CHIMEDICAL MANAGEMENT GROUP, LLC
CHIROPRATIC, MEDICAL & PHYSICAL THERAPY
APPLICATION FOR TREATMENT

STEPHEN B. COOPER, D.C., FACMUAP
EXECUTIVE DIRECTOR
FELLOW AMERICAN COLLEGE OF MUA PHYSICIANS
FACMUAP

MEDICAL DIRECTOR:
THEIN QUACH M.D.

DATE: _____

PLEASE CHECK THE TYPE OF VISIT
TYPE OF VISIT: PERSONAL INJURY _____ WORKERS' COMP_____ COMMERICAL INSURANCE_____
CHIROHEALTH/CASH_____ FEDERAL WORKERS' COMP _____ VES: _____ OTHER _____

DEMOGRAPHICS

NAME: _____ ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ EMAIL: _____

HOME PHONE: _____ CELLPHONE: _____ WHICH NUMBER DO YOU PREFER? _____

DOB: _____ AGE: _____ GENDER IDENTITY: _____ BIRTH SEX: _____ SSN: _____

EMPLOYER: _____ OCCUPATION: _____

RACE: _____ ETHNICITY: _____ HISPANIC: _____ NON-HISPANIC: _____ EDUCATION LEVEL: _____ RELIGION: _____

MARITAL STATUS: M S D W SPOUSE NAME:_____EMERGENCY CONTACT:_____ PHONE: _____

WHO IS ALLOWED TO CALL ABOUT YOUR TREATMENT: _____RELATIONSHIP TO THE PATIENT: _____

COMMERICAL INSURANCE INFORMATION

NAME OF HEALTH INSURER: _____POLICY# _____ GROUP # _____
PRIMARY# _____ SECONDARY#_____
IF POLICY IS IN OTHER NAME- RELATIONSHIP: _____ NAME: _____ DOB: _____

AUTO INSURANCE AND WORKERS' COMP CARRIER

AUTO INSURANCE AND WORKERS' COMP CARRIER: _____ NONE_____
AUTO/ WC POLICY #_____ ADJUSTER: _____ PHONE NUMBER: _____
KNOWN MEDPAY LIMITS? _____ IF INSURANCE IS IN ANOTHER'S NAME: _____ DOB: _____SSN: _____

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FEDERAL INJURY WORKERS' COMP CLAIM INFO

EMPLOYER: _____ OCCUPATION (CRAFT): _____

EMPLOYERS ADDRESS: _____ SUPERVISOR NAME: _____ PHONE# _____

IF YOU CASE IS PENDING, DID YOU FILE A CA16 WITHIN 7 DAYS OF THE INJURY? _____ IF NO, IF YOU ARE STILL WITHIN 7 DAYS OF INJURY, PLEASE REQUEST ONE FROM SUPERVISOR

1. CASE #_____ DOI: _____ CA1 OR CA2? _____STATUS? _____ (PENDING, APPROVED, DENIED, OR CLOSED)

2. CASE #_____ DOI: _____ CA1 OR CA2? _____ STATUS? _____ (PENDING, APPROVED, DENIED, OR CLOSED)

OWCP CLAIMS EXAMINER NAME: _____ DID YOU RECEIEVE A COPY OF A CA17 TO BRING WITH YOU? (Y/N) _____
DO YOU HAVE MORE THAN 1 CASE THAT YOU NEED HELP WITH? _____

VETERAN SERVICES

ARE YOU A VETERAN? DO YOU KNOW ANYONE THAT IS A VETERAN? DID YOU KNOW THAT WE TREAT VETERANS?

DO YOU HAVE AN UPCOMING C&P EXAM?

PLEASE ASK FOR STEPHANIE FOR MORE INFORMATION TO START TREATMENT UNDER YOUR VA CLAIM

HISTORICAL FACTORS OF CARE

PAST FAMILY HISTORY (PLEASE INDICATE MOTHER, FATHER, BROTHER, SISTER, OR GRAND PARENTS)							
cancer	Gout	Cataract	Schizophrenia	Epilepsy	Stroke	CAD	Osteo-arthritis
Breast Cancer	Diabetes	Anemia	Osteoporosis	Hypercholesterolemia	Suicide	Tuberculosis	OTHER*
Colon cancer	Asthma	Migraine	Atherosclerosis	Hypercholesterolemia	Depression	Hypertension	
Prostate Cancer	Obesity	Allergy	Leukemia	CHF (Congestive Heart Failure)	Bronchitis	Leukemia	

