14 Mica Lane, Suite 104 | Wellesley Hills, MA 02481 | 781.772.2032

Insurance Coverage Information

DATE: _____
NAME: _____ Phone: (c) _____
(h) _____
Address: _____ Email: _____
City: _____ State: _____ Zip: _____

I authorize direct payment of insurance benefits to Dr. Timothy Morgan of Morgan Therapeutics. I further understand that I am otherwise responsible for charges whether or not covered by insurance.

X*Patient/Guardian Signature:* _____ *Date:* ___/___/____

****

Primary Health Insurance: _____ Phone: _____
Patient ID#: _____ Group #: _____
Patient DOB: ___/___/___
Subscriber: _____ DOB: ___/___/___
Effective Date of Policy: ___/___/___
Is this insurance plan an HRA? (Health Reimbursement Account) Y / N

Secondary Health Insurance: _____ Phone: _____
Patient ID#: _____ Group #: _____
Patient DOB: ___/___/___
Subscriber: _____ DOB: ___/___/___
Effective Date of Policy: ___/___/___

****

For Office Use Only

Chiropractic Benefits

Benefit Limit: _____visits/yr ☐ calendar year ☐ plan year : ____/___/____
$_____/year to ___/___/____
Policy Effective Date: ___/___/____
Policy Deductible: Individual: $ _____/yr Family: $ _____/yr
Deductible Met to Date Individual: $ _____/yr Family: $ _____/yr
Co-Payment: $ _____ Co-Ins: _____%

Referral? Y / N Pre-Authorization? Y / N

I have been informed and understand the above noted Chiropractic Benefits.
X*Patient/Guardian Signature:* _____ *Date:* ___/___/____

Patient Health Questionnaire

MORGAN THERAPEUTICS

Patient Name _____ ***Date*** _____

When did your symptoms start:_____

Describe your symptoms and how they began: _____

_____

_____

How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

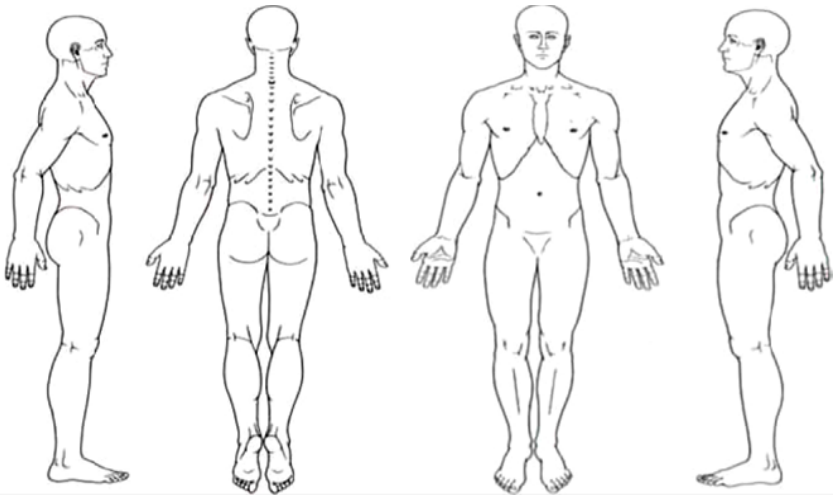
What describes the nature of your symptoms?

① Sharp ④ Shooting _____
② Dull Ache ⑤ Burning _____
③ Numb ⑥ Tingling _____

How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

Indicate where you have pain or other symptoms



How bad are your symptoms at their:

	None										*Unbearable*
a. worst	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No Complaints		*Mild, forgotten w/ activity*		*Moderate, Interferes w/ activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

What activities make your symptoms worse: _____

What activities make your symptoms better: _____

Who have you seen for your systems?

① No One ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

① X-Rays date:_____ ③ CT Scan date:_____
② MRI date:_____ ④ Other date:_____

MORGAN THERAPEUTICS

Patient Health Questionnaire - page 2

Patient Name _____ ***Date*** _____

Have you had similar symptoms in the past? ① Yes ② No

If you have received treatment in the past for this same or similar symptoms, who did you see?

① This Office (approximate date): _____
② Other Chiropractor : _____
③ Medical Doctor : _____
④ Physical Therapist : _____
⑤ Other : _____

Tell us about your past and present health history. For each of the conditions listed below, place a mark in the 'Past' column if you have had the condition in the past. If you are presently experiencing the condition, place a mark in the 'Present' column.

