HEAD PAIN INSTITUTE

Patient Information and Health Questionnaire

Please print clearly and complete every section that applies to you.

PATIENT INFORMATION

TODAY'S DATE	TITLE	SEX	MARITAL STATUS
	☐ Mr. ☐ Ms. ☐ Miss ☐ Mrs. ☐ Dr.	☐ Male ☐ Female	☐ Single ☐ Married

FIRST NAME	MIDDLE INITIAL	LAST NAME	AGE

DATE OF BIRTH	SOCIAL SECURITY #	DRIVER'S LICENSE # / STATE	COPY OF DRIVER'S LICENSE*
			☐ Provided

CONTACT INFORMATION

STREET ADDRESS	CITY / STATE / ZIP

CELL PHONE	HOME PHONE	WORK PHONE

EMAIL	EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE #

VISIT INFORMATION

REFERRED BY

☐ DDS ☐ MD ☐ ENT ☐ DC ☐ Other: _____

REASON FOR THIS APPOINTMENT

☐ Face Pain ☐ Jaw Pain ☐ Headaches ☐ Fatigue/Breathing Concerns ☐ Other: _____

EMPLOYMENT INFORMATION

EMPLOYER NAME	JOB TITLE	EMPLOYER PHONE

EMPLOYER ADDRESS	CITY / STATE / ZIP

PAYMENT AND INSURANCE INFORMATION

PAYMENT TYPE

☐ Insurance ☐ Self Pay ☐ Auto ☐ Workers' Compensation

HEALTH INSURANCE NAME	POLICY / GROUP #	COPY OF INSURANCE CARD*
		☐ Provided

PRIMARY INSURED NAME	PRIMARY INSURED DATE OF BIRTH

RELATIONSHIP TO PRIMARY INSURED

☐ Self ☐ Spouse ☐ Child ☐ Other: _____

**Collected in accordance with the Federal Trade Commission's Red Flag regulations to protect your medical record and identity.*

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CHIEF COMPLAINTS

What are the three chief complaints for which you are seeking treatment? Check only your three main complaints, then rate the intensity of each on a scale of 0 to 10 (0 = none, 10 = worst).

Complaint	Rating (0 to 10)	Complaint	Rating (0 to 10)
☐ Jaw Pain		☐ Ear Pain	
☐ Headache Pain		☐ Pain when chewing	
☐ Facial Pain		☐ Eye Pain	
☐ Throat Pain		☐ Neck Pain	
☐ Tooth grinding		☐ Limited ability to open mouth	
☐ Jaw Joint Locking		☐ Jaw Joint Noises	
☐ Dizziness		☐ Tinnitus (ringing in the ears)	
☐ Kicking and jerking leg repeatedly		☐ Dry Mouth when waking	
☐ Fatigue		☐ Difficulty falling asleep	
☐ Repeated awakening		☐ Feeling unrefreshed in the morning	
☐ Significant daytime drowsiness		☐ Frequent heavy snoring	
☐ Told that "I stop breathing" during sleep		☐ Unable to tolerate CPAP	

YOUR MEDICAL STORY

When did your condition first occur? _____

What do you believe is the cause of your pain or condition? (Select one)

☐ Auto Accident ☐ Motorcycle Accident ☐ Work Related Accident ☐ Athletic Endeavor ☐ Fight

☐ Fall ☐ Accident ☐ Illness ☐ Injury ☐ Unknown

☐ Other: _____

Is there anything that makes your pain or discomfort worse? Please describe.

_____

_____

Is there anything that makes your pain or discomfort better? Please describe.

_____

_____

What other information is important to understanding your pain or condition? Please describe.

_____

_____

ALLERGIC REACTIONS

List all medications, and check or list all substances, that have caused an allergic reaction.

☐ Anesthetics ☐ Iodine ☐ Latex ☐ Metals

☐ Other: _____ ☐ Other: _____

☐ Other: _____ ☐ Other: _____

CURRENT MEDICATIONS

☐ Patient medication list attached

List all medications you are taking and the reason you take each one. Include all over the counter medications, vitamins, herbs, and supplements.