PAST MEDICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)				
Unremarkable PMHx	Arthritis	High Blood Pressure	Swelling & Edema	Memory Loss
Bleeding Disorders	Kidney Disease Hx	Anesthesia Reactions	HIV Hx	Seizures Hx
ENT Hx	Eye Hx	GI Hx	Musculoskeletal Hx	Skin Hx
COVID Disease	Cardiovascular Hx	Asthma Med Hx	Diabetes Med Hx	Hepatitis
Cancer Med Hx	Stroke	Gastrointestinal Hx	Genitourinary Hx (M)	Genitourinary Hx (F)
CNS Hx	Psychiatry Hx	Endocrine Hx	Hemato./Lymphatic Hx	Allergy/Immu. Hx
Unplanned hospitaliz	Bone & Joint Disease			

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REVIEW OF SYSTEMS (PLEASE CIRCLE ALL THAT APPLY)

General	cataracts	Swelling	discolored foot/hand	**Genitourinary**	hair loss	fractures
fever	sensitive to light	dental problems	hot feet or hands	bed wetting	warts	dislocation
sweats	flashes in vision	hoarseness	leg cramps	difficulty urinating	brittle nails	**Vaccinations**
chills	spots in vision	**Neck**	calf pain	pain urinating	changes in moles	flu
fatigue	**Ears/Nose**	masses	varicose veins	blood in urine	itching	varicella
weight loss	ringing in ears	Swelling	low blood pressure	incontinence	peeling	pneumonia
weight gain	frequent infection	stiffness	high blood pressure	foul odor of urine	**Neurologic**	**OB GYN**
sleep disturbance	hearing loss	**Respiratory**	**Gastrointestinal**	increased urination	seizures	age period began
change in routine	drainage	difficulty breathing	gas/belching	decreased	epilepsy	last breast exam
Head	ear pain	asthma	heartburn	urination	strokes	Breast feeding
headache	nasal polyps	pneumonia	indigestion	urinary infection	tingling sensation	last PAP date
dizziness	postnasal drip	wheezing	ulcers	genital infection	numbness	past pregnancy(s)
head trauma	nosebleeds	persistent cough	vomiting	kidney stones	weakness	hx of mastectomy
concussion	sinus infections	coughing up phlegm	nausea	**Psychologic problems**	difficulty walking	lumps in breast
fainting	**Mouth**	coughing up blood	abdominal pain	excessive stress	poor coordination	nipple discharge
blacking out	bleeding gums	tuberculosis	diarrhea	depression	**Muscle/Bone**	hysterectomy
Eyes	cold sores	**Vascular**	constipation	anxiety	joint pain	PMS
change in vision	dentures	chest pain	blood in stool	mood swings	stiffness	irregular periods
glasses	trouble swallowing	heart murmur	hemorrhoids	**Skin**	muscle aches	hot flashes
contacts	sore throat	irregular heartbeat	gall bladder disease	rash	Arthritis	menstrual cramps
blurry vision	Jaw pain	ankle swelling	liver disease	eczema	deformity	Traumatic Events
double vision	changes in taste	cold feet or hands	other	bruising	bone pain	

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ALLERGIES AND MEDICATIONS

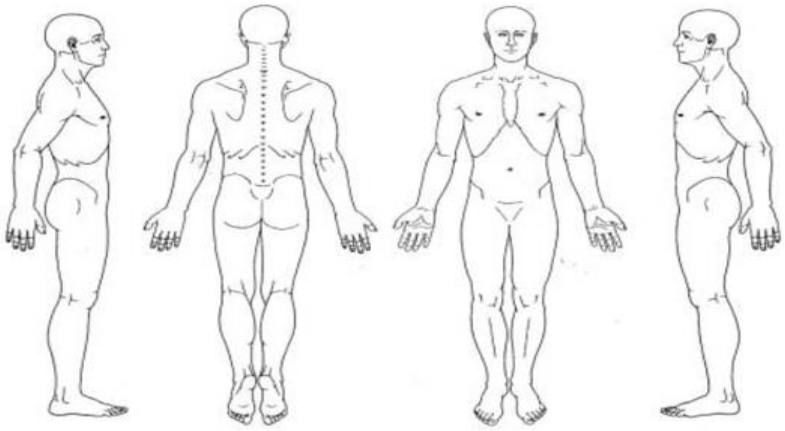
ALLERGY	REACTION	SEVERITY

MEDICATION	STRENGTH	PURPOSE	FREQUENCY

PAIN CHART

PLEASE MARK EVERY AREA USING THE KEY BELOW. YOU CAN USE ARROWS TO SHOW SHOOTING PAIN AND NUMBER 1-6 TO SHOW THE MOST SIGNIFICANT

