CHIROPRACTIC & SPORTS CLINIC

PERSONAL INJURY HISTORY

Name_____Phone(H)_____(C)_____

Address_____City_____State_____Zip_____

Age_____Birthdate_____Marital Status M S W D Children_____

Occupation_____SS#_____Employer_____

Address_____Office Phone_____

Driver's License Number_____ Email_____

Name of Wife or Husband_____SS#_____

Employer_____Office Phone_____

PATIENT'S Nearest Relative_____

Address_____

Referred by:_____

_____

NATURE OF ACCIDENT

Date of Accident_____Time of Day_____

In your own words, please describe accident:_____

_____

_____

Did you have any physical complaints BEFORE THE ACCIDENT? □ Yes □ No. If yes, please describe in detail:_____

_____

_____

Please describe your physical complaints:

a. DURING the accident:_____

b. IMMEDIATELY AFTER the accident:_____

d. THE NEXT DAY:_____

What are your PRESENT complaints and symptoms?_____

_____

Have you been treated by another doctor sine the accident for your injuries? ☐ Yes ☐ No

If yes, please list doctor's name and address_____

What type of treatment did you receive?_____

_____

Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arm	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins and Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms Other Than Above_____

Have you lost time from work as a result of this accident? ☐ Yes ☐ No If yes, please complete this question._____

_____

a. Last Day Worked:_____

b. Type of Employment:_____

c. Present Salary:_____

d. Are you being compensated for time lost from work? ☐ Yes ☐ No If yes, please state type of compensation your are receiving:_____

Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No If yes, please describe in detail:_____

_____

_____

ANSWER THE FOLLOWING <u>ONLY IF</u> YOU HAD AN <u>AUTOMOBILE</u> ACCIDENT.

Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat

What direction were you headed? ☐ North ☐ East ☐ South ☐ West

on (name of street)_____

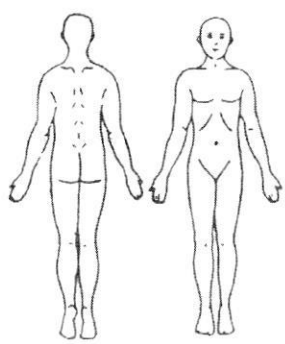
What direction was other vehicle headed: ☐ North ☐ East ☐ South ☐ West

on (name of street)_____

Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

Were you knocked unconscious? ☐ Yes ☐ No

Were police notified? ☐ Yes ☐ No



Please mark on the diagram the area of discomfort.

PAST HEALTH HISTORY

Please check or describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Hernia ☐ Gall Bladder ☐ Hernia
☐ Broken Bones:_____ ☐ Other:_____
Major Accidents or Falls:_____
_____
Hospitalization (Other Than Above):_____
_____
Previous Chiropractic Care: ☐ None
☐ Doctor's Name & Approx. Date of Last Visit:_____
Have you been treated for any health condition in the last year? ☐ Yes ☐ No
If yes, please explain:_____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

☐ Appendicitis	☐ Malaria	☐ Chicken Pox	☐ Alcoholism
☐ Scarlet Fever	☐ Tuberculosis	☐ Diabetes	☐ Venereal Infection
☐ Diphtheria	☐ Whooping Cough	☐ Cancer	☐ Arthritis
☐ Typhoid Fever	☐ Anemia	☐ Heart Disease	☐ Epilepsy
☐ Pneumonia	☐ Measles	☐ Goiter	☐ Mental Disorder
☐ Rheumatic Fever	☐ Mumps	☐ Influenza	☐ Lumbago
☐ Polio	☐ Small Pox	☐ Pleurisy	☐ Eczema

At the Chiropractic & Sports Clinic, we take pride in providing quality health care to our patients. Therefore, we would like to request your assistance with the following office policies and privacy practices.

MEDICAL RECORDS POLICY AND PROCEDURES

As a patient of the Chiropractic and Sports Clinic, you are entitled, at any time during regular operating hours, to request your medical records or diagnostic films from our office. The following are the policies/procedures aimed at making the process of completing your request as quickly and efficiently as possible:

* Notify the Custodian of Records of your request. Your records will be copied at our earliest convenience.
* Requests by third parties (attorneys, insurance carrier, doctor's office, etc.)must be made directly to the Custodian of Records in writing and accompanied by a signed release from you.