Medication	Dosage	Reason for Taking

PREVIOUS TREATMENTS AND MEDICATIONS *for the condition we are evaluating*

Treatment and/or Medication	Doctor/Provider Name	Approximate Date of Treatment

HEALTH AND MEDICAL HISTORY

Have you ever had orthodontic treatment? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

Surgical History

Have you had your wisdom teeth removed? ☐ Yes ☐ No

Have you ever had a root canal or any other tooth removal for this condition? ☐ Yes ☐ No

Have you ever had jaw joint surgery? ☐ Yes ☐ No

Have you ever had orthognathic surgery? ☐ Yes ☐ No

Any other types of surgery? _____

_____

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MEDICAL HISTORY

Check all that apply and leave the others blank. If a condition is not listed, please write it in the "Other History Items Not Listed" box.

Allergy History
- ☐ Allergy Skin Testing
- ☐ Allergen Desensitization
- ☐ Hay Fever

ENT History
- ☐ Adenoidectomy
- ☐ Tonsillectomy
- ☐ Turbinectomy

Cancer History
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation Therapy

Eye History
- ☐ Cataract
- ☐ Visual Impairment
- ☐ Glaucoma

Pulmonary History
- ☐ Asthma
- ☐ COPD
- ☐ Bronchitis

Infectious Disease
- ☐ Measles
- ☐ Chicken Pox
- ☐ Smallpox
- ☐ Diphtheria

Cardiac History
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Rhythm Disorder
- ☐ Functional Murmur
- ☐ Mitral Valve Prolapse
- ☐ Angina Pectoris
- ☐ Prior MI
- ☐ Coronary Artery Disease
- ☐ Peripheral Vascular Disease
- ☐ Hypertension

Gastrointestinal History
- ☐ Hepatitis
- ☐ Acute Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Esophageal Reflux
- ☐ Esophageal Ulcer
- ☐ Peptic Ulcer
- ☐ Chronic Reflux Esophagitis
- ☐ Esophagitis
- ☐ Esophageal Stricture
- ☐ Hiatal Hernia

Trauma
- ☐ Facial Injury
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Mouth Injury

Hematological History
- ☐ Anemia
- ☐ Bleeding/Clotting
- ☐ Leukemia
- ☐ HIV

Kidney/Bladder History
- ☐ Prostate Disorders
- ☐ Renal Failure
- ☐ Stress Incontinence
- ☐ Urinary or Bladder Infections
- ☐ Kidney Stones
- ☐ Urinary Calculus

Neurological History
- ☐ Epilepsy
- ☐ TIA
- ☐ Stroke Syndrome
- ☐ Multiple Sclerosis
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ ADHD
- ☐ Migraine Headaches
- ☐ Vascular Headaches

Musculoskeletal History
- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Fibromyalgia

Endocrine History
- ☐ Diabetes Mellitus
- ☐ Thyroid Disorders
- ☐ Chronic Fatigue

Other History Items Not Listed

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CURRENT SYMPTOMS

Check all that apply and leave the others blank.

Systemic Symptoms
- ☐ Feeling tired or poorly
- ☐ Weight change
- ☐ Chills
- ☐ Fever

Otolaryngeal Symptoms
- ☐ Mouth sores
- ☐ Difficulty swallowing (dysphagia)
- ☐ Difficulty chewing
- ☐ Dentures currently being worn
- ☐ Dentures improperly fitting

Head Symptoms
- ☐ Headache
- ☐ Facial pain
- ☐ Sinus pain
- ☐ Tooth pain

Musculoskeletal Symptoms
- ☐ Joint pain, localized in the jaw joint
- ☐ Diffuse joint pains (arthralgias)
- ☐ Joint pain, localized
- ☐ Joint swelling, localized
- ☐ Muscle aches
- ☐ Muscle cramps
- ☐ Legs feel restless
- ☐ Other

Neurological Symptoms
- ☐ Dizziness
- ☐ Vertigo
- ☐ Fainting (syncope)
- ☐ Motor disturbances
- ☐ Sensory disturbances
- ☐ Decreased concentrating ability