Past	Present		Past	Present		Past	Present	
○	○	*headaches*	○	○	*general fatigue*	○	○	*abnormal weight gain/loss*
○	○	*neck pain*	○	○	*muscular incoordination*	○	○	*loss of appetite*
○	○	*upper/mid back pain*	○	○	*visual disturbances*	○	○	*abdominal pain*
○	○	*lower back pain*	○	○	*dizziness*	○	○	*ulcer*
○	○	*shoulder pain*				○	○	*hepatitis*
○	○	*arm pain*	○	○	*high blood pressure*	○	○	*liver/gallbladder disorder*
○	○	*wrist/hand pain*	○	○	*heart attack*	○	○	*cancer* _____
○	○	*hip/thigh pain*	○	○	*chest pains*	○	○	*benign tumor* _____
○	○	*knee/lower leg pain*	○	○	*stroke*	○	○	*asthma*
○	○	*ankle/foot pain*	○	○	*kidney disorders/stones*	○	○	*chronic sinus issues*
○	○	*jaw pain*	○	○	*bladder infection*	○	○	*diabetes*
○	○	*joint swelling stiffness*	○	○	*painful urination*	○	○	*excessive thirst*
○	○	*arthritis*	○	○	*loss of bladder control*	○	○	*frequent urination*
○	○	*rheumatoid arthritis*	○	○	*prostate problems*	○	○	*allergies* _____
○	○	*depression/anxiety*	○	○	*autoimmune disorder*	○	○	*communicable disease* _____

MORGAN THERAPEUTICS

Patient Health Questionnaire – lifestyle & activity

What is your occupation? ① Professional/Executive ③ Tradesperson ⑤ Homemaker ⑦ Retired
② White Collar/Secretarial ④ Laborer ⑥ FT Student ⑧ Other

Occupation: _____

What is your height & weight?

Height ☐☐☐ ***Weight*** ☐☐☐ ***lbs.***

feet ***inches***

What is your current level of Physical Activity? (<u>in addition</u> to your normal activities of daily living)

○ At least 30 min of moderate intensity aerobic activity (i.e. brisk walk), at least 5 days per week for a total of 150 min (in bouts of at least 10 min) Type of Activity(ies): _____

○ At least 25 min of vigorous aerobic activity (i.e. jogging) at least 3 days per week for a total of 75 min; or a combination of moderate & vigorous intensity aerobic activity (i.e. combination of activities such as brisk walking & jogging)
Type of Activity(ies): _____

○ Moderate to high intensity muscle strengthening activity (8-10 exercises) at least 2 days per week (i.e. weight training, weight bearing calisthenics, stair climbing) Type of Activity(ies): _____

_____

Do you smoke or use smokeless tobacco products? ○ ***Yes*** ○ ***No***

Do you have drug or alcohol dependence? ○ ***Yes*** ○ ***No***

If yes, explain: _____

OTC/Rx Medications/Supplements: _____

_____

List all surgical procedures and major injuries not addressed above: _____

_____

_____ _____

Patient Signature ***Date***

Informed Consent - Authorization to Receive Care

The receipt of informed consent is required of all health care providers prior to initiating anyu medical procedure, treatment or therapy program. The purpose of which is to help the patient make an informed decision as to available treatment options and to ensure that the patient is informed of the inherent risks and benefits of the proposed treatment.

In your case, treatment options include the therapy program proposed by Dr. Morgan, your right to seek the advice and/or treatment of another provider (such as our PCP or other licensed health care providers) and also your choice for no treatment at all.

As with all the medical disciplines, chiropractic care also has potential risks that you as a patient have the right to be informed of. you have the right to ask your provider directly and at any time any question you may have regarding the safety profile of any procedure or treatment provided or recommended by this office.

Generally speaking, chiropractic care has an excellent safety profile. In comparing the risks of chiropractic treatment to the risks of traditional medicine's use of drugs and surgical procedures for treating similar conditions, the risk of serious injury is much less with chiropractic care. This is not stating that traditional medicine is unsafe or may not be a viable option in some cases, but rather is offered to put into perspective the relative safety of chiropractic care. The overall safety porfile for chiropractic is probably more similar to that of traditional physical therapy.

With this perspective in mind, please consider the following possible adverse side effects.

Minor side effects: As with most manual therapies such as massage therapy or physical therapy, chiropractic treatment could possibly irritate the area being treated. These minor side effects are usually mild and may include: Localized stiffness and/or soreness of the muscles and soft tissues being treated. Skin irritation could possibly occur from lotions or therapies such as massage, ice packs, muscle stimulation. These symptoms are self limiting and may last a few hours or possibly a few days.

Moderate very iinfrequent side effects: It is fairly rare that the manual therapies such as massage therapy, physical therapy and chiropractic therapy cause injury which could include strained muscles, sprain of ligaments or cartilage, nerve irritation, and bruising or minor injury of the soft tissues (such as skin or fatty tissue).