We appreciate your patience during the process of completing your request.

CONTACT INFORMATION

Home Number:_____

Work Number:_____

Cell Number:_____

A detailed message may be left at this number:	HOME	WORK	CELL
A message may be left with only a name and call back number:	HOME	WORK	CELL
Please do not leave a message at this number:	HOME	WORK	CELL

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature Printed Name Date

I wish to object to the following in the "Notice of Privacy Practices":_____
_____
_____

INSURANCE INFORMATION

Personal Injury Protection (your own auto insurance)

Name of Ins. Co._____

Address_____Phone_____

Name of Insured_____Policy #_____

Liability Insurance (person responsible for the accident)

Name of Ins. Co._____

Address_____Phone_____

Name of Insured_____Policy #_____

Health Insurance (your personal health insurance)

Name of Ins. Co._____

Address_____Phone_____

Name of Insured_____Policy #_____

Spouse's Health Insurance

Employer_____

Name of Ins. Co._____

Address_____Phone_____

Name of Insured_____

Social Security #_____Group #_____

Have you retained an attorney? ☐ Yes ☐ No Name_____

_____

BENEFITS ASSIGNED

I hereby authorize the insurance company to pay directly to Chiropractic and Sports Clinic all benefits to which I am entitled under the terms of the policy. I also authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or to the party who accepts assignments above.

_____

Name

_____

Date

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic and Sports Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that the amount authorized to be paid directly to the Chiropractic and Sports Clinic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend to terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's
Signature_____Date_____

CHIROPRACTIC & SPORTS CLINIC

Cleburne
1649-A W. Henderson
Cleburne, Texas 76033
(817) 641-4042

Fort Worth
4747 S. Hulen St. #101
Fort Worth, Texas 76132
(817) 292-3553

Burleson
1001-D SW Wilshire
Burleson, Texas 76028
(817) 447-1414

AUTOMOBILE BENEFITS

In order to be treated for an automobile accident we must have one of the following forms of insurance, **REGARDLESS OF WHO WAS AT FAULT.**

1. **MEDPAY** or **PIP**(Personal Injury Protection)-Both of these can be opened through your automobile insurance policy. Using either form of coverage does not cause you rates to increase or your policy to be cancelled. Both forms of coverage are there to help pay you medical bills and/or lost wages up to the limit of the policy. Filing with your MEDPAY or PIP does not relieve the other party from having to pay in full for you loss. Your automobile insurance will pursue payment from the liability insurance. Filing will help ensure that you are not left to pay out or your own pocket.

2. **Attorney**-Retaining an attorney is another way to get your medical bills paid, An attorney will pursue the liability insurance and help get all medical bills paid.

The important thing to remember is that you are not guaranteed of receiving full payment or any payment from the other driver's liability insurance company, **EVEN IF YOU HAVE AN ATTORNEY.**

As a courtesy we will send all claims to the liability insurance; however, we do not accept the liability insurance as a primary form of insurance, you must have one of the forms listed above.

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LIABILITY WAIVER

I hereby authorize and direct Chiropractic & Sports Clinic to file my claims with my health insurance. I understand, however, that in the event that my charges are submitted in their full amount to any other form of insurance or source of payment (liability, MEDPAY, PIP, attorney, etc). I hereby direct Chiropractic & Sports Clinic to collect any Write-off or discount issued by my health insurance, out of proceeds from the other insurance or source of payment.