Neck Symptoms
- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Lump or swelling

Gastrointestinal Symptoms
- ☐ Appetite
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Regurgitation
- ☐ Yellow skin/eyes (jaundice)
- ☐ Inability to pass gas
- ☐ Bowel movement frequency
- ☐ Diarrhea
- ☐ Unable to control passing gas
- ☐ Constipation
- ☐ Rectal pain

Cardiovascular Symptoms
- ☐ Chest pain or discomfort
- ☐ Palpitations
- ☐ Slow heart rate
- ☐ Leg pain with exercise
- ☐ Cold hands/feet

Endocrine Symptoms
- ☐ Temperature intolerance
- ☐ Excessive sweating
- ☐ Hot flashes
- ☐ Muscle weakness
- ☐ Sexual complaints
- ☐ Changes in body proportion
- ☐ Hair symptoms

Psychological Symptoms
- ☐ Mood
- ☐ Energy level
- ☐ Behavior
- ☐ Sleep disturbances
- ☐ Neurological symptoms

Skin Symptoms
- ☐ Pruritus
- ☐ Skin lesions
- ☐ Rashes

Other Symptoms Not Listed

_____

HEAD PAIN INSTITUTE

HEAD PAIN

If you have different levels of headaches, answer for your worst headache rather than a daily tension type headache.

Location	Side			Recent	Chronic	Severity			Duration			Frequency		
	L	R	B		Over 6 months	Mild	Moderate	Severe	Minutes	Hours	Days	Occasional	Frequent	Constant
Frontal (Forehead)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Generalized	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Parietal (Top of Head)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Occipital (Back of Head)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Temporal (Temple Area)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Side: L = Left, R = Right, B = Both

JAW, EYE, EAR, MOUTH, AND SLEEP CONDITIONS

Please check the appropriate boxes, if applicable. L = Left, R = Right.

Jaw Pain

☐ L ☐ R Jaw pain when opening
☐ L ☐ R Jaw pain when chewing
☐ L ☐ R Jaw pain at rest

Jaw Joint Sounds (clicking, crunching, popping)

☐ L ☐ R Jaw sounds when opening
☐ L ☐ R Jaw sounds when chewing
☐ L ☐ R Jaw sounds at rest

Jaw Locking

☐ Yes ☐ No Jaw locks closed
☐ Yes ☐ No Jaw locks open

Jaw Joint Symptoms

☐ Yes ☐ No Teeth clenching If yes: ☐ Day ☐ Night
☐ Yes ☐ No Teeth grinding If yes: ☐ Day ☐ Night

Eye Related Conditions

☐ Yes ☐ No Blurred vision
☐ Yes ☐ No Double vision
☐ Yes ☐ No Eye pain
☐ Yes ☐ No Pain or pressure behind the eyes
☐ Yes ☐ No Extreme sensitivity to light
☐ Yes ☐ No Wear glasses or contacts

Ear Related Conditions

☐ L ☐ R Buzzing in the ears
☐ L ☐ R Ear congestion
☐ L ☐ R Ear pain
☐ L ☐ R Hearing loss
☐ L ☐ R Itching or stuffiness in the ears
☐ L ☐ R Pain behind the ear
☐ L ☐ R Pain in front of the ear
☐ L ☐ R Recurrent ear infections
☐ L ☐ R Ringing in the ear (tinnitus)

Mouth and Nose Related Conditions

☐ Yes ☐ No Dry mouth
☐ Yes ☐ No Chronic sinusitis
☐ Yes ☐ No Frequent snoring
☐ Yes ☐ No Burning tongue
☐ Yes ☐ No Broken teeth
☐ Yes ☐ No Frequent biting of the cheek

HEAD PAIN INSTITUTE

Sleep Conditions

Answer based on your average sleep experience and/or what a sleep partner has told you.