PAIN INDICATORS
B= BURNING
S= SHOOTING
X= PAIN
V= SEVERE PAIN
D= DULL PAIN
N= NUMBNESS
W= WEAKNESS



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AUTO ACCIDENT, SLIP AND FALL & PERSONAL INJURY PATIENTS COMPLETE THIS SECTION
PLEASE BE AS THOROUGH AS POSSIBLE, THE MORE INFORMATION THE BETTER.
IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK FOR HELP.

DATE AND TIME OF ACCIDENT	LOCATION OF ACCIDENT	CITY AND STATE OF ACCIDENT	DO YOU HAVE ANY RECOLLECTION OF THE ACCIDENT? (UNCONSCIOUS)	WHERE WERE YOU IN THE VEHICLE? (PASSENGER, FRONT SEAT, DRIVER, ETC.)	WHAT WERE YOU DRIVING? (MAKE AND MODEL)	WHAT TYPE OF VEHICLE HIT YOU? (MAKE AND MODEL)
DID YOU HAVE TIME TO BRACE FOR IMPACT?	WERE YOU WEARING A SEATBELT?	CROSSBODY OR LAP STYLE?	HOW DID THE VEHICLE HIT YOU? (T-BONED, HEAD ON, SIDE SWIPED, ETC)	DID THE AIRBAGS DEPLOY?	WERE YOU BURNED BY THE AIRBAG?	WHAT DIRECTION WERE YOU FACING? (HEAD TURNED, LOOKING BEHIND YOU)
DID YOUR SEAT BREAK?	WERE YOU KNOCKED OFF THE ROAD- INTO A DITCH?	WAS IT A HIT AND RUN?	WERE YOU THROWN FROM THE CAR?	WERE YOU PUSHED INTO ANOTHER VEHICLE?	WERE YOU RUN OFF THE ROAD?	DID THE VEHICLE SPIN AROUND?
DID THE VEHICLE FLIP? IF SO, HOW MANY TIMES?	DID ANY WINDOWS BREAK? IF SO PLEASE LIST	WAS THE VEHICLE YOU WERE IN TOTALED? IF NOT WAS THE DAMAGE MILD, MODERATE, OR SEVERE BY WHAT DO YOU REMEMBER?	DID YOU GO TO THE EMERGENCY ROOM? IF SO, WERE YOU TAKEN BY AMBLANCE OR CAR? DID YOU GO BY YOURSELF OR DID SOMEONE TAKE YOU?	ANY OTHER DETAILS THAT WE NEED TO KNOW?	HAVE YOU HAD ANY PREVIOUS ACCIDENTS THAT WE NEED TO KNOW ABOUT?	ANY PRIOR SURGERIES AFFECTED BY THIS ACCIDENT?

DESCRIBE THIS ACCIDENT IF NOT AN AUTO ACCIDENT:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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HX OF HOSPITAL VISIT

HOSPITAL: _____ CITY/STATE? _____
CIRCLE WHAT APPLIES TO YOUR HOSPITAL VISIT:
EXAMINED / XRAYED: (HEAD, NECK, BACK, SHOULDER, ARM, HIP, KNEE, OR (_____)
MRI / CT: (HEAD, NECK, BACK, SHOULDER, ARM, HIP, KNEE, OR (_____
SURGERY? _____ STICHES? _____WHERE? _____
IV MEDICATION? _____DO YOU RECALL THE NAME? _____
SCRIPT FOR ADDITIONAL MEDICATION?
_____
PAST HEALTH HISTORY:
HAVE YOU BEEN INVOLVED IN AN AUTO ACCIDENTPRIOR TO THIS ONE? Y/ N
ARE YOU PREGANANT? Y/N
HAVE YOU HAD ANY PREVIOUS HOSPITALIZATIONS Y/ N
HAVE YOU HAD ANY PRIOR SURGERIES? Y/ N
IF SO PLEASE LIST:
_____
_____
_____

ACTIVITY DAILY LIMITATIONS

PLEASE CHECK EITHER NORMAL OR LIMITED FOR EACH ACTIVITY AND STATE HOW LONG YOU CAN PERFORM EACH ONE.

