Adams Health Centers, PC
3151 W. 15th St., Plano, TX 75075
Phone: (972) 596 – 1611
FAX: (972) 596 – 9072

NEW PATIENT INFORMATION

Patient Number: _____

Date: _____

Please print all answers

Name: _____ Age: _____ Sex: _____

Address: _____ City: _____ ZIP: _____

Phone: _____ Work Phone: _____ Cell: _____

Best time to call: _____ Which Number: _____ Birthday: _____

e-Mail: _____ Social Security Number: _____ - _____ - _____

Family Doctor: _____

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Your Employer: _____ Spouse's Employer: _____

Employer Address: _____ Spouse's Birthdate: _____

Employer Phone: _____ Spouse's Social Security: _____ - _____ - _____

Parent's Employer (if Patient is Minor / Child): _____

Parent's Social Security # (If patient is a Minor / Child): _____ - _____ - _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Please provide the receptionist with your driver's license & insurance card to be photocopied for your permanent medical record.

Welcome to our multi-specialty group practice, offering chiropractic, physical therapy, rehabilitation, massage therapy & nutritional counseling. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any and all applicable parties on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read and sign the federally governed Health Care Privacy Notice. This notice is detailed on page -3- of this document. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff.

Your signature on this document confirms that you have read, understand and agree to comply with all of the terms and conditions of the Health Care Privacy Notice and all policies, consents, terms and conditions regarding your responsibilities to this facility and that you grant the physicians, therapists, and/or all staff of the Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities. Please direct any questions or concerns to any member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before & after work. If you need to reschedule an appointment please notify us. If you do not show up for your scheduled appointment with one of our massage therapists without calling at least 1 HOUR in advance, you will be charged $25.00 as a missed appointment fee that you must pay during your next appointment. We are available to see new patients the same day or through our 24-hour-7-day emergency service. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call, mail, e-Mail, or send reminder cards to you, please let us know in writing for your file.

--Please proceed to page 2--

✗ _____(initials)

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SYMPTOM SURVEY

What caused the problem or symptoms to occur? _____

When did the problem or symptoms begin? _____

Have you seen another doctor for this problem? ☐ No. If yes, who _____

What tests/procedures have been performed? ☐ X-ray ☐ MRI ☐ Surgery ☐ Hospitalization ☐ _____

Have you had this problem or symptoms in the past? ☐ No. If yes, explain _____

Have you tried any other treatments for this problem? ☐ No. If yes, explain _____

Is the problem or symptoms getting worse? ☐ No. If yes, explain _____

☑ ALL OF THE ITEMS THAT APPLY TO YOU NOW AND IN THE PAST:

☐ Arthritis / Gout	☐ Depression/Anxiety	☐ Pregnancy	☐ Seasonal Allergies	☐ Headaches
☐ Eye Pain-Strain	☐ Dizziness	☐ Seizures	☐ Ringing in Ears	☐ Blurred Vision
☐ Jaw Pain	☐ Bleeding Gums	☐ Neck Pain / Spasms	☐ Chronic Fatigue	☐ Heart Disease
☐ Gall Stones	☐ Swallowing Difficulty	☐ Thyroid Problems	☐ Chest Pain	☐ Chest Congestion
☐ Anemia	☐ Hypertension	☐ Stroke	☐ Kidney Stones	☐ Pancreatitis
☐ Shortness of Breath	☐ Irregular Heart Beat	☐ HIV / AIDS	☐ Asthma / Bronchitis	☐ Mid-Back Pain
☐ Shoulder/Elbow Pain	☐ Wrist or Hand Pain	☐ Low Back Pain	☐ Hip/Knee/Leg Pain	☐ Foot or Ankle Pain
☐ Abdominal Pain	☐ Diabetes	☐ Groin or Rectal Pain	☐ Female Disorders	☐ Urinary Problems
☐ Skin Problems	☐ Broken Bones	☐ Digestive Problems	☐ Nausea - Vomiting	☐ Irregular Bowels