Sleep position: ☐ Side ☐ Back ☐ Stomach ☐ Varies **Average hours of sleep per night:** _____

Is it easy to fall asleep?	☐ Yes	☐ No
Do you wake often during the night?	☐ Yes	☐ No
Do you feel rested when you wake in the morning?	☐ Yes	☐ No
Do you gasp or choke during sleep?	☐ Yes	☐ No
Have you stopped breathing during sleep?	☐ Yes	☐ No
Have you ever had a sleep study (PSG)?	☐ Yes	☐ No

If yes, the sleep study result was: _____

FAMILY AND SOCIAL HISTORY

Check all that apply.

Family History

☐ Diabetes Mellitus
☐ Loss of Hearing
☐ Stroke
☐ Asthma
☐ Coronary Artery Disease (CAD)
☐ Pulmonary Hypertension
☐ Migraine Headache
☐ Meniere's Disease
☐ Cancer
☐ Allergies
☐ Hypertension
☐ Heart Disease
☐ Congestive Heart Failure (CHF)
☐ Peripheral Vascular Disease (PVD)
☐ Cluster Headache
☐ Neurofibromatosis Type 1 (Recklinghausen's Disease)

Social History

☐ Life circumstance event
☐ Caffeine use
☐ Tobacco use
☐ Smoking cigarettes
☐ Alcohol
☐ Drug use
☐ Marijuana use
☐ Occupation: _____

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

By signing below, I authorize the release of all examination findings, diagnoses, reports, and treatment plans to any referring or treating health care provider. I also authorize the release of any medical information to insurance companies, or for legal documentation, as needed to process claims. I understand that I am responsible for all charges incurred for my treatment, regardless of insurance coverage.

_____ _____
Patient or Guardian Signature Date

_____
Printed Patient Name

HEAD PAIN INSTITUTE

Epworth Sleepiness Scale

Patient Name: _____ **Date:** _____

How likely are you to doze off or fall asleep in the following situations?

Check one box in each row.

Situation	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (for example, a theater)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
In a car while stopped for a few minutes in traffic	☐	☐	☐	☐
Total Score				

HEAD PAIN INSTITUTE

Health Care Practitioners and Communication

Please provide the names and addresses of all your doctors and health care providers.

Family Dentist

Provider Name: _____

Street Address/City/State: _____

☐ Orthodontist ☐ Oral Surgeon ☐ Endodontist

Provider Name: _____

Street Address/City/State: _____

Family Physician

Provider Name: _____

Street Address/City/State: _____

Specialty Providers

Specialty: _____

Provider Name: _____

Street Address/City/State: _____

Specialty: _____

Provider Name: _____

Street Address/City/State: _____

Specialty: _____

Provider Name: _____

Street Address/City/State: _____

By signing below, I give permission for Head Pain Institute to communicate with the health care providers named above regarding my treatment.

_____ _____

Patient or Guardian Signature Date

_____

Printed Patient Name

HEAD PAIN INSTITUTE

Consent for Care

I agree to be evaluated and treated at Head Pain Institute (hereinafter referred to as "the Practice") by a Practice provider as deemed medically appropriate. I acknowledge that no procedure will be performed without my first being given appropriate information about the treatment and its possible side effects or consequences. Signing this document indicates informed consent on my part, and in this regard, the Practice is released from harm. Although the provider and staff will make every effort to obtain my appropriate medical history and information, the Practice shall not be held responsible for any omission or negligence on my part.

I further acknowledge that the Practice is not functioning as my primary care or family physician. If issues arise that relate to my primary care or internal medicine, the Practice may refer them to my primary care physician. There may also be instances in which a Practice provider refers me for additional specialty care and evaluation as needed.

As my responsibility to the Practice, I agree to attend appointments and therapies as scheduled. Multiple missed appointments or inappropriate behavior may result in termination of services and referral to my physicians. Failing to cancel an appointment, or failing to show for an appointment, will be subject to a charge for that visit.

During my therapy, it may become necessary to discuss surgical treatment options if painful or restricted joint function continues. These may include arthroscopic or open TMJ surgery and/or jaw repositioning surgery. If necessary, a Practice provider will discuss these options with me thoroughly. Following initial appliance therapy, the doctor and I may need to make decisions about stabilizing or correcting my bite at the natural jaw position, as determined by my muscles. As my joints and muscles relax and heal, there will be changes in my bite (how my teeth come together). Once it is felt that I have reached my optimum level of improvement, adjusting my bite to my new jaw position may be recommended.

