How Would You Rate Your Symptoms in The LAST WEEK? _____ TODAY? _____
AFTER Completing the Treatment Plan, What Would Be an Acceptable Level of Pain? _____

What is Your CHIEF COMPLAINT that You Want Addressed?

_____

PRESENT HEALTH CONDITION

CERVICAL /Neck Year_____
- ☐ Stenosis
- ☐ Herniated Discs
- ☐ Degenerative Discs

THORACIC/upper back Year _____
- ☐ Stenosis
- ☐ Herniated Discs
- ☐ Degenerative Discs

LUMBAR/lower back Year _____
- ☐ Stenosis
- ☐ Herniated Discs
- ☐ Degenerative Discs

FOOT # of Years _____
- ☐ Foot Drop
- ☐ Swelling
- ☐ Gout
- ☐ Balance Issues

HAND # of Years _____
- ☐ Difficulty Grasping Things
- ☐ Carpal Tunnel Syndrome

DO YOU USE A:
- ☐ Walker
- ☐ Wheel Chair
- ☐ Cane
- ☐ Brace

SURGERIES
- ☐ Laminectomy Area _____ Year _____
- ☐ Discectomy Area _____ Year _____
- ☐ Fusion Area _____ Year _____
- ☐ Other: _____
- ☐ Hip Replacement Year _____
- ☐ Knee Replacement Year_____
- ☐ Foot Surgery Year _____
- ☐ Amputation Year _____

- ☐ Pacemaker Year _____
- ☐ Stents Year _____
- ☐ Bypass Year _____
- ☐ Defibrillator Year _____

TESTS:
- ☐ Cervical MRI Year: _____
- ☐ Lumbar MRI Year: _____
- ☐ Doppler Study Year: _____
- ☐ NCV / EMG Year: _____
- ☐ X-Ray Year: _____
- ☐ CT Scan Year: _____

ENDOCRINE

Diabetes:
Type 1 ☐ Type 2 ☐
How Many Years? _____
Fasting Blood Sugar _____
A1C _____

HEART
- ☐ High Blood Pressure
- ☐ (BP: _____/_____)
- ☐ Congestive Heart Failure: Year _____
- ☐ Heart Attack: Year _____

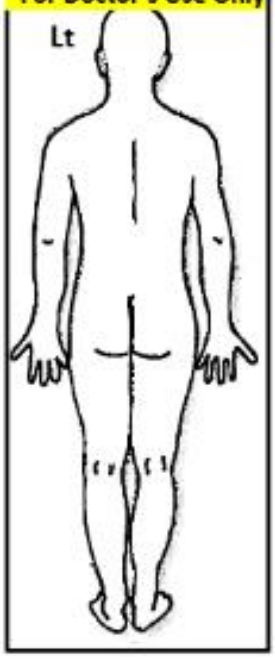
CANCER
- ☐ Type _____ Active ☐ Remission ☐
- ☐ Chemo or Radiation: Year _____

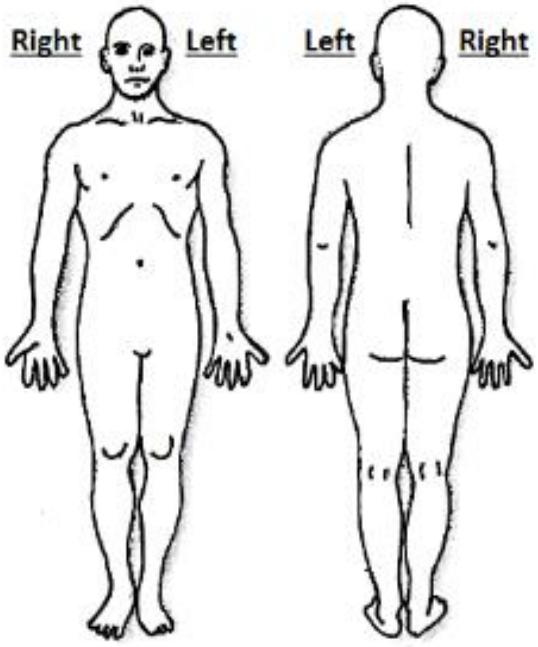
AREAS & TYPES OF PAIN

Please mark the types of symptoms on the drawing below using the codes listed:

N- Numbness T- Tingling S- Soreness P- Pain A- Ache St- Stiffness

For Doctor's Use Only





DOCTOR NOTES ONLY:

Patient Name: _____ Initials _____ Page

PRESENT HEALTH CONDITION

Is This Condition Interfering with Any of The Following?

□ **Sleep** □ **Walking** □ **Recreational Activities** □ **Standing** □ **Work** □ **Housework** □ **Daily Activities**

How Long Have You Been Searching for Answers for this Problem? _____

What treatment have you had prior to this visit? (check all that apply)

____Hormone Replacement ___Tens Unit ___Stem Cell or Other Injections ___ IV Therapy ___ CBD

____ Physical Therapy ___ Cold Laser Therapy ___ Infared Light Therapy ___Other, Not Listed

Did any of the treatments you checked work for you? _____

Over the Past 6 months to a Year, Have Your Symptoms: □ Improved □ Worsened □ Stayed the Same

How do you usually get relief for your discomfort? _____

Is There A Certain Time of Day Any of These Problems Are Better or Worse? _____

Did Your Doctor explain Neuropathy to you? _____

Were You Told That Neuropathy Will Improve Over Time? _____

Additional Notes for the Doctor :

_____

_____

_____

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Advanced Nerve & Health Center DFW and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for Advanced Nerve & Health Center DFW to retrieve and review my medication history. I understand that this will become part of my medical record. I acknowledge that I have had the opportunity to review Advanced Nerve & Health Center DFW's Notice of Privacy Practices, which is displayed for public inspection at its facility. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the Advanced Nerve & Health Center DFW to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Advanced Nerve & Health Center DFW to release any information required in obtaining procedure authorization or the processing of any insurance claims. I understand that Advanced Nerve & Health Center DFW will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility.

