Life Force Chiropractic 202 N. Allen Drive, Suite F, Allen, TX 75013 (469) 777-8532

Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: We need this information because we care enough to want to know, and your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_____ Sex _____ Marital Status_____ Date of Birth _____ Home Phone _____

Address_____ City _____ State _____ Zip _____

Occupation _____ Who referred you to our office?_____

(Indicate if child, student, housewife, unemployed, retired)

Social Sec. # _____ Business Phone _____ Company Name_____ Location _____

Spouse's First Name_____ Spouse's Soc. Sec. #_____ Spouse's Employer _____ Location _____

Please explain in detail how your accident happened _____

_____

_____

Insurance Co._____ Policy No. _____ Claim No. _____

Driver of other vehicle (if any)

Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (If applicable)

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjuster_____

Have you retained an attorney? ❒ Yes ❒ No

If so, his name and address_____

You were heading ❒ North ❒ East ❒ South ❒ West on_____ (street or highway)

Other vehicle was headed ❒ North ❒ East ❒ South ❒ West on _____ (street or highway)

Were police notified? ❒ Yes ❒ No

Were you knocked unconscious? ❒ Yes ❒ No If so, for how long? _____

You were struck from ❒ Behind ❒ Front ❒ Left side ❒ Right side

You were ❒ Driver ❒ Passenger ❒ Front seat ❒ Back seat ❒ Using seat belts ❒ Other protective devices

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident?_____

What treatment was given? _____

Was any other doctor consulted after the accident? ❒ Yes ❒ No

If so, what was the doctor's name _____❒ D.C. ❒ M.D. ❒ D.O. ❒ D.D.S.

What was the diagnosis?_____

What treatment was given? _____

How often did you see the doctor?_____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ❒ Yes ❒ No

If so, what were the complaints? _____

Before the injury, were you capable of working on an equal basis with others your age? ❒ Yes ❒ No

Are your work activities restricted as a result of this accident? ❒ Yes ❒ No

Since this injury, are your symptoms ❒ Improving? ❒ Getting worse? ❒ Same?

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HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes: 1 -- never had; 2 -- previously had; 3 -- presently have.

MUSCULO-SKELETAL SYSTEM

_____ Low back problems
_____ Pain between shoulders
_____ Neck problems
_____ Arm problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Stiff joints
_____ Sore muscles
_____ Weak muscles
_____ Walking problems
_____ Ruptures
_____ Broken bones

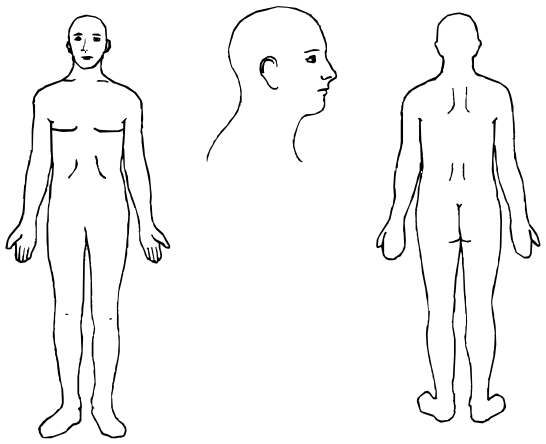
GENITO-URINARY SYSTEM

_____ Bladder trouble
_____ Excessive urination
_____ Scanty urination
_____ Painful urination
_____ Discolored urine

FEMALE

_____ Vaginal discharge
_____ Vaginal bleeding
_____ Vaginal pain
_____ Breast pain
_____ Lumps on breast
_____ Are you pregnant?
_____ Yes____ ___No

Please mark your areas of pain on the figure below.



GASTRO-INTESTINAL SYSTEM

_____ Poor appetite
_____ Excessive hunger
_____ Difficult chewing
_____ Difficult swallowing
_____ Excessive thirst
_____ Nausea
_____ Vomiting food
_____ Vomiting blood
_____ Abdominal pain
_____ Diarrhea
_____ Constipation
_____ Black stool
_____ Bloody stool
_____ Hemorrhoids
_____ Liver trouble
_____ Gall bladder trouble
_____ weight trouble

NERVOUS SYSTEM

_____ Numbness
_____ Loss of feeling
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Muscle jerking
_____ Convulsions
_____ Forgetfulness
_____ Confusion
_____ Depression

