LONGEVITY MEDICAL

128 West McCart / Krum, TX 76249 / (940) 482-3599 Phone / (940) 482-1775 Fax

Dear New Patient,

We have enclosed your new patient paperwork with this letter. Please complete the forms in their entirety. We will need all paperwork returned at least 2 business days prior to your appointment. The paperwork may be returned in person, by e-mail to longevitykrumtx@gmail.com or faxed to (940) 482-1775.

On the day of your appointment, please bring with you:

- Your insurance cards and photo identification (preferably driver's license).
- Any prescription medicines you are taking (in the original packaging).
- If you use a mail-in prescription service, bring your drug formulary list that shows which medicines they pay for.
- Any over-the-counter supplements.

Thank you for choosing Longevity Medical. We look forward to meeting you. If you have any questions, please let us know at (940) 482-3599.

Sincerely,

Longevity Medical Staff

Longevity Medical

128 West McCart, Krum, TX 76249
(940) 482-3599 / Fax # (940) 482-1775

STAFF USE ONLY:

PATIENT #

Patient Information

Date: Patient Name:
Address: City/St: Zip:
SS#/SIN: Date of Birth: Male Female
Driver's License#: Cell Phone: Home Phone:
Email Address:
Check appropriate box: Minor Single Married Divorced/Separated Widowed
If Married, Spouse's Name:
If Patient is a student, name of School/College: City/St:
Person to contact in case of emergency: Phone:
In case of a medical emergency, if the patient is of school age 15+, it is ok to treat in my absence: YES NO
Whom may we thank for referring you?

Employer Information

Patient's Employer: Work Phone:
Employer Address: City/St: Zip:

Spouse's Employer: Work Phone:
Spouse's Employer Address: City/St: Zip:

Parent/Guardian's Name: Phone:
Parent/Guardian's Employer:
Employer Address: City/St: Zip:

Responsible Party Information

Name of the person responsible for this account:
Relationship to patient:
Address: City/St: Zip:
Home Phone: Cell Phone:
Email Address:
Driver's License#: Date of Birth:

Insurance Information

Do you have Medical Insurance? No Yes (if yes, complete the following)
Name of the Insured Policyholder:
Relationship to patient: Date of Birth: SS#/SIN:
Address: City/St: Zip:
Home Phone: Cell Phone:
Email Address:
Name of Employer: Work Phone:
Address of Employer: City/St: Zip:
Insurance Company: Group# Union or Local#
Insurance Company Phone Number:
Secondary Insurance Company Name: Group#
Secondary Insurance Company Phone Number:

(Rev. 9/28/2018 10:31 AM)

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 **Longevity 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 service, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20_____.

_____
Signature of Patient

_____
Printed Name of Patient

_____
Signature of Guardian (if applicable)

Longevity Medical

HEALTH HISTORY QUESTIONNAIRE

PATIENT NAME:	☐ M ☐ F	DOB:

Chief Complaint:

History of Present Illness:

Location:	**Quality:**
(Where is the pain/problem?)	(Example: normal vs abnormal color, activity, etc.)
Severity:	**Duration:**
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)	(How long have you had this pain/problem? When did it start?)
Timing:	**Context:**
(Does the pain/problem occur at a specific time?)	(Where were you at the onset of this pain/problem?)
Associated Signs/Symptoms:	**Modifying Factors:**
(What other associated problems have you been having?)	(What makes the pain worse or better? Have you had previous episodes?)

PAST MEDICAL HISTORY

Check if you have, or have had, any of the following: (Leave blank if you are uncertain.)