ACTIVITY	NORMAL	LIMITED	HOW LONG?
SITTING			
DRIVING			
STANDING			
SLEEPING			
WALKING			
KNEELING			
RIDING			
USING A COMPUTER			
SITTING TO STANDING			
PUSHING			
PULLING			
REACHING			
LIFTING			
OTHER(DESCRIBE)			

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FEDERAL INJURY WORKERS' COMP

PLEASE ONLY COMPLETE THIS SECTION IF YOU ARE BEING TREATED FOR A OWCP CLAIM.

DOL NEW PATIENT INFORMATION

HOW DID YOU HEAR ABOUT OUR OFFICE? _____
HAVE YOU FILED A CLAIM? (Y/N) _____ IF SO, CLAIM NUMBER: _____
DOI: _____ IS YOUR CLAIM A CA1 OR CA2? _____ DID YOU FILE A CA16? _____
WHAT IS YOUR CRAFT? _____ EMPLOYER(AGENCY): _____
SUPERVISOR NAME: _____ EMPLOYER PHONE NUMBER: _____
HAVE YOU RECEIEVED ANY PRIOR MEDICAL TREATMENT FOR THIS INJURY? (Y/N) _____
IF YES, WHEN DID YOU RECEIVED TREATMENT? _____ INJURED BODY AREA: _____
NAME OF FACILITY AND/OR DOCTOR WHERE YOU WERE TREATED_____
ADDRESS: _____ PHONE NUMBER: _____ FAX NUMBER: _____

WHAT TYPE OF TREATMENT DID YOU RECEIVE? PLEASE CIRCLE ALL THAT APPLY

ACUTE MEDICAL CARE (911/ HOSPITAL)	PHYSICAL THERAPY/ REHAB	IMAGING (XRAY, MRI, OR CT SCAN)
SURGERY	URGENT CARE/MEDICAL EXAM	OTHER

PATIENT QUESTIONAIRE:

FOR **TRAUMATIC INJURY (CA1)** ONLY ANSWER QUESTION 1
FOR **REPETITIVE CONDITIONS (CA2)** ANSWER QUESTIONS 1-3

1. DESCRIBE IN DETAIL THE EMPLOYMENT-RELATED ACTIVITES WHICH YOU BELIEVE CONTRIBUTED TO YOUR CONDITION.(HOW THE INJURY HAPPENED) _____
   _____
   _____
   _____
2. WHEN DID YOU FIRST NOTICE IT? DOES IT COME AND GO, OR HAS IT BEEN PRESENT CONTINUOUSLY? WHAT SYSMPTOMS HAVE YOU EXPERIENCED? _____
   _____
   _____
3. DO YOU HAVE ANOTHER JOB OR ACTIVITES, SUCH AS HOBBIES, THAT COULD HAVE CONTRIBUTED TO THIS INJURY?
   _____

   DO YOU HAVE ANY OTHER WORK INJURIES THAT WE CAN HELP YOU WITH _____

I HAVE REVIEWED THE ABOVE INFORMATION AND CERTIFY THAT IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE.
PATIENT SIGNATURE: _____ DATE: _____

FIC OFFICE USE: INTAKE SPECIALIST/CASE MANAGER INITIALS: _____ DATE: _____

REMINDER:

- BRING ALL YOUR MEDICAL RECORDS FOR THIS INJURY TO YOUR INITIAL VISIT, HOWEVER, IF YOU CAN'T GATHER EVERYTHING PRIOR TO THE APPOINTMENT PLEASE COME ANYWAY.
- BRING ANY AND ALL LETTERS AND OTHER CORRESPONDENCE YOU HAVE RECEIVED FROM THE DEPARTMENT OF LABOR.
- BRING ALL FORMS GIVEN TO YOU BY YOUR SUPERVISOR (INCLUDING THE CA1/CA2)

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FEDERAL INJURY WORKERS' COMP

PLEASE ONLY COMPLETE THIS SECTION IF YOU ARE BEING TREATED FOR A OWCP CLAIM.

