Comprehensive Health History

Patient Information

Patient Name: ____
(last) *(first)* *(middle initial)*

Address: ____

City: ______________________ State __________ Zip ___________

Home Ph: (_____) _______________ Cell Ph: (_____) _______________

Work Ph: (_____) _______________ Best Contact: Phone Text Email

Email: ______________________________________ Sex: M or F

SS#:____________________ DOB: _____________ Age: _________

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

Occupation: ____

Employer: ____

In Case of Emergency

Name: ____________________________ Relationship ____________

Home Ph: (_____) _______________ Cell Ph: (_____) _______________

How Did You Hear About Us?

☐ Referral: ______________________ ☐ Direct Mail
☐ Internet ☐ Magazine
☐ TV ☐ Other: __________________

Insurance Information

Who is responsible for this account? ☐ Self ☐ Other:_______________

If other, what is the relationship to patient: _________________________

Insurance Company: ____

Policy #:____________________ Group #:__________________

Is the patient covered by additional Insurance? ☐ Yes ☐ No

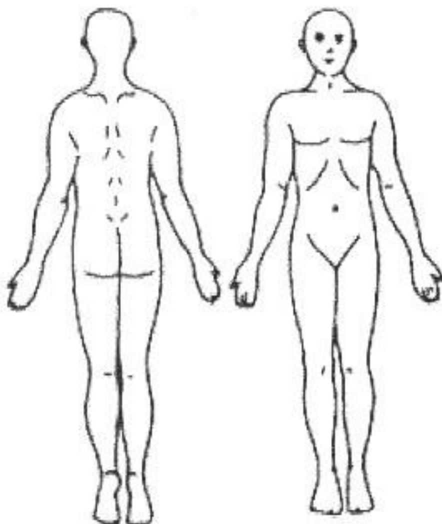
Subscribers Name: ____

DOB:___________________ SS#:____________________________

Relationship to Patient: ______________________________________

Insurance Company: ____

Policy # ____________________ Group # __________________



Label on the Diagram the CURRENT Areas of Discomfort:

A= Aching
B= Burning
C= Cramps
D= Dull
N= Numbness
P= Pins&Needles
S= Stabbing
SH= Sharp
ST= Stiffness
SW= Swelling
T= Tingling

Current Condition

If you could erase 3 health problems, what would they be?

1. ____
2. ____
3. ____

Problem #1

When did you 1st notice this problem? ___________________________
Has it occurred before? ☐ Yes ☐ No When? _______________

Is the condition getting worse? ☐ Yes ☐ No ☐ Unknown

Is the Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury
☐ Slip/Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause
☐ Other __________________

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) _______

How often do you have this pain? ______________________________

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

What treatment have you received for this problem?
☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services
☐ None ☐ Other ______________________________

Problem #2

When did you 1st notice this problem? ___________________________
Has it occurred before? ☐ Yes ☐ No When? _______________

Is the condition getting worse? ☐ Yes ☐ No ☐ Unknown

Is the Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury
☐ Slip/Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause
☐ Other __________________

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) _______

How often do you have this pain? ______________________________

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

What treatment have you received for this problem?
☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services
☐ None ☐ Other ______________________________

Problem #3

When did you 1st notice this problem? ___________________________
Has it occurred before? ☐ Yes ☐ No When? _______________

Is the condition getting worse? ☐ Yes ☐ No ☐ Unknown

Is the Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury
☐ Slip/Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause
☐ Other __________________

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) _______

How often do you have this pain? ______________________________

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

What treatment have you received for this problem?
☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services
☐ None ☐ Other ______________________________

If Auto or Job Related:
To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Work Comp ☐ Other __________
Attorney Name: *(if applicable)* ______________________________

Current Medications

Medication **Dosage/How Long** **For What Condition?**

____

____

____

____

____

Medication Allergies: ______________________________

Reaction? ______________________________

Supplement Allergies: ______________________________

Reaction? ______________________________

Food Allergies: ______________________________

Reaction? ______________________________

Do you have any surgical devices in your body? (*ie screws, pins, plates, etc)*

□ Yes □ No If yes, where located ____________________

Have your medications or supplements ever caused you unusual side effects or problems? □ Yes □ No Describe: ____________________

____

Have you had prolonged or regular use of:

NSAIDS (Advil, Aleve, etc.), Motrin or Aspirin? □ Yes □ No

Tylenol? □ Yes □ No

Acid Blocking Drugs (Tagament, Zantac, Prilosec)? □ Yes □ No

Frequent Antibiotics (> 3 times a year) □ Yes □ No

Long Term Antibiotics □ Yes □ No

Steroids Present or Past (Prednisone, Nasal Allergy Inhalers) □ Yes □ No

Work Activity

Labor Activity:
□ Light □ Moderate □ Heavy □ Sedentary

Work Activity Postures:
□ Bending □ Climbing □ Kneeling □ Pulling
□ Pushing □ Reaching □ Sitting □ Standing
□ Twisting □ Walking □ Computer □ Repetitive

Work Activity Level:
□ Full-Time □ Part-Time □ Homemaker □ Student □ Unemployed

Hours per week ________ Mostly □ Sitting □ Walking □ Standing

Work Environment:
□ Difficult □ Enjoyable □ Relaxed □ Stressful

Lifestyle History

Check Your Exercise Levels:

□ **Inactive** – no regular physical activity with a sit-down job.

□ **Light Activity** – no organized physical activity during leisure time.

□ **Moderate Activity** – occasionally involved in activities (2-3x/week)

□ **Heavy Activity** – consistent lifting, stair climbing, heavy construction, etc., or regular participation in active sports. (3-5x/week)

□ **Vigorous Activity** – participation in extensive physical exercise for at least 60 minutes per session (4-7x/week)

Please check all that apply:

□ Tobacco – Type ____________________ Amt/Day: ____________

Are you exposed to 2nd hand smoke regularly? ____________________

□ Alcohol Drinks/Week: __________

□ Coffee/Caffeine Drinks Cups/Day: ____________

Do you currently or have previously used recreational drugs? □ Yes □ No

If yes, what types/method (IV, inhaled, smoked, etc) ____________________

Patient Name ____________________ Patient Signature ____________________ Date__________

Medical History

Please check all that apply / Indicate When and any Comments/Results

Surgeries (Indicate what year)

___ N/A	___________	___ None Reported	___________
___ Appendectomy	___________	___ Bunionectomy	___________
___ Cardiac Bypass	___________	___ Cataracts	___________
___ C-Section	___________	___ Carpal Tunnel	___________
___ Cosmetic	___________	___ Ear Tubes	___________
___ Gall Bladder	___________	___ Hysterectomy	___________
___ Implants	___________	___ Knee	___________
___ Lasik	___________	___ Spinal Fusion	___________
___ Tonsillectomy	___________	___ Wisdom Discectomy	___________

Injuries

___ Back Injury	___________	___ Broken Bones/Fractures	___________
___ Head Injury	___________	___ Industrial	___________
___ Neck Injury	___________	___ Severe Fall	___________
___ Soft Tissue	___________	___ Other	___________

Medical History - Past or Present Illnesses

Please check all that apply (past or present) / Circle **CURRENT** Conditions

___ ADD	___ AIDS/HIV	___ Alcoholism	___ Allergies
___Alzheimer's	___ Anemia	___ Anorexia	___ Appendicitis
___ Arthritis	___ Asthma	___ Atopic Dermatitis	___ Bed Wetting
___ Bleeding Disorders	___ Blood Clot	___ Blood Transfusion	___ Breast Lump
___ Bronchitis	___ Bulimia	___ Cancer	___ Cataracts
___ Cerebral Palsy	___ Chemical Dependency	___ Chest Pain	___ Chicken Pox
___ Cholera	___ Chronic Fatigue Syndrome	___ Crohn's/Colitis	___ CRPS (RSD)
___ Constipation	___ CVA (Stroke)	___ Cystic Kidney Disease	___ Depression
___ Diabetes (*insulin*)	___ Diabetes *(non insulin*)	___ Ear Infections	___ Eating Disorder
___ Eczema	___ Emphysema	___ Epilepsy/Convulsions	___ Eye Problems
___ Fetal Drug Exposure	___ Fibromyalgia	___ Fractures	___ Gallbladder Disorder
___ Gallstones	___ German Measles	___ Glaucoma	___ Goiter
___ Gonorrhea	___ Gout	___ Headaches	___ Heart Attack
___ Heart Disease	___ Heart Failure	___ Hepatitis	___ Hernia
___ Herniated Disk	___ Herpes/Lesions/Shingles	___ High Blood Pressure	___ High Cholesterol
___ Hormone Replacement	___ Hypertension	___ Hypoglycemic	___ Influenza Pneumonia
___ IBS (*Irritable Bowel Syndrome*)	___ Jaundice	___ Kidney Stones	___ Liver Disease
___ Lung Disease	___ Lupus Erythema (*Discoid*)	___ Lupus Erythema (Systemic)	___ Malaria
___ Measles	___ Migraine Headaches	___ Miscarriage	___ Mononucleosis
___ Multiple Sclerosis	___ Mumps	___ Nervous Breakdown	___ Osteoporosis
___ Pacemaker	___ Parkinson's Disease	___ Pinched Nerve	___ Pleurisy
___ Pneumonia	___ Polio	___ Pregnancy	___ Prostate Problems
___ Prosthesis	___ Psoriasis	___ Psychiatric Care	___ Rheumatoid Arthritis
___ Rheumatic Fever	___ Scarlet Fever	___ Scoliosis	___ Seizure Disorder
___ Sickle Cell Anemia	___ Sinusitis	___ Sleep Apnea	___ Spina Bifida
___ STD	___ Stroke	___ Suicide Attempt(s)	___ Swelling Feet
___ Thyroid Problems	___ Tonsilitis	___ Tuberculosis	___ Tumors, Growths
___ Typhoid Fever	___ Ulcers	___ Unspec. Pleural Effusion	___ Vaginal Infections
___ Vertigo	___ Whooping Cough	___ Other: ___________	