As part of my care, I may receive injections of various kinds. Usually, these are trigger point injections into the motor point of painful muscles; on occasion, a joint injection will be performed. I acknowledge that any injection can cause side effects, including allergic reactions, localized pain at the injection site, or pain along the referral pattern of the nerve or muscle injected. On rare occasions, more serious adverse events have been known to occur, such as fever, infection, muscle and bone atrophy, rash, anaphylaxis, pneumothorax, breathing difficulty, sudden changes in blood pressure, convulsions, and/or death.

If a procedure is going to be performed, it will be discussed further, and I am encouraged to ask questions. The Practice wishes to empower me to seek a higher level of health by getting involved and helping the care team understand me. Headache, TMJ disorders, and sleep apnea are chronic conditions that are managed, not cured; the Practice cannot guarantee that every patient’s condition will improve. On rare occasions, conditions and symptoms may worsen.

No intraoral dental exam will be performed. The Practice will not examine my teeth or oral cavity, even though the provider will look in my mouth for other issues, and will not take x-rays of my teeth. It is my responsibility to have a general dentist examine and maintain my oral health. If I do not have a general dentist, the Practice may be able to recommend one.

Imaging of the head and neck (CT or MRI) may be required and performed for diagnostic and treatment purposes. Ultrasound and ICAT units are available on the premises, or a referral to an imaging center will be made.

At random times and at the doctor’s discretion, I may be asked to provide a specimen for screening. This is intended to help understand what chemical factors are contributing to my symptoms. An inquiry to the State Pharmacy Board may also be made when indicated.

Patient or Guardian Signature

Date

Printed Patient Name

HEAD PAIN INSTITUTE

Financial Policy

General

Please be aware that your insurance company may not pay for all treatment, and we cannot guarantee which services or items your insurance will cover. If your insurance company does not pay for the services or items provided, you will be responsible for payment in full. Some services may not be covered by your plan or may not be considered medically necessary. It is your responsibility to check your in network and out of network insurance benefits, which can vary widely among insurance plans. If you have not met your deductible, it may be collected at the time of service. If you wish to self pay for services, please discuss this option with a Head Pain Institute representative.

If Head Pain Institute® is out of network with your insurance company, you will be responsible for bringing us all correspondence from your insurance company, and for either signing over any insurance checks sent directly to you or making payment directly to Head Pain Institute.

Non Insurance Patients

All payments are due at the time of service. Head Pain Institute accepts cash, checks, and debit and credit cards. We also offer the option of financing your treatment. If you wish to bill an insurance company for reimbursement at any time during or after treatment, we can provide the necessary forms upon request.

All Patients

A $75.00 fee will be charged for missed appointments without 48 hours' advance notice. A $35.00 fee will be charged for any check returned for insufficient funds. Any amount that is 90 days past due may be sent to collections, and you agree to be responsible for legal fees (court, attorney, process server, etc.), collection agency fees, interest charges (2% per month), and any other expenses incurred in collecting the debt. If an appliance is not accepted and received by the patient for any reason other than a fabrication error, the patient will be responsible for paying an $888.00 fabrication fee for each appliance. If treatment is provided to a minor child, the parent or guardian who accompanies the child to the appointment is financially responsible for the amount due.

I understand that all fees paid are for services rendered. Fees are not refundable and are not based on the results of treatment.

By signing below, I confirm that I understand and agree to the terms of this Financial Policy.

Patient or Guardian Signature

Date

Printed Patient Name

HEAD PAIN INSTITUTE

Notice of Privacy Practices and HIPAA Acknowledgment

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a Privacy Rule to help ensure that personal health care information is kept private. The Privacy Rule also provides a standard for certain health care providers to obtain their patients' consent for uses and disclosures of the patient's health information to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to take reasonable precautions to protect your privacy at all times. When it is appropriate or necessary, we provide only the minimum necessary information, and only to those we feel need your health care information for treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that interact only with the physician and not with patients) and may have to disclose personal health information to them for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but you must do so in writing. Under this law, we have the right to refuse to treat you if you choose to refuse to disclose your personal health information. If you give consent in this document, you may later request to refuse all or part of the use of your personal health information. You may not revoke actions that have already been taken in reliance on this or a previously signed consent.