Federal Injury Centers Patient Policies

Initial Each Line

_____ I understand that I must provide this office ALL documentation whether sent to my agency by me or my representative or received from my agency irrespective of whether I believe it to be important or not so it may be reviewed for action items and added to my file.

_____ I understand that I must provide this office ALL documentation whether sent to OWCP by me or my representative or received from OWCP irrespective of whether I believe it to be important or not so it may be reviewed for action items and added to my file.

_____ I understand that my treatment may be terminated, paused, or postponed should I not provide ALL documentation required of me for the acceptance of my case. I will promptly respond to any, and all, inquiries from my agency and OWCP.

_____ I understand that this office bills OWCP directly for my care after the claim has been approved by OWCP. The issuing of a claim number does not mean or indicate the claim has been accepted by OWCP. Should I not provide documentation to this office which is required for approval (employee statements/narrative, factual data, information requests, imaging/diagnostic information, denial letters, appeal forms, etc.) or timely processing of my claim, I will personally be liable for any, and all, fees associated with my care, as this office does not accept any other insurance other than OWCP. I understand that I simply need to provide all requested documentation or information in order not to be personally liable for any, and all, fees.

_____ I understand that it is my responsibility to call OWCP to verify the receipt of documentation. Case status updates at the request of the staff and will record it on the provided call log.

_____ I understand that while this office will help in assisting me with my claim and provide claim management it is my responsibility to provide my agency and OWCP with the requested information and documentation. I will provide my agency with all CA-17 Duty Status Reports and all supporting documentation when submitting claims for compensation by use of firm CA-7 and CA-7a. I further understand that all information provided as claim management is not legal advice and does not replace the advice of an attorney.

_____ I understand that neither Federal Injury Centers nor any employees of FIC represent me in OWCP. FIC submits paperwork to OWCP and assists in getting injury claims approved, but they do not represent me to OWCP.

_____ I understand that missing appointments will negatively impact my case, and therefore, will reschedule all appointments at the next available time.

_____ I completely understand the above and have asked any questions need for clarification prior to signing this form.

_____

PATIENT NAME DATE OF BIRTH

_____

PATIENT SIGNATURE DATE

PLEASE ONLY COMPLETE THIS SECTION IF YOU ARE BEING TREATED FOR A OWCP CLAIM.

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Request to Change Treating Physican

INJURED EMPLOYEE'S NAME: _____
SOCIAL SERCURITY NUMBER: _____
CLAIM NUMBER: _____
DOI: _____/_____/_____

TO WHOM IT MAY CONCERN:

- ❑ MY TREATING PHYSICIAN HAS BEEN UNABLE/UNWILLING TO GET MY OWCP INJURY CLAIM APPROVED.
- ❑ MY INJURY CLAIM HAS BEEN DENIED_____ TIMES OVER THE LAST _____ MONTHS/YEARS.
- ❑ MY ORGINAL TREATING PHYSICIAN IS TOO FAR FOR ME TO DRIVE_____ MILES FROM HOME.
- ❑ MY ORGINAL TREATING PHYSICIAN DOES NOT SPECIALIZE IN OWCP WORK INJURIES.
- ❑ I AM NOT GETTING BETTER UNDER THE CARE OF MY ORGINAL TREATING PHYSICIAN AND I WANT TO GET BACK TO WORK FULL DUTY.
- ❑ MY TREATING PHYSICIAN NO LONGER TREATS OWCP WORK INJURIES
- ❑ OTHER_____
  _____

PLEASE ALLOW ME THE OPPORTUNITY TO GET MY INJURY CLAIM APPROVED. I AM EXPERIENCING THE FOLLOWING PROBLEMS BY NOT HAVING AN APPROVED OWCP CLAIM.