Patient Name ______________________ Patient Signature ____________________ Date__________

Family Health History

Check all family members that apply	Mother	Father	Brother (s)	Sister (s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at Death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (ex: Rheumatoid Psoriatic)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Disease (ex: Lupus, Hashimotos)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson’s												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as Alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

Patient Name ________________________________ Patient Signature _________________________ Date__________

Review of Symptoms

Indicated which of the below you have experienced in the **last 1-2 months.**
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Ears/Nose

- Decreased Hearing 1 2 3 4 5
- Ear Drainage 1 2 3 4 5
- Ear Pain/Ear Infection 1 2 3 4 5
- Frequent Sneezing 1 2 3 4 5
- Headaches 1 2 3 4 5
- Hayfever 1 2 3 4 5
- Itchy/Watery Eyes 1 2 3 4 5
- Loss of Smell 1 2 3 4 5
- Nose Bleeds 1 2 3 4 5
- Nose Drainage/Runny 1 2 3 4 5
- Ringing in Ears 1 2 3 4 5
- Snoring 1 2 3 4 5
- Stuffy Nose 1 2 3 4 5
- TMJ 1 2 3 4 5

Eyes/Vision

- Blindness 1 2 3 4 5
- Blurred/Double Vision 1 2 3 4 5
- Cataracts 1 2 3 4 5
- Eye Pain 1 2 3 4 5
- Field Cuts 1 2 3 4 5
- Glaucoma 1 2 3 4 5
- Itching 1 2 3 4 5
- Photophobia 1 2 3 4 5
- Tearing 1 2 3 4 5
- Wear Glasses/Contacts 1 2 3 4 5

Skin

- Excessive Sweating 1 2 3 4 5
- Eczema 1 2 3 4 5
- Dryness 1 2 3 4 5
- Hives 1 2 3 4 5
- Itching 1 2 3 4 5
- Lumps 1 2 3 4 5
- Nail Texture/ Skin Color Changes 1 2 3 4 5
- Rashes 1 2 3 4 5
- Skin Lesions 1 2 3 4 5
- Varicosities 1 2 3 4 5

Cardiovascular

- Angina 1 2 3 4 5
- Chest Pain 1 2 3 4 5
- Claudication (leg pain/ache) 1 2 3 4 5
- Congestive Heart Failure 1 2 3 4 5
- Coronary Artery Disease 1 2 3 4 5
- Difficulty Breathing Lying 1 2 3 4 5
- Heart Murmur 1 2 3 4 5
- Heart Problems 1 2 3 4 5
- High Blood Press (no meds) 1 2 3 4 5
- High Blood Press (on meds) 1 2 3 4 5
- Low Blood Pressure 1 2 3 4 5
- Pacemaker/Defibrillator 1 2 3 4 5
- Palpitations 1 2 3 4 5
- Shortness of Breath with Exertion/Exercise 1 2 3 4 5
- Swelling of Legs 1 2 3 4 5
- Ulcers 1 2 3 4 5
- Varicose Veins 1 2 3 4 5
- Waking at Night - Shortness of Breath 1 2 3 4 5