Please be sure to review the Notice of Privacy Practices for important information about your rights under HIPAA.

By signing below, I acknowledge that the Notice of Privacy Practices was made available for my review upon request, that I had the opportunity to request a copy for myself, and that I may view the document on the Head Pain Institute website.

Patient or Guardian Signature _____ Date _____

Printed Patient Name _____

HEAD PAIN INSTITUTE

Insurance Benefits Acknowledgment

Head Pain Institute will contact your insurance company to confirm coverage before treatment and will provide you with pricing based on the information we receive from your insurance company.

On rare occasions, we receive information from insurance representatives that is not accurate. Unfortunately, this usually becomes evident only after the claim has been processed by the insurance company.

While Head Pain Institute will make every effort to obtain accurate information from insurance carriers, we cannot be responsible for inaccurate information we receive.

We encourage you to understand your insurance benefits. A knowledgeable patient is the best defense in ensuring that charges are accurate. The Explanation of Benefits (EOB) your insurance carrier issues after a visit is a helpful reference for understanding your coverage and charges.

At Head Pain Institute, we remain available to explain our treatment, our charges, and, to the best of our ability, your insurance coverage. At times, you may need to contact your insurance company directly for further explanation or to appeal a decision.

I understand that the pricing provided by Head Pain Institute is based on information provided by my insurance carrier. I will not hold Head Pain Institute responsible for any errors made by the insurance company when quoting coverage.

Signature (Parent or Guardian, if a minor) _____ Date _____

Printed Name _____

HEAD PAIN INSTITUTE

New Patient Health Assessment

Patient Name: _____ **Age:** _____ **Date:** _____

What are your three chief complaints?

1. _____
2. _____
3. _____

Circle any symptoms you are experiencing, or have experienced, that we should be aware of for today's visit.

Cardiology		**Constitutional**	
Palpitations	Heart Rate	Fatigue	Fever
Leg Pain	Chest Pain	Weight Gain	Weight Loss
Cold Extremities			
Dermatology		**Endocrinology**	
Dry or Sensitive Skin	Hives	Hot Flashes	Hair Symptoms
Rash		Cold Tolerance	Excessive Sweat
		Excessive Thirst	Excessive Urination
		Fatigue	Heat Tolerance
		Sleep Disturbance	
Ears, Nose, and Throat		**Gastroenterology**	
Mouth Sores	Difficulty Swallowing	Appetite Normal	Excessive Gas
Difficulty Chewing	Wear Dentures	Abdominal Pain	Blood in Stool
Tongue Burning	Mouth Burning	Vomiting	Constipation
Tooth Pain	Sinus Pain	Diarrhea	Difficulty Swallowing
Snoring	Change in Voice	Heartburn	Nausea
Ear Pain	Hearing Loss		
Ringing in Ears	Sore Throat		
Musculoskeletal		**Neurology**	
Neck Pain	Neck Lump/Swelling	Facial Pain	Dizziness
Jaw Pain	Muscle Cramps	Fainting (Syncope)	Headache
Neck Stiffness	Restless Legs	Sensory Disturbances	Decreased Concentration Ability
Joint Pain	Joint Swelling	Vertigo	
Respiratory		**Psychology**	
Gasping for Air While Sleeping	Cough	Energy Level Change	Receiving Counseling
Stop Breathing While Sleeping	Chest Pain	Eating Disorder	High Stress
Shortness of Breath	Wheezing	Serious Depression	Sleep Disturbances

HEAD PAIN INSTITUTE

Patient Office Policy Agreement

Please read each of the following office policies and initial in the space provided to acknowledge your agreement.

1. Cell Phones

Please silence your cell phone or set it to vibrate when you enter the office, and refrain from taking phone calls in the treatment areas. We appreciate your consideration for other patients and our staff. If you need to make or receive an urgent call, please step outside or to the designated area in the lobby. Photography and recording are addressed in the Photography and Recording policy below.