- ❑ LOSS OF SICK/ ANNUAL LEAVE
- ❑ EXHAUSTED FMLA TIME
- ❑ LOSS OF INCOME
- ❑ ANXIETY OVER LOSS OF EMPLOYMENT
- ❑ FEAR MY CONDITION WILL WORSEN
- ❑ UNABLE TO RETURN TO WORK FULL DUTY
- ❑ HARRASSMENT BY MY SUPERVISOR
- ❑ FEAR OF FEDERAL DISABILITY RETIREMENT
- ❑ CAN'T AFFORD MEDICAL CARE FOR MY INJURY
- ❑ OTHER: _____
- ❑ OTHER: _____

PLEASE CHANGE MY TREATING PHYSICIAN TO:
CHIMEDICAL MANAGEMENT GROUP

- ❑ PHENIX CITY LOCATION
  DR. THEIN QUACH M.D.
  3700 SOUTH RAILROAD ST SUITE B
  PHENIX CITY AL, 36867
- ❑ FOREST PARK LOCATION
  DR. THEIN QUACH
  541 FOREST PARKWAY SUITE 14
  FOREST PARK GA 30297

CHIMEDICAL MANAGEMENT GROUP, LLC
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ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE THE FOLLOWING INSURANCE COMPANIES OR LIABLE PAY PARTIES:

1._____
2._____
3._____

I AGREE TO PAY BY CHECK OR WITH CREDIT CARD THROUGH EITHER MAILING THE CHECK PAYABLE TO PHENIX CITY SPINE AND JOINT CENTER, CHIMED REHAB PHENIX CITY- PO. BOX 1611 PHENIX CITY, AL 36867, OR SOUTH ATLANTA SPINE AND JOINT CENTER, CHIMED REHAB SOUTH ATLANTA, DECATUR SPINE AND JOINT CENTER, SOUTH ATLANTA MUA CENTER- PO BOX 1601 PHENIX CITY, AL 36868. THIS COVERSTHE EXPENSE BENEFITS ALLOWABLE AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT POLICY, AS PAYMENT TOWARDS THE TOTAL CHARGES FOR PROFESSIONAL SERVICES RENDERED. I HAVE AGREED TO PAY, IN CURRENT MANNER, ANY BALANCE OF SAID APPLICABLE CHARGES. I FURTHER STATE AND AGREE THAT THIS OFFICE GIVEN A LIMITED POWER OF ATTORNEY TO ENDORSE/SIGN MY NAME ON ANY AND ALL DRAFTS DIRECTED FOR THE PAYMENT OF MY BILL.THIS ASSIGNS ALL FINANCIAL BENEFITS OF TREATMENT BILLED FROM LISTED COMPANIES AND ANY OTHER INSURANCE COMPANY DETERMINED TO BE LIABLE AFTER CARE IS ISSUED.THESE COMPANIES MAY BE ADDED AFTER ORIGINAL SIGNATURE AS THE CLAIM NUMBER, RESPOSIBLE PARTY OR INSURANCE CARRIER MAY CHANGE OR NOT BE KNOWN AT TIME OF CARE.

PATIENT NAME(PRINTED) _____
PATIENT SIGNATURE: _____ DATE: _____
WITNESS NAME_____ SIGNATURE_____ DATE: _____

CONSENT TO TREAT

I, _____ (PRINT NAME), DO HEREBY AUTHORIZE ANY PROVIDER MANAGED BY CHIMEDICAL MANAGEMENT GROUP AND WHOMEVER THEY MAY DESIGNATE AS ASSISTANTSTO PERFORM DIAGNOSTIC TESTS, INCLUDING BUT NOT LIMITED TO RADIOGRAPHS, PHYSICAL EXAMINATION AND ADMINISTER TREATMENT AS DIRECTED, INDICATED OR DEEMED NECESSARY.
THIS INCLUDES EMERGENCY ACTIONS THAT MAY NEED TO BE PERFORMED SHOULD I BE PHYSICALLY INCAPASITATED. COMPLIACATIONS TO CHIROPRATIC CARE MAY INCLUDE RIB FRACTURE AND STROKE, HOWEVER, SPECIFIC TESTS DESIGNED TO MINIMIZE THESE RISKS ARE EMPLOYED AND DO MINIMIZE THESE OUTCOMES. **I ALSO CERTIFY THAT IN NO WAY HAS ANY GUARANTEE OR ASSURANCES AS THE RESULTS THAT MAY BE OBTAINED. I** UNDERSTAND AND AGREE THAT HEALTH AND MEDICAL INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURNACE CARRIER AND MYSELF(PATIENT). FUTHERMORE, I UNDERSTAND AND AGREE THAT THIS OFFICE AND CONTRACTED RESPRESENTIVES MAY PREPARE OR RECIEVE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM MY INSURANCE COMPANY, AND THAT ANY AMOUNT BILLED IS ASSIGNED AND AUTHORIZED TO BE PAID AND SENT DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I PERMIT THIS OFFICE TO ENDORSE REMITTANCES FOR THE CONVEYANCE OF CREDIT TO MY ACCOUNT.HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT I HAVE SOUGHT TREATMENT, RECEIEVED TREATMENT, AND DIRECTLY RESPONSIBLE FOR THE BILLS THAT ACCUMULATE FROM THIS TREATMENT.
NAME (PRINTED) _____
PATIENT SIGNATURE: _____ DATE: _____
WITNESS NAME_____ SIGNATURE_____ DATE_____

