

Health Works OF ARLINGTON

At Health Works of Arlington, we take pride in providing quality health care to our patients. Therefore, we would like to request your assistance with the following office policies and privacy practices.

MEDICAL RECORDS POLICY AND PROCEDURES

As a patient of Health Works of Arlington, you are entitled, at any time during regular operating hours, to request your medical records or diagnostic films from our office. The following are the policies/procedures aimed at making the process of completing your request as quick and efficient as possible:

- *Notify the Custodian of Records of your request. Your records will be copied at our earliest convenience.
- *Requests by third parties (attorneys, insurance carrier, doctors office, etc.) must be made directly to the Custodian of Records in writing and accompanied by a signed authorized release from you.

We appreciate your patience during the process of completing your request.

CONTACT INFORMATION

Home Number: _____
Work Number: _____
Cell Number: _____

A detailed message may be left at this number:	HOME	WORK	CELL
A message may be left with only a name and call back number:	HOME	WORK	CELL
Please do not leave a message at this number:	HOME	WORK	CELL

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office’s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature Date

Printed Name

I wish to object to the following in the “Notice of Privacy Practices”:

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Malaria | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal Infection |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Eczema |

CHECK ANY OF THE FOLLOWING YOU **HAVE** HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- | | |
|--|---|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Gas/Bloating After Meals |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Black/Bloody Stool |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Joint Pain/Stiffness | |
| <input type="checkbox"/> Walking Problems | |
| <input type="checkbox"/> Difficulty Chewing/Clicking jaw | |

NERVOUS SYSTEM CODE

- Numbness
- Paralysis
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsion
- Cold/Training Extremities

GENERAL CODE

- Allergies
- Loss of Sleep
- Fever
- Headaches

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Trouble
- Gall Bladder, Problems
- Weight Trouble
- Abdominal Cramps

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling

EENT CODE

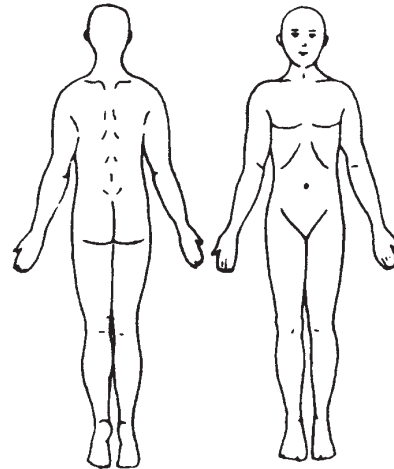
- Vision Problem
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Genital Herpes

FEMALES ONLY:

When was your last period?
Are you pregnant? Yes No Maybe



Please outline on the diagram the area of your discomfort.

INSURANCE INFORMATION

Policyholder and/or Employer

Name of Insurance Co. _____

Address _____

City, State, Zip _____

Phone# _____ Toll Free# _____

Name of Insured _____

Social Security # of Insured _____

Group or Policy # of Insured _____

BENEFITS ASSIGNED

I hereby authorize the insurance company to pay directly to Healthworks of Arlington all benefits to which I am entitled under the terms of the policy.

Name

Date

I hereby authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or to the party who accepts assignment above.

Name

Date

PAYMENT IS EXPECTED AT THE TIME OF VISIT

Name of person responsible for payment _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Healthworks of Arlington will prepare any necessary reports and forms to assist me in making collection from the insurance company and that the amount authorized to be paid directly to Healthworks of Arlington will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date: _____

Guardian or Spouse's Signature _____ Date: _____