Patient Signature_____

Date_____

ASSIGNMENT, LIEN, AND, AUTHORIZATION
FOR DIRECT PAYMENTS BY MY PAYER TO CHIROPRACTIC & SPORTS CLINIC

(ASSIGNMENT & LIEN" OR ASSIGNMENT)

Purpose. The purpose of this Assignment & Lien is to assist the office in obtaining Proceeds from various Payers for the payment of my Charges. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment & Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to [Chiropractic & Sports Clinic] located at [4747 S.Hulen St. #101, Fort Worth, TX 76132]. "Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, adjuster, claims handler, medical examiner, individual reviewer or review entity, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse proceeds, either now or in the future, or which may be involved directly or indirectly in determining the obligation to pay or disburse proceeds, either now or in the future; "Proceeds" shall include without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, the proceeds relating to "health-care-insurance receivables" and "payment intangibles" as such are defined by the applicable Uniform Commercial Code, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare and Medicaid, workers' compensation, disability, liability, uninsured and under insured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, errors & omissions, and malpractice; "Charges" shall include without limit the full fees for the Office's goods and services (including without limit treatment, diagnostic services, medical equipment, supplies, supplements, narrative reports, photocopies, pre-authorization requests, no-shows, depositions, and testimony, whether rendered before or after the date of this Assignment & Lien), any Collection Costs incurred by the Office, delinquency penalties and interest to the maximum extent permitted under law or at the annual rate of eighteen percent (18%), whichever is greater, and any other charges incurred by me at the Office; "Collection Costs" shall include without limit any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, fees or costs associated with requests for reconsideration, independent reviews, appeals, mediation, arbitration, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Assignment and Lien Terms. I hereby assign to the Office to the extent permitted by law, but only to the extent of my Charges, all of my claims to, right to, and interests in, Proceeds, whether resolved or unresolved, including without limit ownership rights, which I may have now or in the future relating directly to indirectly to my Charges, condition, or causes of my condition ("Claims to Proceeds"), including without limit any and all causes of action, receivables, payment intangibles, and remedies that I might have against or with respect to any Payer now or in the future, and the right to prosecute, seek, settle, or otherwise resolve such Claims to Proceed either in my name or in the Office's name and as the Office otherwise sees fit. I agree that this assignment shall be effective as of the date and time the initial cause of my condition occurred. I further intend for this Assignment & Lien to create a security interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to the Office a primary, non-contingent security interest in all of my Claims to Proceeds to the extent permitted by law for the purpose of securing payment of my Charges, the attachment and perfection of which shall relate back to, and be effective as of, the date and time that the initial cause of my condition occurred. I further authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency relating to such security interests, and to make such filings in all relevant jurisdictions as the Office sees fit in its sole discretion. I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my agreement with the Office such security interest shall be removed or terminated solely upon my written request sent through the US. Postal Service Certified Mail. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of , the Office to the full extent of my Charges. To the extent that any law, including without limit a lien statue, purports to limit, reduce, or modify the distribution of Proceeds in any manner inconsistent with this Assignment & Lien including without limit through the reservation of a portion of the Proceeds exclusively to me, I hereby waive such limits, reductions, or modifications. Such waiver shall not adversely affect or prejudice any rights which the Office may have and elect to exercise under said law.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. IN the event that I retain one or more attorneys who receive(s) Proceeds from one or more Payers, I hereby direct (and the Office hereby requests) each attorney to provide to provider immediate notice to the office regarding such Proceeds, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of such Proceeds shall be primarily to pay my charges. If I have dispute regarding the Charges, any remedies I may have shall not include instruction my attorney to withhold or delay payment of Proceeds to the Office. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney's fees and costs, or other expenses of obtaining Proceeds.

Disclosure Directive. I hereby direct each and every Payer to immediately release to the Office any Pertinent Information relating to (a) any coverage I may have and (b) any Proceeds Determination by the Payer relating to the Office's Charges. "Pertinent Information" shall include without limit the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information" shall also include without limit copies of all documents, records, and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny, or delay payment of any Proceeds relating to the Office's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or for me by the Office to all Payers, including without limit a copy of my Charges and a copy of this Assignment & Lien, unless otherwis agreed to in writing.

Miscellaneous. Except as provided in this paragraph, this Assignment & Lien shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment & Lien. I agree that each and every provision of this Assignment & Lien is reasonably necessary. However, should any provision of this Assignment & Lien be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment & Lien shall, nevertheless, remain in full force and effect. This Assignment & Lien shall be governed under the laws of the state where the Office is located, and is performable in the county where he office is located. In any action based upon this Assignment & Lien, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statue of limitations which may apply in any action based upon this Assignment & Lien.