Signed:_____Date: _____

What is Neuropathy?

Approximately 20 million Americans are living with peripheral neuropathy. While the term "neuropathy" simply means "nerve damage," peripheral neuropathy is the impairment of the nerves in the body's outer extremities -- such as the hands and feet. While the explanation for an individual's neuropathy is sometimes unknown, a wide range of factors can cause it. Here are some causes of this chronic neurological disease.

- Trauma from injury and repetitive stress is the most common cause, and medical treatments, like certain types of chemotherapy and surgeries, can damage nerves.
- Nearly 70 percent of people with diabetes live with some level of neuropathy.
- Inflammation from autoimmune diseases like lupus and rheumatoid arthritis can destroy nerve fibers.
- The majority of people on dialysis for kidney disease develop neuropathy because excess toxic chemicals accumulate and damage nerves.
- Infections, both bacterial and viral, are a major cause of neuropathy.
- Heavy drinking can cause nerve damage.

But What About Insurance? Medicare Won't Cover This?!

We understand how hard it is to live with neuropathy. We only wish that our innovative treatment services were available to everyone through Medicare and insurance. Many people often mistake that we as a clinic CHOOSE to not accept Medicare or major insurance. The nature of our treatment process is regenerative, which is to restore and generate nerve function.

We believe that we can no longer be dependent on insurance companies to determine what type of care and treatments we are able to give. The reality is, it is up to you on choosing how you want to treat your body and chronic pain, not an insurance company. Traditional medicine is needed, but it's time we move beyond it and no longer use just medication and surgery to heal ourselves. The use of regenerative medicine can be exactly what you are looking for to help you achieve your functional goals.

A few different reasons why insurance companies do not pay for regenerative medicine treatment is a result of the Medicare guideline, section 2251.3: This states ***"if a treatment is designed to help prevent disease, promote health, and extend and improve the quality of life; or a therapy is being used to either maintain or prevent deterioration of a chronic condition, it is essentially believed to be not medically necessary."*** And when it comes to regenerative medicine, the goal is to help prevent further deterioration, which fits in this statement.

Even if you don't have Medicare, most insurance companies have the same viewpoint as Medicare guidelines, which again says, because it's a "regenerative process" and is supposed to prevent additional deterioration that Medicare will not cover the cost.

Because we have years of success in treating our patients by regenerating and rejuvenating nerves and reliving nerve related pain; it is our continued mission to educate, innovate and treat all those that suffer from neuropathy.

Insurance coverage should never dictate your quality of life.

We're here to help.

PATIENT FINANCING: Every Patient Is Approved

What You Need to Know Before Your In-Office Neuropathy Consultation

During your consultation, your Doctor and/or Nurse will spend whatever time is necessary to respond to your questions and address all your concerns. He or she wants to make sure you have all the information you need to make an informed decision on the personalized neuropathy treatment plan, with realistic expectations about the outcome.

Finally, you will be informed about available treatment dates that will accommodate your schedule. You will also meet with your patient advocate to discuss the investment involved in your treatment plan.

We have found options to help our patients take on the financial obligation, along with providing incentives and savings opportunities. If you wish to try financing, please fill out the following information.
Please note: **We will not proceed with any financing until you have all your options.** The choice is always yours.

Do You Have a Lender Preference?

[ ] CareCredit [ ] LendingUSA

Patient Name:

_____

Patient Social Security:

_____

CO-APPLICANT NAME (not mandatory)

_____

Co-Applicant Social Security:

_____

Gross Monthly Income

(please check one box):

- ☐ $2200 – $3500
- ☐ $3600 - $4200
- ☐ $4300 - $5000
- ☐ $5100 - $6000

Do you RENT or OWN (circle one please)

Monthly Rent/Mortgage: _____

Employment Status of Patient:

- ☐ Employed
- ☐ Unemployed
- ☐ Retired
- ☐ Military
- ☐ Self Employed

Employment Status of Co-Applicant:

- ☐ Employed
- ☐ Unemployed
- ☐ Retired
- ☐ Military
- ☐ Self Employed

Current or Previous Employer:

_____

Years With Employer: _____

HIPAA Right of Access Form for Family Member/Friend

Name: _____ Date Of Birth: _____

[ ] I authorize the release of information including the diagnosis, records, and examination rendered to me. This information may be released to:

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____

[ ] Information is not to be released to anyone.

This authorization shall be in effect until terminated by myself in writing.

Please Call: [ ] My Home [ ] My Work [ ] My Cell

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ Please text me a detailed message
- ☐ Other

Signed: _____ Date: _____

HIPAA Authority for Right of Access: 45 C.F.R.