Extremely rare adverse effects: As the manual therapies including chiropractic care have such a good safety profile, serious adverse side effects are extremely rare. Extremely rare adverse effects could include fracture or dislocation of bone or injury to blood vessels. Because the incidents are so rare, the statistics regarding the incidence of major neurological complications due to cerebrovascular injury or CVA resulting from manual therapy is not conclusive and more information is needed to further define the actual frequency. The existing studies and literature suggests the incidence of CVA following manual cervical manipulation as provided by physical therapists, doctors of osteopathy and doctors of chiropractic collectively to be somewhere around 1 in 4 million. This is more than 100 times safer than the regular use of NSAIDS such as Ibuprofen/Advil/Motrin or Naproxen/Aleve.

Pre-existing conditions such as osteoporosis, artery weakening diseases, high blood pressure, cancer, smoking, hormone therapy, steroid use, some medications and previous injury may put some individuals at a higher risk than others. For this reason it is important that you share with all your providers your detailed medical history. For your safety, Dr. Morgan routinely performs screening procedures which may help identify pre-existing complicating factors.

Authorization:
I have read and understand the preceding informed consent document. I also understand that particular results of theerapy cannot be guaranteed. I hereby give my consent to receive care at Morgan Therapeutics.

Signature: _____ Date: _____

MORGAN
THERAPEUTICS

Consent for Chiropractic Treatment of a Minor Child

I _____, the Mother/Father/Legal Guardian of

(Name of Minor) _____
Date of Birth: _____

consent to the rendering of care, including examination, diagnostic procedures, and treatment given by Dr. Timothy Morgan of Morgan Therapeutics.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

I have read this form and certify that I understand its contents. This consent may be rescinded in writing at any time.

Signature: _____

Date: _____

Mother/Father/Legal Guardian

Witness: _____

Date: _____

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AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

As a patient of Morgan Therapeutics, you have the right to know how we may use and disclose information about you. Information about our disclosure is provided in our 'Notice of Privacy Practices for Protected Health Information', and a copy of this notice has been made available to you. You have the right to review our notice before signing this form and should read our notice carefully before signing this form. As our notice of Privacy Practices explains, we need your authorization to use or disclose information about you for any purpose other than treatment, payment, or normal healthcare operations. This document provides your authorization.

1. I authorize the use and disclosure of my protected health information for the following purpose(s):

- ☐ For contacting and/or communicating with any of my health care providers. I understand communication may take the form of mailed documents, paper or electronic, phone calls/messages, or in person communications
- ☐ For the purpose of communicating with my health, auto or work insurance company, or any other party responsible for the reimbursement of my health care expenses at Morgan Therapeutics
- ☐ For the sake of business purposes, as conducted by Morgan Therapeutics, to communicate with me regarding my health information, scheduling or billing matters, or any such matter that normally arises during the course of business.

2. With my signature below, I acknowledge that the Morgan Therapeutics ***Notice of Privacy Practice for Protected Health Information*** has been made available to me. Furthermore, I hereby authorize the use and disclosure of my protected health information that may pertain to any healthcare I have received to date, in keeping with the aforementioned ***Notice of Privacy Practice for Protected Health Information.***

Printed Name of Patient: _____

Signature of Patient (or Legally Authorized Representative): _____

Date: _____

Authority of Legally Authorized Representative:_____

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CANCELLATION / NO-SHOW / RE-SCHEDULING POLICY

In order to provide the most effective, thorough healthcare, it is Dr. Morgan's scheduling practice to commit a large block of time per individual appointment. For this reason, Morgan Therapeutics asks for your respect when cancelling or rescheduling appointments. Specifically, **Morgan Therapeutics requires a 24 hour notice on all cancellations and/or re-scheduled appointments**.

The following cancellation/re-scheduling policies apply:

Cancellation/re-schedule 24+ hrs prior to scheduled appointment**……..no fee, thank you

Cancellation/re-schedule 4-24 hours prior to scheduled appointment*……..$30 fee

Cancellation/re-schedule <4 hours prior to scheduled appointment*.....……..$60 fee

No-show (failure to attend a scheduled appointment without having……..…$60 fee
previously communicated with Morgan Therapeutics
re: re-scheduling or cancellation)

****

***NOTE:** Morgan Therapeutics will attempt to accommodate any and all changes in appointment times on short notice to avoid a fee being assessed to our patients. This cannot always be accomplished due to scheduling availability. If a mutually agreeable appointment time cannot be arranged for the same day, the above noted fees will apply.

****NOTE:** Changes to the schedule (cancellations or re-scheduling) must be made by either direct contact with Morgan Therapeutics or by way of ***confirmed*** text or voicemail. The time of contact will determine extent of fee, if applicable.

I, _____, have been informed of, and accept the above sated agree to Morgan Therapeutics cancellaion/No-show policy.

Patient/Guardian Signature: _____ Date: ___/___/_____