☐ Measles	☐ Anemia	☐ Back Trouble
☐ Mumps	☐ Bladder Infection	☐ High Blood Pressure
☐ Chicken Pox	☐ Epilepsy	☐ Low Blood Pressure
☐ Whooping Cough	☐ Migraine Headaches	☐ Hemorrhoids
☐ Scarlet Fever	☐ Tuberculosis	☐ Asthma
☐ Diphtheria	☐ Diabetes	☐ Hives of Eczema
☐ Small Pox	☐ Cancer	☐ AIDS & HIV
☐ Pneumonia	☐ Polio	☐ Infectious Mono
☐ Rheumatic Fever	☐ Glaucoma	☐ Date of Last Chest X-ray:
☐ Arthritis	☐ Hernia	☐ Other pain/discomfort or disease:
☐ Venereal Disease	☐ Blood or Plasma Transfusion	
☐ Bronchitis	☐ Mitral Valve Prolapse	
☐ Stroke	☐ Hepatitis	
☐ Ulcer	☐ Kidney Disease	
☐ Thyroid Disease	☐ Bleeding Tendency	

List any medical problems that other doctors have diagnosed or surgeries you have had in the past

Description	Year	Hospital, City, State

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Have you ever taken Fen-Phen/Redux? Yes No		
Are you taking any medications (prescription or over-the-counter) for acid indigestion? Yes No		

Allergies to medications	
Name the Drug	Reaction You Had

PATIENT SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Marital Status	Single		
	Married		
	Separated		
	Divorced		
	Widowed		
Use of Alcohol	Never		
	Rarely		
	Moderate		
	Daily		
Use of Tobacco	Never		
	Rarely		
	Moderate		
	Daily		
Drugs	Do you currently use recreational or street drugs?	Yes	No
	If so, type and frequency?		
Excessive exposure at home or at work to:	Fumes?	Yes	No
	Dust?	Yes	No
	Solvents?	Yes	No
	Airborne Particles?	Yes	No
	Noise?	Yes	No

FAMILY MEDICAL HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS OR CAUSE OF DEATH, IF DECEASED		AGE	SIGNIFICANT HEALTH PROBLEMS OR CAUSE OF DEATH, IF DECEASED
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

RECENT MEDICAL CONDITIONS

Check the box to indicate which of the below you have experienced in the last 1-2 months.

Eyes / Ears / Nose / Throat / Respiratory	Never	Rarely	Occasionally	Frequently	Constantly
Asthma					
Stuffy Nose					
Hay Fever					
Sore Throat					
Chronic Cough					
Chest Congestion					
Frequent Sneezing					
Itchy/Watery Eyes					
Drainage					
Ear ache or Ear Infections					
Itching					
Hoarseness					
Shortness of Breath					
Wheezing					

Neurological	Never	Rarely	Occasionally	Frequently	Constantly
Headaches					
Migraines					
Dizziness					
Numbness					
Tingling					
Pins/Needles in hands or feet					

Muscular/Skeletal	Never	Rarely	Occasionally	Frequently	Constantly
Muscle Aches					
Fibromyalgia					
Arthritis					
Joint Pain					
Low Back Pain					
Neck Pain					
Wrist/Hand Pain					
Elbow Pain					
Shoulder Pain					
Hip Pain					
Knee Pain					
Ankle/Foot Pain					
Pain between shoulder blades					

General	Never	Rarely	Occasionally	Frequently	Constantly
Fatigue					
Malaise					
Weakness, tiredness					
Lightheadedness					
Irritability					
Constipation					
Diarrhea					
Feeling foggy					
Forgetfulness					

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

_____ _____

Signature of Doctor Date

NOTICE OF PRIVACY PRACTICES

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

USES AND DISCLOSURES OF HEALTH INFORMATION

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

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

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. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

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 or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, emails, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

_____ _____

Signature of Patient or Parent or Legal Guardian Date

I,_____, acknowledge that

(Printed Name of Patient)

I have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive and I consent to the use and disclosure of my personal health information by your office for treatment, Billing / Payment and Healthcare Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

LONGEVITY MEDICAL

128 W. McCart, Krum, TX 76249
(940) 482-3599 / Fax (940) 482-1775
Adrian Jones, FNP

AUTHORIZATION TO DISCLOSE INFORMATION

I, _____, hereby authorize the release of information as indicated.