PATIENT & FAMILY HISTORY

What is your occupation? _____ ☐ Full Time ☐ Part Time

What is your employment status? ☐ Working ☐ Sick Leave ☐ Unemployed ☐ Retired ☐ Temp Disability ☐ Perm Disability ☐ Last Day of Work

Do you use tobacco? ☐ No ☐ Yes Explain: _____

Do you consume alcohol? ☐ No ☐ Yes Explain: _____

Do you have a history of substance abuse? ☐ No ☐ Yes Explain: _____

List all past Surgeries: _____

Do you have any known drug allergies? ☐ No ☐ Yes, please explain: _____

List all current and past medications / drugs:

Drug Name: _____ _____

_____ _____

_____ _____

List all Physicians you have seen in the past 5 years:

Name _____ For What? _____

_____ _____

_____ _____

_____ _____

Family History

Father	☐ Living	Age: _____	☐ Deceased – cause of death	_____
Mother	☐ Living	Age: _____	☐ Deceased – cause of death	_____
Brother	☐ Living	Age: _____	☐ Deceased – cause of death	_____
Brother	☐ Living	Age: _____	☐ Deceased – cause of death	_____
Sister	☐ Living	Age: _____	☐ Deceased – cause of death	_____
Sister	☐ Living	Age: _____	☐ Deceased – cause of death	_____
Children	☐ Living	Age: _____	☐ Deceased – cause of death	_____
Children	☐ Living	Age: _____	☐ Deceased – cause of death	_____

☐ Other problem(s) not listed: _____

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✗ _____(initials)

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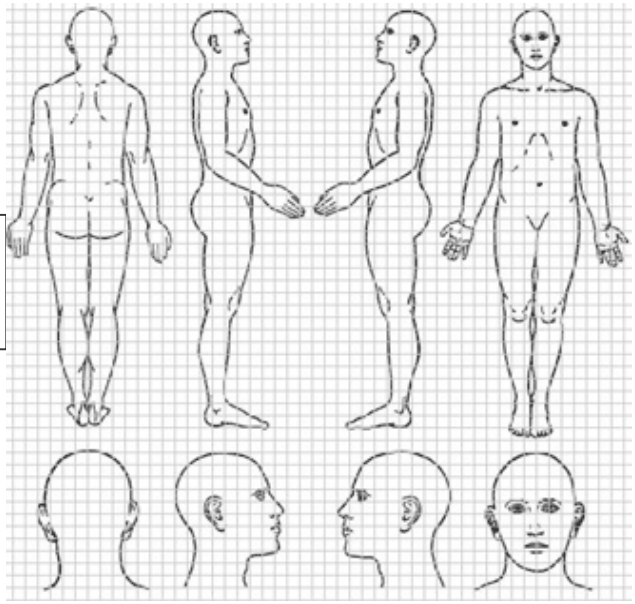
PAIN DRAWING

Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation.

Describe your pain (check all that apply):

- ☐ Constant
- ☐ Intermittent
- ☐ Recurring
- ☐ Stabbing
- ☐ Dull Ache
- ☐ Sharp
- ☐ Deep Ache
- ☐ Throbbing
- ☐ Tingling
- ☐ While Resting
- ☐ Daily
- ☐ During Exercise
- ☐ Nightly
- ☐ _____

Pain	•
Numbness	+
Burning	/
Ache	X



Onset of Pain:

- ☐ Sudden
- ☐ Gradual

On a scale of 1 to 10 how would you rate your pain level? _____ (1 = Mild, 10 = Intense)

What if anything gives your relief? _____

~IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN ACCIDENT OR INJURY PLEASE COMPLETE BELOW~

☐ NOT APPICABLE
☐ AUTO ACCIDENT Date _____ Time _____ (am) (pm) Location _____

Were You:	☐ Driver	☐ Passenger
	☐ Unconscious	☐ Treated in E.R.
	☐ Wearing a seat belt	☐ Yes ☐ No
	☐ Transported by ambulance	☐ Yes ☐ No
Vehicle Damage:	☐ Minimal – Moderate	☐ Severe – Totaled
	Was the vehicle towed away?	☐ Yes ☐ No
Police Report:	☐ None	☐ Yes with Police Department _____
Activities:	☐ No Restrictions	☐ Missed _____ days of work or school
	☐ I felt fine before the accident	