Muscular/Skeletal

- Ankle/Foot Pain 1 2 3 4 5
  (Circle all that apply)
  Popping, Clicking, Weakness, Stiffness
- Arthritis 1 2 3 4 5
- Balance Problems
- Elbow Pain 1 2 3 4 5
  (Circle all that apply)
  Popping, Clicking, Weakness, Stiffness
- Fibromyalgia 1 2 3 4 5
- Hip Pain 1 2 3 4 5
  (Circle all that apply)
  Popping, Clicking, Weakness, Stiffness
- Joint Pain 1 2 3 4 5
- Knee Pain 1 2 3 4 5
  (Circle all that apply)
  Popping, Clicking, Weakness, Stiffness
- Low Back Pain 1 2 3 4 5
- Muscle Aches 1 2 3 4 5
- Muscle Cramping
- Muscle Stiffness(in a.m.)
- Neck Pain 1 2 3 4 5
- Pain Between Shoulder 1 2 3 4 5
- Pain Wakens You 1 2 3 4 5
- Shoulder Pain 1 2 3 4 5
  (Circle all that apply)
  Popping, Clicking, Weakness, Stiffness
- Weakness in Arms/Legs 1 2 3 4 5
- Wrist/Hand Pain 1 2 3 4 5
  (Circle all that apply)
  Popping, Clicking, Weakness, Stiffness

Gastrointestinal

- Abdominal Pain/Cramps 1 2 3 4 5
- Abnormal Stool 1 2 3 4 5
- Belching 1 2 3 4 5
- Black/Tarry Stools 1 2 3 4 5
- Bloating/Gas 1 2 3 4 5
- Change in Appetite 1 2 3 4 5
- Change in Bowel Habit 1 2 3 4 5
- Constipation 1 2 3 4 5
- Crohn's Disease 1 2 3 4 5
- Diarrhea 1 2 3 4 5
- Hemorrhoids 1 2 3 4 5
- Indigestion 1 2 3 4 5
- Jaundice 1 2 3 4 5
- Rectal Bleeding 1 2 3 4 5
- Reflux/Heartburn 1 2 3 4 5
- Nausea/Vomiting 1 2 3 4 5
- Vomiting Blood 1 2 3 4 5

Throat/Respiratory

- Asthma/ Wheezing 1 2 3 4 5
- Bleeding Gums 1 2 3 4 5
- Chronic Cough 1 2 3 4 5
- Coughing up Blood 1 2 3 4 5
- Chest Congestion 1 2 3 4 5
- Dentures 1 2 3 4 5
- Difficulty Swallowing 1 2 3 4 5
- Hoarseness 1 2 3 4 5
- Shortness of Breath 1 2 3 4 5
- Sore Throat 1 2 3 4 5

Hematologic

- Anemia 1 2 3 4 5
- Ease of Bleeding 1 2 3 4 5
- Blood Clotting 1 2 3 4 5
- Blood Transfusion 1 2 3 4 5
- Bruise Easily 1 2 3 4 5
- Lymph Node Swelling 1 2 3 4 5

Neurological

- Dizziness 1 2 3 4 5
- Facial/Limb Weakness 1 2 3 4 5
- Fainting/ Loss of Consciousness 1 2 3 4 5
- Headaches 1 2 3 4 5
- Loss of Memory 1 2 3 4 5
- Migraines 1 2 3 4 5
- Numbness 1 2 3 4 5
- Seizures 1 2 3 4 5
- Sleep Disturbance 1 2 3 4 5
- Slurred Speech 1 2 3 4 5
- Stroke 1 2 3 4 5
- Tingling 1 2 3 4 5
- Tremor 1 2 3 4 5
- Unsteadiness of Gait 1 2 3 4 5