1. _____ Initial to Select

I authorize disclosure of health care information (related to my medical history, diagnosis, treatment or prognosis) to all inquiries or only to the following people or entities (for example: family, friends, employer, insurance companies, clergy, etc.)

List Names: _____

_____

_____

2. _____ Initial to Select

I wish to limit disclosure of only certain kinds of health care information (related to my medical history, diagnosis, treatment or prognosis) to the following people or entities:

List Names	List information which may be released
_____	_____
_____	_____
_____	_____

3. _____ Initial to Select

I DO NOT authorize release of information regarding my healthcare, diagnosis, prognosis, and/or treatment. I wish to be a "no information" patient, and I realize that nobody will be allowed to obtain any information relating to my medical history, diagnosis, treatment, and/or prognosis.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Signature of witness Date

LONGEVITY MEDICAL

128 West McCart / Krum, TX 76249 / (940) 482-3599 Phone / (940) 482-1755 Fax

PRACTICE POLICIES AND GUIDELINES AGREEMENT

Welcome! We are so glad that you have decided to become a part of our practice. Our goal is to provide you with excellent healthcare in a friendly and compassionate environment. Please take a moment to become familiar with our office's policies and guidelines, then sign the acknowledgement at the bottom of this page and return it to our office. Thank you for your cooperation.

First Time Visit: Please arrive at least 10 – 15 minutes prior to your appointment time. A nurse will go over your past medical history. Please bring all your medications, in their original containers. If you have a co-pay or have not yet met your deductible, or if you are a self-pay patient, payment will be collected after you see the doctor. Payment is due at the time of service.

Late Arrivals: We all run late sometimes. In the event that you are late for your appointment, we will try our best to work you back in to the schedule. Depending on how busy we are, you may be required to reschedule your appointment.

Appointment Cancellations: We understand that sometimes plans change. We ask that you reschedule appointments *at least* 24 hours in advance so that we may give that time to someone else. Although unexpected events may necessitate missing an appointment, if you miss 2 appointments without following the cancellation protocol then you will be charged $20.00 at your next visit.

No Show Appointments: Our scheduling software automatically sends out reminders for appointment with phone calls and emails. Failing to not call or not arrive for your appointment makes it difficult for us to fill that time slot with patients that want to come in. If you fail to call and cancel your appointment or reschedule to another time you will be charged $25.00, due at your next visit. If you fail to contact us after 3 appointments without following the cancellation protocol, you will be required to pay for next visit prior to scheduling.

As a courtesy, please turn off or silence your cell phone during your office visit.

I have read and understand the above office policies and agree to abide by them.

_____ _____

Signature Date

LONGEVITY MEDICAL

PRESCRIPTION REFILL POLICY

In order to provide outstanding quality care Longevity Urgent Care, PLLC adheres to a strict prescription refill policy. Medication refills are best addressed at the time of your visit with our provider. This allows you to update the provider on any changes in your medication or advise him of any new or ongoing symptoms. We understand, however, that sometimes this is not possible, and, in those situations, it will be necessary to follow our refill policy.

Please call your pharmacy for all prescription refills. Most pharmacies will contact our office regarding renewal of medications. Should your pharmacy decline renewal; your pharmacist will instruct you regarding the next steps to take.

In order to effectively process your prescription refill request, we will need the following information:

1. Your name - spell your first and last name
2. Your date of birth
3. Spell the name of the medication(s) to be refilled
4. The name and location of your pharmacy
5. Area code and telephone number where we can reach you

The following guidelines will be followed when processing your refill request:

- There will be no refills given on Fridays, weekends, or Holidays
- A process time of **7 days minimum will be needed for all requests**
- There will be no early refills. Patient must follow prescription directions. Prescription phone-in/ pickup must be done Monday-Thursday during business hours ONLY (9 am – 4:30 pm)
- Non-controlled/non-narcotic prescriptions will require a follow-up appointment every 3 months.
- Controlled substances/narcotic prescriptions will require a follow-up appointment every 30 days.
- New symptoms and/or events require an appointment.
- No refills will be given for prescriptions not initiated by Longevity Medical.
- Signed "Prescription Refill Policy" required if using narcotic/controlled medications.