☐ NOT APPLICABLE
☐ WORK RELATED Date _____ Time _____ (am) (pm) Location _____

or Other Injury Describe the injury and how it happened:

_____
_____
_____
_____
_____
_____
_____
_____.

Accident Reported to _____ on _____ (date)

☐ No restrictions ☐ Missed _____ days of work or school
☐ I felt fine before the injury

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✗ _____(initials)

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HEALTH CARE PRIVACY NOTICE ~ INFORMED CONSENT ~ ASSIGNMENT OF BENEFITS ~ AUTHORIZATION & LIEN

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patients working together as a team to obtain the maximum results. Patient's satisfaction is a vital interest to our staff.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of the Notice at anytime without additional notice to your except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of the Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility.

Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical/mental health or condition and the care and treatment you receive form our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice, and direct questions, misunderstandings or concerns to the Compliance Officer of this Facility.

Our Facility may use and disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must be in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Office and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated and comprehensive Health Care Privacy Notice is available for your review in this Facility.

I understand that this Facility, its Doctors and staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur.

I further understand that in the practice of medicine, chiropractic, psychological counseling, massage therapy & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions and reactions and/or other injuries or side effects which cannot be pre-determined.

I do not expect the doctors/provider to be able to anticipate and explain all risks and/or complications, an I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore, I give my full consent to the doctor/provider to render treatment on me, or the minor for whom I am legally responsible by a health care provider of this Facility.

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any and all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee, further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and/or including all insurance or third party benefits.

Assignee agrees that this Facility and staff may deliver medical records, consultants, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse and/or sign my name on any & all checks for payment of any indebtedness.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay.
2. Co-Pays, deductible and all non-covered service charges are due the day the service is rendered.
3. Patients are responsible for charges on all services(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
5. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to physical therapy equipment rentals or purchases, vitamins, supplements, ointments, and weight loss programs.
6. A service charge is computed by a 'periodic rate' of 1 ½ % per month – 18% per annum and is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court and filing fee's. Returned checks, debit and credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $25.00 charge.
7. Patients are eligible for a maximum $250 personal credit limit when approved. For your convenience we accept most major credit & debit cards, personal checks, and cash.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

_____
Print Name of Patient

✗ _____ _____
Signature (if minor, parent or legal guardian must sign) Date

--Please proceed to page 5--

Adams Health Centers, PC
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CONSENT TO TREAT A MINOR

I (WE) being the parent, guardian or custodian of the minor:

Name of Patient: _____

Social Security Number: _____

Date of Birth: _____

do hereby authorize, request and direct Adams Health Center's doctors and staff to perform examinations, diagnostic tests, x-rays, laboratory test and any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff have full authority from me the legal parent/guardian to continue with examinations, diagnostic tests and treatments as will be needed while said minor shown above is under care in the office until legal age is attained.

A minor child as described by law. Further I warrant that my authority to act on the child's behalf is by virtue of:

☐ Being the child's natural parent

☐ Having been duly appointed legal guardian by a Court of Competent Jurisdiction. (A copy of the order is attached hereto.)

I agree to be held fully responsible for all costs for all treatment and/or care rendered to this child.

_____ _____
Signature of Parent or Legal Guardian Date Signed

_____ _____
Witness by Staff/Signature Date Signed

NOTE: Custodial Guardians must provide proof of legal guardianship!

~Original copy of retained for records~

~Photocopy may be released~

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PATIENT'S PRIVACY AGREEMENT AUTHORIZATION FOR USE AND DISCLOSURE

Patient Name: _____ Date: _____

I, _____, authorize Adams Health Center to use and/or disclose my protected health information (PHI) to family members and/or friends listed below:

☐ Please DO NOT disclose my personal information to anyone at this time!