Mental/Emotional

- Anxiety/Panic 1 2 3 4 5
- Behavioral Change 1 2 3 4 5
- Bi-Polar Disorder 1 2 3 4 5
- Blackouts/Amnesia 1 2 3 4 5
- Clumsy 1 2 3 4 5
- Confusion 1 2 3 4 5
- Cry Often 1 2 3 4 5
- Daytime Sleepiness 1 2 3 4 5
- Convulsions 1 2 3 4 5
- Depression 1 2 3 4 5
- Emotional Numbness 1 2 3 4 5
- Foggy Thinking 1 2 3 4 5
- Forgetfulness 1 2 3 4 5
- Have Considered Suicide 1 2 3 4 5
- Have Hallucinations 1 2 3 4 5
- Have Overused Alcohol 1 2 3 4 5
- Hyperactive 1 2 3 4 5
- Insecure 1 2 3 4 5
- Insomnia 1 2 3 4 5
- Jittery 1 2 3 4 5
- Memory Loss 1 2 3 4 5
- Mood Swings/Irritability 1 2 3 4 5
- Nervous Breakdown 1 2 3 4 5
- Grumpiness 1 2 3 4 5
- Poor Concentration 1 2 3 4 5
- Restless Leg Syndrome 1 2 3 4 5
- Shy 1 2 3 4 5
- Uses Tranquilizers 1 2 3 4 5
- Withdrawn 1 2 3 4 5
- Workaholic 1 2 3 4 5

Urinary

- Blood in Urine 1 2 3 4 5
- Burning or Pain 1 2 3 4 5
- Frequency 1 2 3 4 5
- Incontinence 1 2 3 4 5
- Kidney Stones 1 2 3 4 5
- Urgency 1 2 3 4 5

Endocrine

- Abnormal Urination 1 2 3 4 5
- Change in Appetite 1 2 3 4 5
- Decreased Endurance 1 2 3 4 5
- Diabetes 1 2 3 4 5
- Excessive Hunger 1 2 3 4 5
- Excessive Thirst 1 2 3 4 5
- Fatigue/Drowsiness 1 2 3 4 5
- Feel "Burned Out" 1 2 3 4 5
- Goiter 1 2 3 4 5
- Hair Loss/Hair Growth 1 2 3 4 5
- Hot Flashes/Night Sweats 1 2 3 4 5
- Hypo/Hyper Thyroid 1 2 3 4 5
- Inability to Lose Weight 1 2 3 4 5
- Poor Sleep 1 2 3 4 5
- Voice Changes 1 2 3 4 5
- Weight Loss/Gain 1 2 3 4 5

Reproductive

- Burning Urination 1 2 3 4 5
- Cramps 1 2 3 4 5
- Frequent Urination 1 2 3 4 5
- Hormone Therapy 1 2 3 4 5
- Itching/Rash 1 2 3 4 5
- Decreased Libido 1 2 3 4 5
- Mood Swings 1 2 3 4 5
- STI's 1 2 3 4 5
- Infertility

Males Only:

Have you had a PSA? ☐ Yes ☐ No

Levels? ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10

- Erectile Dysfunction 1 2 3 4 5
- Genital Pain 1 2 3 4 5
- Hernia 1 2 3 4 5
- Impotence 1 2 3 4 5
- Urination at Night 1 2 3 4 5
- Prostate Enlargement 1 2 3 4 5
- Prostate Infection 1 2 3 4 5

Females Only:

- Heavy Bleeding 1 2 3 4 5
- Hot Flashes 1 2 3 4 5
- Irregular Menstruation 1 2 3 4 5
- Ovarian Cysts 1 2 3 4 5
- Pain During Sex 1 2 3 4 5
- Painful Periods 1 2 3 4 5
- Vaginal Discharge 1 2 3 4 5
- Vaginal Dryness 1 2 3 4 5

Notes:

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Patient Name ________________________________ Patient Signature ________________________ Date__________

ADVANCED MEDICAL CONSENT TO TREAT

I hereby request and consent to the performance of spinal manipulation and manual therapy techniques and other physical rehabilitation procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the health care staff of Advanced Medical/Living Wellness and/or other licensed doctors of chiropractic who now or in the future work in this facility.

I have had an opportunity to discuss with a registered or licensed health care provider, the nature and purpose of diagnostic or treatment procedures. I understand that results are not guaranteed.

I understand and am informed that, in the practice of medicine and in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) f)or which I seek treatment.

____ ____

Signature of Patient, Parent, Guardian or Personal Representative   Print Name of Patient, Parent, Guardian or Personal Representative

____________________ ____________________

Relationship to Patient   Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Living Wellness/Advanced Medical** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

____ ____

Signature of Patient, Parent, Guardian or Personal Representative   Print Name of Patient, Parent, Guardian or Personal Representative

____________________ ____________________

Relationship to Patient   Date

Patient Name ______________________________ Patient Signature _______________________ Date__________