CARDIO-VASCULAR-SYSTEM

_____Chest pain
_____Pain over heart
_____Difficult breathing
_____Persistent cough
_____Coughing phlegm
_____Coughing blood
_____Rapid heart beat
_____Blood pressure problems
_____Heart problems
_____Lung problems
_____Varicose veins

EYE, EAR, NOSE & THROAT

_____Eye strain
_____Eye inflammation
_____Vision problems
_____ Ear pain
_____ Ear noises
_____ Ear discharge
_____ Hearing loss
_____ Nose pain
_____ Nose discharge
_____ Difficult breathing thru nose
_____ Sore gums
_____ Dental problems
_____ Sore mouth
_____ Sore throat
_____ Hoarseness
_____ Difficult speech

_____
Patient's Signature

---------- DO NOT WRITE BELOW THIS LINE ----------

_____

_____

_____

_____

_____

_____

_____

Patient accepted? Yes_____ No_____ Doctor's signature _____

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Terms of Acceptance

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and method that will be used to obtain such goal.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of a vetebral subluxation. Our Chiropractic method of correction is to provide specific adjustments to the spine.

HEALTH: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vetebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vetebral subluxations. However, if during the course of a Chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment of those findings, we will recommend that you seek the services of another health provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference of the expression of the body's innate wisdom. Our only method is specific adjusting to correct vetebral subluxations.

I, _____ have read and fully understand the above statement.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

(Signature) (Date)

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____, being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care in this office.

_____ _____

(Signature) (Date)

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FINANCIAL POLICY

We will make every good faith effort in an attempt to collect from your insurance company for services rendered to you in our office. Regardless of insurance reimbursement or denial, it is ultimately the patients responsibility for payment of all services rendered in this office.

_____ _____

Patient's Signature Date

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to the spine, as he deems appropriate.I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due or payable.

Ownership of X-ray films

It is understood and agreed upon that payment to the Doctor for x-ray procedures is for the review and examination of said x-rays. The x-ray negatives, and/or CD's will remain the property of this Chiropractic office. The x-ray films are to be kept on file where they may be seen upon request while I am a patient of this office. If, I the patient require or request a copy of my x-rays films, I understand that copies must be obtained from the imaging center at which the x-rays were initially taken for a fee determined by the imaging center.

Patients Signature_____

Date_____

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ASSIGNMENT AND AUTHORIZATION

For good and valuable consideration, including the agreement of Life Force Chiropractic and Dr. Dan Fleishman, D.C. to accept this assignment in lieu of demanding full payment for services from the undersigned on the date each service is rendered, the undersigned patient executes this document hereby assigning to Life Force Chiropractic and Dr. Dan Fleishman, D.C. the right to receive insurance benefits directly from any insurance company that may be obligated to provide insurance benefits, to me or on my behalf, for services rendered by Life Force Chiropractic and Dr. Dan Fleishman, D.C., for a motor vehicle accident that occurred on or about _____.

Any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, for the aforesaid accident for services provided by Life Force Chiropractic and Dr. Dan Fleishman, D.C., is hereby directed to issue payment for those benefits directly to and payable to Life Force Chiropractic and Dr. Dan Fleishman, D.C.

I also authorize and assign to Life Force Chiropractic and Dr. Dan Fleishman, D.C. the right to file suit and pursue all legal remedies to obtain payment for services provided to me by Life Force Chiropractic and Dr. Dan Fleishman, D.C. This authorization to file suit is an assignment of my cause of action to obtain payment for services provided to me by Life Force Chiropractic and Dr. Dan Fleishman, D.C. and includes the assignment to pursue declaratory relief or any other legal remedies.

Life Force Chiropractic and Dr. Dan Fleishman, D.C., accepts the aforesaid assignment and hereby notifies any insure issuing payment that Life Force Chiropractic and Dr. Dan Fleishman, D.C. objects to any "repricing" or reduction of billed amounts unilaterally made by any insurer. Any such reduced payments issued by any insurer are accepted under protest and without waiving any right of the provider to pursue all legal remedies against the insurer.

Please read this document completely before signing. If you do not completely understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below your agreement you fully understand this document and you fully agree to the terms of this document.

_____ Date _____
Patient's or guardian's signature

_____ Date _____
Witness to patient or guardian's signature

_____ Date _____
Authorized signatory for medical provider

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DIRECT PAYMENT AUTHORIZATION

To Whom It May Concern:

I herby authorize and direct you, my insurance company, and/or my attorney, to pay directly to Life Force Chiropractic and Dr. Dan Fleishman, D.C. such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office. I herby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgement or verdict, which may be paid to me as a result of the injuries or illness for which I have been treated by said Office.