Family member/friend 1:

Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ - _____

Family member/friend 2:

Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ - _____

I was advised of the purpose for which my protected health information (PHI) will be used, and authorize the release of medical and billing information to the above-mentioned individual(s).

I understand that I may refuse to sign this authorization, and I will not be denied treatment because of my refusal. The clinic may disclose and use my PHI for all health care delivery purposes (i.e., treatment, payment, and health care operations).

I have the right to revoke this agreement at any time by delivering written notice to the compliance officer.

I fully understand this authorization for use and disclosure of my protected health information, and I agree to this authorization.

_____ _____
Patient's Signature Date

_____ _____
Signature of Compliance Officer Date

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Adams Health Centers, PC
3151 W. 15th St., Plano, TX 75075

Patient Number: _____

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HEALTH CARE PRIVACY NOTICE

ADAMS HEALTH CENTERS, PC _____, Compliance Officer

Our staff is committed to maintaining the privacy or your protected health information known as (PHI). PHI is information about you, including demographic information, that may identify you and that may relate to your present, future and past physical or mental health or condition and that care and treatment you receive from our practice. This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and ask any questions, misunderstanding or concern to the Compliance Officer of this office.

This office is required by law to abide by the terms of this Health Care Privacy Notice as well as all other applicable federal and state laws governing privacy practices in health care. Our office may change and/or modify the terms of this Notice at any time without additional notice to you except to publicly post in our office and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request.

USE & DISCLOSURE OF PHI

Our office may use & disclose your PHI for health care delivery purposes. Your PHI may be used by doctors and staff of this office for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. Following is a list of situations in which your PHI can be disclosed without your written authorization.

Business Associate: Your PHI may be used or disclosed to a business associate, from whom we have obtained assurances that they will safeguard your PHI and use it only for the purposes for which it was intended.

Emergency Situations: In an emergency situation, where written acknowledgment from you is not practical until after the situation has ended.

Employee Limitations: Your PHI will be limited to the members of the clinic and its workforce who may need access for treatment, payment or health care operations.

Health Care Operations: For certain administrative, financial, legal, and quality control activities that are necessary to run its business and support the core functions of treatment and payment.

Legal Proceeding: If requested by judicial or administrative proceedings, court order, subpoena or law enforcement purpose.

Minimum Necessary Standard: The disclosure of and requests for your PHI will be the minimum required to accomplish the intended purpose.

Payment: The provider may disclose your PHI to third party and/or other parties to obtain reimbursements and/or payments for your health care services.

Personal Representative: Your PHI may be disclosed to a person who is authorized by state law to act on your behalf in making your health care decisions.

Public Health Purposes: Your PHI may be disclosed to legally authorize public health authorities for the purpose of the prevention, control, investigations, intervention, and reporting of disease, injury, disability and vital events such as births or deaths. Your PHI may be disclosed for public health activities such as child abuse, neglect, safety and effectiveness of a product regulated by the FDA, and persons at risk of contracting and spreading disease.

Research Purposes: Your PHI may be disclosed for research purposes either with your written permission or without any identifying characteristics.

Treatment: For the coordination or management or your health care services, your health care provider may consult with another health care provider, a third party, or for the referral to another health care provider.

Worker's Compensation: State laws may permit disclosure of your PHI to comply with worker's compensation laws without your authorization and no minimum necessary standard is required.

Miscellaneous: We may use or disclose your PHI in the normal course of operations, notifying you of appointments, services, and clinic news.

The Privacy Rule allows you the right to receive and receive copies of your records as it relates to your health care. The request must be in writing, allowing your doctor 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your doctor may charge a copy fee, which will not exceed the amount permitted by State Law.

The Privacy Rule allows you the right to request that the disclosure of your PHI have restrictions on how your doctor will use your PHI regarding treatment, payment and health care operations. Your doctor may not agree to your restrictions, but would be bound by any restrictions you agree upon.

Your doctor must comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed on your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the doctor has the right to respond with a rebuttal statement if he/she feels it is necessary.

You have a right to receive your doctor's Notice of Privacy Practices.

