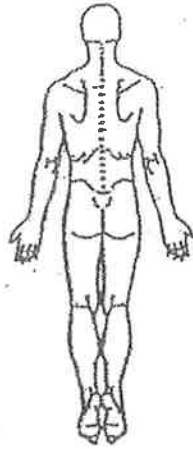
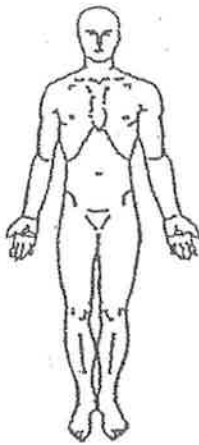


HISTORY OF INJURIES

NAME _____

DATE _____

PLEASE MARK ALL PLACES THAT HAVE EVER BEEN INJURED
(Sprains/Strains, Broken Bones, Severe Bruises, Surgery, Scars, Head Bumps, Cuts, Burns, Etc.)

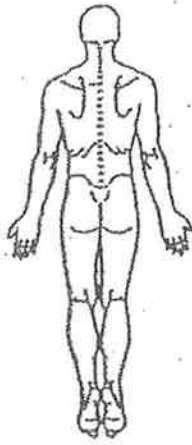
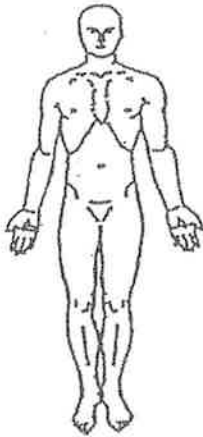


What happened?

When did it happen?

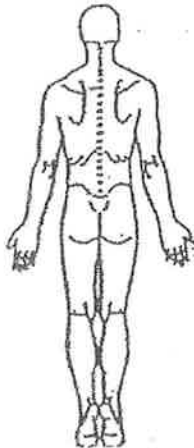
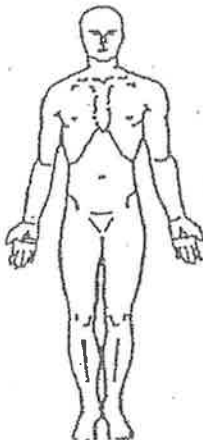
What happened?

When did it happen?



What happened?

When did it happen?



Functional Medicine & Wellness Center
Todd Oczkowski
2653 Sagebrush Dr. Suite 230 Flower Mound Tx. 75208
T:214.395.7264 F:972.899.8146

Confidential Patient Information Form

Please fill out ALL information: (Please print)

Today's Date _____ Referred by _____
Last Name _____ First Name _____ Middle Initial _____
Home Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Email _____
Age _____ Date of Birth ____/____/____ Drivers License No. _____
Sex- Male/Female Marital Status – Single/Married/Divorced/Widowed
Spouse's Name _____
Occupation _____ Employer _____ Work Phone _____
Social Security Number _____ Guardian's SSN (if patient under 18) _____
Person Responsible for account _____ Relationship to Pt. _____
Person to contact in case of emergency _____
Address _____ Phone _____
Date of last physical exam _____ Doctor's name/type _____
Reported findings _____
Has your back or neck been x-rayed within the last 3 yrs? Yes/No Where _____
List all surgeries/serious illness/hospitalizations (Include dates) _____

Have you ever suffered from (circle all that apply)

Dizziness Arthritis Tuberculosis Heart Problems Cancer
Headaches Numbness Breathing Problems Diabetes Venereal Disease
Sinus Problem Neuritis Asthma Rheumatic Fever Backache Nervousness
Digestive Disorders Anemia

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions before? _____

What activities aggravate your condition? _____

Improve your condition? _____

Is this condition becoming progressively worse? Yes/No

Status of your condition? Constant/Comes and goes

This condition interferes with (circle all that apply) Work/Sleep/Daily/Routine/Other

List previous diagnosis/treatments you have received for this condition: _____

Additional Complaints? _____

What current medications/drugs are you taking? (list reason for taking) _____

Patient Information:

Do you have insurance? Yes/No Insurance Company's name: _____

Is this a work-related injury ? Yes/No Motor vehicle accident? Yes/No

If yes is this your first doctors visit ? Yes/No

I hereby give my consent to the Functional Medicine & Wellness Center and/or Ballpark Chiropractic (Todd Oczkowski, D.C.) to provide services to myself/or family member. I understand that there is a fee for services, and that fees are payable at time services are rendered. I hereby agree to such fees, and understand that I am liable for any and all legal fees if collection services become necessary.

Responsible Party/Patient _____ **Date** _____

For Insurance/Worker's Compensation filing: I authorize the release of any medical or other information necessary to process claims. I also request payment of medical benefits to Todd Oczkowski, D.C. for services rendered.

Signature of Insured _____ **Date** _____

FUNCTIONAL MEDICINE AND WELLNESS CENTER

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/05/2005, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice "at any time, provided such changes are permitted by applicable law." We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, healthcare operations. For example:

Treatment: We may use, or disclose, your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up chiropractic supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use, or disclose, your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces Personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence, and other national security activities. We may disclose to correctional institutions or law

enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Office Usage: At Cornerstone Family Chiropractic we have an open adjusting area so that we can serve as many families as possible. We may also use or disclose your health information to provide you with appointment reminders (such as voicemail messages, phone calls, birthday cards, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at, or get copies of, your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information.) You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$2.00 for each page to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of the Notice for a full explanation of our fee structure. If you wish to receive copies of your x-rays a cost-based fee of \$45 will be assessed in advance. Copies will be provided to you in a timely manner appropriate to the time to process your request. All requests must be submitted in writing to the address at the end of the Notice.

Disclosure accounting: You have the right to receive a list of instances in which we, or our business associates, disclosed your health information for purposes other than treatment, payment healthcare operation and certain other activities, for the last 6 years but not before January 5, 2005. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that which we place additional restrictions on, our use or disclose, of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints: You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address that follows. We will not take any action against you for filing a complaint.

If you would like further information about our privacy practices, please contact:

Functional Medicine and Wellness Center
2653 Sagebrush Drive Suite 230
Flowermound, TX. 75028
Phone 214-395-7264
972-899-8146

Patient Signature _____

Date _____