CONSENT FOR TREAMENT OF A MINOR:
HEREBY AUTHORIZE ANY PROVIDER MANAGED BY CHIMEDICAL MANAGEMENT GROUP AND WHOMEVER THEY MAY DESIGNATE AS ASSISTANTSTO PERFORM DIAGNOSTIC TESTS, INCLUDING BUT NOT LIMITED TO RADIOGRAPHS, PHYSICAL EXAMINATION AND ADMINISTER TREATMENT AS DIRECTED, INDICATED OR DEEMED NECESSARY TO A MINOR CHILD UNDER MY GUARDIANSHIP. I ALSO ACCEPT A LL TERMS AND CONDITIONS NAMED HEREIN WITH REGUARDS TO PAYMENT AND LEIN ARRANGEMENTS AND AM RESPONSIBLE FOR THE EXECUTION OF THESE AGREEMENTS ON THIS MINORS BEHALF.

GUARDIAN NAME (PRINTED)_____ SIGNATURE_____DATE_____
GUARDIAN DOB: _____GUARDIAN SSN#_____
WITNESS NAME(PRNITED)_____ SIGNATURE_____ DATE_____

CHIMEDICAL MANAGEMENT GROUP, LLC
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LEIN CONTRACT INFORMATION

This document and all that is contained herein is a specifically designed instrument to detail an irrevocable assignment, enforceable contract, and lien. This contract and lien is entered into between The ChiMedical Management Group and its Clinics: Phenix City Spine & Joint Center, LLC, South Atlanta Spine & Joint Center, LLC, Decatur Spine & Joint Center, LLC ChiMed Rehab Phenix City, South Atlanta, Decatur, and the South Atlanta MUA (Manipulation Under Anesthesia) center, Hereafter known as the clinics and our chosen counselor.

(print patient's or guardian name clearly) _____ here forth known as "patient" and (print attorney& or insurance company) _____ here forth known as the "attorney" and/or "insurance company" and is binding on these listed parties for the following text. The patient hereby directs the attorney or insurance company that for any balance such as may be due owing to this office for services rendered to the patient to withhold such funds from any disability benefits, medical payment benefits, health and accident benefits, medical or personal injury settlements or any such other insurance benefit obligated to reimburse the patient, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately satisfy any balance owing and protect the interest of the clinics. I further irrevocably authorize this clinic to obtain a perfected lien attaching any and all insurance benefits, judgments, and settlements named herein. Once I have accepted terms and or conditions or made an agreement with any third party for any amount relating to this injury or claim, this document is to serve as an irrevocable assignment and lien of these benefits or proceeds of the agreement or settlement to the amount necessary to adequately satisfy any balance owing and protect the interests of the clinics. If there is an attorney representing me, this lien against me is to be enforced against the third-party insurance company for direct payment or payment through the attorney at the discretion of the clinic. If the clinic at its discretion does allow payment from the attorney, the patient is bound personally and jointly with the attorney, if retained, or other noted counsel responsible for the total amounts due to said office. The attorney is only released from this binding lien if there is no settlement of any amount for the above mentioned injury or: if the patient acquires new counsel the contract is now binding on the new counsel in its entirety, and if all legal representation in reference to this accident has been terminated prior to the settlement with the previous attorney, the previous attorney mentioned in this document is therefore re-leased from all aspects of this contract upon written notice received in this office by US Mail according to the post marked date. The patient and attorney understand that not honoring the full extent and purpose of this contract constitutes default and binds upon both parties separately and individually all charges, collection costs, attorney fees and finance charges. This contract can only be altered with the amount of settlement by written signed verification from The ChiMedical Management Group, clinics and the bound third party or attorney. (Attorney Name and Insurer may be added after original signer if new party or attorney changes or becomes known after this date. The representative of the clinic is authorized to make this addition or change.