I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Direct Payment Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Direct Payment Authorization. I agree that the above-mentioned Office be given the power of attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

Signature _____ Date _____

ADDITIONAL AUTHORIZATION AND DIRECTIONS TO INSURER

AUTHORIZATION FOR DISCLOSURE OF INSURANCE DECLARATION PAGE: I, the patient and insured, further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide Life Force Chiropractic, Dr. Dan Fleishman a copy of any declarations page of any insurance policy that may provide any insurance benefits to me for the aforesaid accident.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE PAYMENT RECORD: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on by behalf, to provide to Life Force Chiropractic, Dr. Dan Fleishman a copy of any ledger or payment record of payments made under any insurance coverage available to me, without redacting the names of amy other medical provider or entity to whom insurance benefits have been paid and without redacting the amount of any insurance benefits that have been paid.

DIRECTION NOT TO EXHAUST BENEFITS BY PAYMENT OF OTHER CLAIMS: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to not exhaust insurance benefits or coverage until all claims submitted by Life Force Chiropractic, Dr. Dan Fleishman have been paid in full, or at 80% if the insurance policy is limited to pay 80% coverage of medical claims. If any insurance company obligated to pay any insurance benefits to me, or on my behalf, has denied payment of a claim submitted by Life Force Chiropractic, Dr. Dan Fleishman, or made payment to Life Force Chiropractic, Dr. Dan Fleishman at an amount lesser than the amount billed, or lesser than 80% of the amount billed if my coverage is limited to 80% for medical claims, I direct the aforesaid insurance company to hold in escrow the amount in dispute, and if other claims would exhaust benefits I direct the aforesaid insurance company to hold in escrow the disputed amount and to not exhaust benefits or coverage by payment of the amount I have hereby requested be held in escrow. I further authorize and direct the aforesaid insurance company to notify Life Force Chiropractic, Dr. Dan Fleishman that benefits have been exhausted except for the amount held in escrow, to enable Life Force Chiropractic, Dr. Dan Fleishman to attempt to resolve the disputed claim in a manner acceptable to Life Force Chiropractic, Dr. Dan Fleishman.

DIRECTION TO INSURER TO MAINTAIN CONFIDENTIALITY: I further direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to maintain the privacy and confidentiality of my medical records. I do not authorize any insurer to provide my medical records to any one without first obtaining a written authorization from me to provide the medical records to any other entity.

AUTHORIZATION FOR RELEASE OF RECORDS TO PROVIDER: I herby authorize any insurance company that my be obligated to pay any insurance benefits to me, or on

my behalf, to release a copy of my completed medical records in possession of such insurer to Life Force Chiropractic, Dr. Dan Fleishman upon the request of Life Force Chiropractic, Dr. Dan Fleishman. This authorization includes the authorization to release to Life Force Chiropractic, Dr. Dan Fleishman a copy of any medical examination or evaluation of me requested by any insurance company.

DIRECTION TO INSURER TO PROVIDE TO PROVIDER ADVANCE NOTICE OF IME OR EUO: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide at least 15 days advance notice to Life Force Chiropractic, Dr. Dan Fleishman of any physical examination or examination under oath of myself that any insurance company may schedule.

Please read this document completely before signing. If you do not completely understand this document or have any questions about this document, please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

_____ _____

Patient's Signature (or guardian's signature) Date

_____ _____

Witness to patient or guardian's signature Date

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Dan K. Fleishman, D.C.

Consent for Purpose of Treatment, Payment and Healthcare Operations (3/03)
In this document, "I" and "my" refer to the patient,
and "Chiropractor" refers to Dan K. Fleishman, D.C.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of my by Chiropractor may be conditioned upon my consent as evidence by my signature below.

I understand I have the right to request a restriction as to how my protected heath information is used or disclosed to carryout treatment, payment or heath care operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time. except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another heath care provider, a health plan, my employer or health care clearinghouse. This protected heath information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected heath information that will occur in my treatment. payment of my bills to in the performance of heath care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 202 N. Allen Drive, Suite F, Allen, TX 75013. This Notice of Privacy Practice also describes my rights and duties of the Chiropractor with respect to my protected heath information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative's Authority