Initials _____

2. Photography and Recording

To protect the privacy of every patient in our office, photography and audio or video recording are not permitted anywhere in the Practice, including the waiting room, front desk, and treatment rooms. This includes recording with cell phones, cameras, smart glasses (such as Meta smart glasses), smart watches, and AI enabled pins, pendants, or other wearable devices that can take photos, record, stream, or transcribe conversations. This policy also applies during virtual visits.

If you wear smart glasses with prescription lenses, please keep the recording features turned off while you are in the office, or wear standard glasses if you have them. Our team may ask you to remove or put away any device that appears to be recording.

This policy applies to patients and to anyone who accompanies them, including family members and caregivers. Please help us by sharing it with them.

If you would like to remember what was discussed: We understand that appointments can include a lot of information. If you would like to record part of your visit, such as your treatment instructions, please ask the doctor first. Recording is permitted only with the doctor's agreement, and only in your treatment room. You may also ask us for written instructions, and you have the right to request a copy of your medical records at any time.

If this policy is not followed: If recording occurs without permission, we will ask you to stop and to delete the recording in our presence. If the request is not followed, we may need to end the appointment and reschedule. Repeated violations may affect your ability to continue care at Head Pain Institute.

Initials _____

3. Treatment of Staff

Our team is committed to providing you with respectful, professional, and compassionate care. We ask that all patients treat our staff with the same level of courtesy and respect. Verbal abuse, threatening language, or disrespectful behavior toward any member of our team will not be tolerated and may result in dismissal from the practice.

Initials _____

4. Good Communication and Appointment Reminders

Clear and timely communication is essential to your care. We will make every effort to send appointment reminders by your preferred method. It is your responsibility to make sure we have your current contact information on file and to notify us promptly of any changes. Reminders are provided as a courtesy and do not replace your personal responsibility to keep scheduled appointments.

Initials _____

5. Text and Email Communication

By providing your mobile number and/or email address, you consent to receive appointment reminders, recall notices, and general practice communications by text message and/or email. Standard messaging and data rates may apply. You may opt out of text or email communications at any time by notifying the front desk in writing. Please note that email and text messages are not secure forms of communication for sensitive health information.

Initials _____

6. Cancellation, No Show, and Late Cancellation Policy

We require at least 48 hours' notice to cancel or reschedule any appointment. Cancellations made with less than 48 hours' notice are considered Late Cancellations. Failing to arrive for a scheduled appointment without prior notice is considered a No Show. A fee may be assessed for late cancellations and no show appointments. Repeated violations of this policy may result in discharge from the practice.

Initials _____

HEAD PAIN INSTITUTE

7. Two Strikes Policy: No Shows and Rescheduling Within One Calendar Year

Patients who accumulate two (2) no show appointments or two (2) late cancellations within a single calendar year (January 1 through December 31) will be reviewed for continued care in the practice. Upon the second occurrence, a formal notice will be issued. A third occurrence may result in termination of the patient and provider relationship. This policy exists to ensure fairness to all patients and to protect the availability of appointment times for those in need.

Initials _____

8. One Additional Person May Accompany the Patient

To maintain a calm, focused treatment environment and to protect patient privacy, we ask that each patient be accompanied by no more than one (1) additional person during the appointment. Additional guests may be asked to wait in the reception area. Exceptions may be made for minor patients who require a parent or guardian, or for patients who require an interpreter or caregiver support. Please notify our office in advance if special accommodations are needed.

Initials _____

9. Constructive Feedback

We are continuously working to improve the quality of care and the experience we provide, and we welcome your feedback, concerns, and suggestions. If at any time you feel your experience did not meet your expectations, please speak with our Office Manager directly. We are committed to addressing your concerns promptly and professionally. Online reviews and social media posts are not a substitute for direct communication, and we ask that you give us the opportunity to resolve any concerns first.

Initials _____

By signing below, I acknowledge that I have read these office policies and understand my responsibilities.

_____ _____

Patient or Guardian Signature | Date

_____

Printed Patient Name