PATIENT PRINTED NAME: _____ SIGNATURE _____ DATE: _____
WITNESS PRINTED NAME: _____ SIGNATURE _____ DATE: _____
ATTORNEY PRINTED NAME: _____ SIGNATURE _____ DATE: _____

INS ADJUSTER PRINTED NAME: _____ COMPANY _____ DATE: _____

I authorize this clinic to release or receive any information pertinent to this injury to or from the attorney and to or from any insurance company or responsible third-party attorney or adjuster to facilitate collection under this assignment and contract. The clinic may perfect an AL or GA lien or obtain a letter of protection from any attorney representing me in this case. Firm

Name: _____ Phone: _____

CHIMEDICAL MANAGEMENT GROUP, LLC
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MEDICAL RECORDS RELEASE

PLEASE CHECK THE FACILITY TO WHERE YOU WOULD LIKE YOUR MEDICAL RECORDS SENT.

THIS IS A FORMAL REQUEST FOR MEDICAL RECORDS
X-RAY'S, MRI'S, LAB TESTS AND REPORTS BE SENT TO:

CHIMEDICAL MANAGEMENT GROUP

- ❑ PHENIX CITY LOCATION
  TO MAIL RECORDS, PLEASE MAIL TO:
  3700 S Railroad St., Suite B
  Phenix City AL 36867
  IF YOU WISH TO FAX RECORDS, PLEASE FAX TO: 866.537.1711
- ❑ FOREST PARK LOCATION
  TO MAIL RECORDS, PLEASE MAIL TO:
  541 Forest Parkway, Suite 14
  Forest Park GA 30297
  IF YOU WISH TO FAX RECORDS, PLEASE FAX TO: 678.922.2133
- ❑ DECATUR LOCATION
  TO MAIL RECORDS, PLEASE MAIL TO:
  3755 Memorial Drive
  Decatur GA 30032
  IF YOU WISH TO FAX RECORDS, PLEASE FAX TO: 404.393.8885

REGARDING THE PATIENT (PLEASE PRINT NAME): _____

SOCIAL SECURITY NUMBER _____ BIRTH DATE _____

PATIENTS SIGNATURE FOR RELEASE: _____

CHIMEDICAL MANAGEMENT GROUP, LLC
CHIROPRATIC, MEDICAL & PHYSICAL THERAPY
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OUR OFFICE PHONE NUMBER: 877.495.7773

HIPAA PRIVACY STATEMENT

HIPAA (Health Insurance Portability and Accountability Act)

HIPAA PRIVACY Statement for the ChiMedical Management Group
This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Understanding your health record information
Each time you visit a hospital, physician or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment and a plan for future care and treatment. This information is often called your health and medical record and serves as the following.

- A basis for planning your care and treatment
- Means of communication along the many health professionals who contribute to your care
- Legal documentation describing the care you received
- Means by which your third-party payer can verify that services billed were actually provided
- A tool in educating health care providers
- A source of date for medical research
- A tool we utilize to assess, analyze, and improve the care we render and the out-comes we have achieved
- Ensure its accuracy
- Understand who and under what circumstances they may access your health information
- Make a more informed decision when signing disclosure statements to authorize access by others.

Your Health Information Rights
Although your health record is the physical property of the health care provider or the facility who compiled it, the information belongs to you. You have the right to

- Obtain an account of the disclosures of your health record
- Revoke authorization for future disclosure except that which has already been provided Our Responsibilities
- Maintain privacy of your health information
- Provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by all the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means to alternative locations

We reserve the right to change our practices and make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied to us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For more information, questions, or to report a problem, you may contact our HIPAA Privacy Officer at (412) 446-9100. If you believe your privacy rights have been violated, you may file a complaint with our HIPAA Privacy Officer. There will be no retaliation for filing a complaint.

- Request a restriction on certain uses and disclosures of your information as provided by CFR 164.522
- Obtain a paper copy of notice of information practices upon request
- Inspect and copy your health record as provided in 45 CFR 164.524Initial (HIPAA stands for the “health insurance portability and accountability act”)

I have read the HIPAA PRIVACY STATEMENT and Understand:

PATIENT SIGNATURE_____ DATE_____