Please enter the name and phone number of your preferred pharmacy:

Name: _____

Phone#: _____ **Fax#:** _____

Address: _____

By signing below, I agree that I understand and accept the policy listed above. Failure to comply may subject immediate termination of prescriptive medications.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Please make sure you filled out your pharmacy's information above.

LONGEVITY MEDICAL

128 West McCart / Krum, TX 76249 / (940) 482-3599 Phone / (940) 482-1755 Fax

FINANCIAL POLICY

A) NO INSURANCE
If you do not have health insurance, payment by cash, check or credit card is required at the time of service.

B) BILLING HEALTH INSURANCE
1. If you have health insurance, we will file the claims for you if:
   a. You allow us to photocopy your insurance card and driver's license
   b. You have completed and signed patient's information forms
2. You will need to pay your co-pay or co-insurance at the time of services.
3. If your insurance company reduces coverage or charges more, you are responsible for the remaining amount, after insurance payment is credited to your account. You are responsible for payment of all "non-covered" services as indicated by your insurance company. If your insurance pays only a part of the bill, you are responsible for the remainder.

C) MEDICARE
1. We are a Medicare participating physician. We accept assignment on Medicare claims filed.
2. You are responsible for your annual deductible (currently $183.00). You must pay the first $183.00 of allowable charges for the current year.
3. Medicare will pay our office 80% of the "allowable" charge. (An "allowable charge" is the charge set by Medicare). By Law, Medicare rules say that we must collect 20% co-insurance from our Medicare patients.
4. Since Medicare pays 100% of the allowable charges on laboratory work, all blood tests are "free" to Medicare patients.

D) STATEMENTS
You will receive a statement once a month on outstanding balances. Payment is due within two weeks after receiving a statement. It is your responsibility to notify us if your address changes.

E) DELINQUENT ACCOUNTS
We will turn delinquent accounts over to an independent collection agency. We want to work with you to avoid this last effort to clear your account, so please notify our office of any changes of address or employment. Your best protection is to pay your co-pay and to pay for non-covered services at each visit so that you are never faced with an accumulation of multiple visits.

F) WORKER'S COMPENSATION
We do not accept worker's compensation.

If you have any questions, problems or changes, please notify us. We are here to help you.

I have read and understand the above financial policies and agree to abide by them.

_____ _____
Signature Date

(Rev. 9/28/2018 5:38 PM)

LONGEVITY MEDICAL

128 West McCart / Krum, TX 76249 / (940) 482-3599 Phone / (940) 482-1755 Fax

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here._____, Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE	(Date)	
(Or Patient Representative)		(Indicate relationship if signing for patient)
OFFICE SIGNATURE	(Date)	

LONGEVITY MEDICAL

128 West McCart / Krum, TX 76249 / (940) 482-3599 Phone / (940) 482-1755 Fax

INFORMED CONSENT TO TREAT WITH MANIPULATION

I hereby request and consent to the performance of manipulation and other procedures that may include various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the provider indicated below and/or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the provider named below and/or with other office or clinic personnel the nature and purpose of manipulation and physical therapy procedures. I understand that the results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further am informed that in the practice of medicine there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocation and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand but there are treatment options available for my condition other than manipulation and physical therapy. These treatment options include, but are not limited to, self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain killers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had the 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) for which I seek treatment.

Longevity Medical, LUC LLC
Provider

_____ _____
Patient or Guardian's Signature Date

(Rev. 9/28/2018 5:41 PM)