I have read, understood, and agree to the terms of this Assignment & Lien.

Patient Name (Print): _____

Patient Signature: _____ **Date:** ____/____/_____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (Please Print):_____

Parent/ Guardian Signature: _____**Date:** ____/____/_____

Chiropractic & Sports Clinic

821 N Nolan River Rd. Cleburne, TX 76033

Ph:817-641-4042 Fax:817-645-4357

I, _____, (Patent Name) _____(SSN), _____(DOB)

Hereby authorize_____

(Facility, party or individual to provide records) to release of the following information:

- Most recent exam and tests
- All of my Medical Records, (including but not limited to treatment notes, reports or studies that were performed at your office)
- Other:

Information is to be released to the following individuals, party, or facility.

Name: _____

Contact Information: _____

_____

I understand that the records are for the care, treatment or medical services provided to me, and retained by you are confidential and are being disclosed for the purpose of:

- Continuation of Care
- Litigation

I further understand that without this authorization, the provider would not be permitted to disclose this information, as indicated by law.

I recognize that I may revoke this consent at any time except to the extent that the information has already been released in reliance of this form. If not revoked, this consent will expire one year from the date signed.

I agree further not to sue or hold the provider of the information, its employees, or agents, responsible for any issue, claims or causes of action arising out of the release of information in conformance with the terms of this release.

_____

Patient Signature (or Parent/Guardian if Patient is a minor) & Date

FINANCIAL POLICY

REGARDING INSURANCE

We may accept assignment of insurance benefits; however, we cannot bill your insurance company without your information and a copy of your card. Your insurance policy is a contract between you and your carrier. We are not a party to that contract. Our office **DOES NOT** guarantee that your insurance will pay. We will make every attempt to receive verification and know what your insurance covers. However, if you claim is denied or paid differently than what your insurance carrier quoted, you are responsible for the bill. Our office **WILL NOT** enter into the dispute with your insurance carrier over your claim. This is your responsibility.

Please be aware that some services may not be covered under your policy, and these will be **YOUR RESPONSIBILITY FOR PAYMENT.**

It is **YOUR** responsibility to inform us of a change in your insurance, name, address, phone number, etc. If your claim is denied because of the updates not being made with out office, the bill is **YOUR** responsibility.

All copays, co-insurance and deductible are due at the time of service, unless other payment arrangements are made prior to the office visit.

If you do not wish to file with your health insurance, we **CANNOT** go back at a later date and file with your insurance. Insurance carriers have a filing time deadline and we are not able to file after you have opted to pay out of pocket. We **CANNOT** go back and file a claim as a workers compensation claim or car accident-**YOU MUST TELL US ON YOUR FIRST DATE OF SERVICE IF IT IS A WORK INJURY OR CAR ACCIDENT!**

CAR ACCIDENTS

If your appointment is due to a CAR ACCIDENT, and you DO NOT wish to file with your PIP (PERSONAL INJURY PROTECTION) We CANNOT go back at a later date and file with the insurance. The insurance company requires certain codes to be used that we DO NOT use with our cash discount.

Patient's or authorized person's signature; I authorized the release of any medical other information necessary to process this claim. I also request payment of benefits be made directly to Chiropractic & Sports Clinic, dba, the phsycian who accepts the assignment.

Printed Name:_____ Signature:_____

Date:

Chiropractic & Sports Clinic
821 N Nolan River Rd
Cleburne Tx 76033-7001
(817) 641-4042

Text/Email Consent Form

Consent to Text Message Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

I consent to receiving appointment reminders and other healthcare communications/information via text from Chiropractic & Sports Clinic.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number.

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is

(_____)_____

_____ (Patient initials) I consent to emails, to receive communications as stated above.

The email address that I authorize to receive messages for appointment reminders, feedback, and general health reminders/information is

_____

_____ (Patient initials) I DO NOT consent to receive text messages or emails from the practice at my cell phone or email. I wish to OPT out at this time.

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Patients Signature:

_____Date:_____

Staff Signature:

_____Date:_____