You may revoke authorization, in writing, at any time, except in the even that the doctor has acted as indicated in the doctor's Authorization Notice.

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✗ _____(initials)

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HEALTH CARE PRIVACY NOTICE - (continued)

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer, and it must be filed within 180 days of when you knew or should have known that the violation occurred. You may also contact a written complaint, either on paper or electronically with the Office of Civil Rights (OCR). The Privacy Law prohibits our office from taking any retaliatory actions against anyone who files a complaint.

I, _____, (patient's name) acknowledge that I have read and was given a copy of the Notice of Privacy Practices for Adams Health Centers, PC and fully understand the same and have all my questions answered to my satisfaction.

_____ _____
Patient's Signature Date

_____ _____
Signature of Compliance Officer Date

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CREDIT POLICIES

The following are the only acceptable terms for payment at our office:

CASH ACCOUNTS	Services must be paid in full at time services are rendered. Time of Service discount may be applied for balances pain in full on the same date that service is rendered.
MEDICARE INSURANCE	Services must be paid in full at time services are rendered. We will file claims with Medicare with benefits being paid directly to you according to reimbursement guidelines. You must follow up on all claims owed to you. Medicare may deny some or all of your treatment based on medical necessity guidelines.
MAJOR MED INSURANCE	Payment for deductibles; co-payments & amounts not covered must be paid at time of service is rendered. All balances must Be paid within 90 days from the date the treatment was rendered.
AUTO ACCIDENT & PERSONAL INJURY	We will file auto med pay and applicable insurance claims. In cases where 100% coverage is applicable, we will await payment for a maximum of 90 days from date of last treatment for full payment. If there is no insurance or auto med pay coverage your account is classified as a Cash account. Cases secured by an attorney must be paid in full within 90 days of date of last treatment and if not are due in full by the patient.
WORKER & INDUSTRIAL INJURY	Treatment and costs must be pre-authorized for full payment by employer or applicable work comp insurance carrier. All balances must be paid within 90 days.
BENEFITS PLANS	Clinic insurance staff will discuss your policy limitations and benefits with you directly. You co-payment is due at each visit when service is rendered.
ORTHOPEDIC SUPPORTS	To be paid in full at the time service is rendered or item(s) is dispensed.
LABORATORY	Same as above
VITAMINS & OINTMENTS	Same as above
CREDIT CARDS ACCEPTED	VISA, MASTERCARD, DISCOVER, & AMERICAN EXPRESS
CREDIT LIMITS	Maximum allowable credit limit of $250 per patient
TIME OF SERVICE DISCOUNT	A 25% discount is given to all parties who pay for all services at the time which they are rendered.
SERVICE CHARGE	1.5% per month added to all account balances past due 60 days.

I, _____, (patient's name) acknowledge that I have read and was given a copy of the Credit Policies for Adams Health Centers, PC and fully understand the same and have all my questions answered to my satisfaction.

_____ _____
Patient's Signature Date

_____ _____
Signature of Compliance Officer Date

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Adams Health Centers, PC
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Patient Number: _____

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MISSED APPOINTMENT with LMT AGREEMENT

DEAR PATIENT:

Due to the demand on our Therapist's time, it has become necessary for our office to discourage late or no-show appointments. When a patient does not keep their appointment time or does not cancel, it inhibits us from offering our services to another individual.

We request that should you be unable to keep your appointment, please notify us **at least 1 hour** prior to the appointment time to avoid a **$25 service fee**. You and not your insurance company will owe this amount. If you arrive more than 10 minutes late, your therapy session will be forfeited and the **$25 service fee** will apply.

We appreciate your attention to this matter.

If you have any questions or concerns regarding this issue, please contact one of our staff at **(972) 596-1611.**

Respectfully,

Adams Health Center

I, _____, (patient's name) acknowledge that I have read and was given a copy of the Missed Appointment with LMT Agreement for Adams Health Centers, PC and fully understand the same and have all my questions answered to my satisfaction.

_____ _____
Patient's Signature Date

_____ _____
Signature of Compliance Officer Date