FIGHT DOC
DR. MARK ZUBER, D.C.

Patient Intake

Today's Date:___/_____/_____

Name_____Sex_____ Age_____Date of Birth_____

Address_____City_____State____Zip_____

Marital Status_____Spouse Name _____Home Phone_____Cell Phone_____

Email Address:_____Occupation_____

Emergency Contact_____Phone_____Relationship _____

How did you hear about our office?

☐ Drive By ☐ Walk-In ☐ Internet ☐ Referral (Please tell us who) _____ ☐ Other: _____

Health Insurance Information

Primary Insurance_____Policy Holder's Name_____DOB_____

Policy Holder's Relationship to Patient_____

Accident Information (SKIP this section if you were not involved in an accident)

Is your condition due to an: ☐ ***Auto Injury*** ☐ ***Work Injury*** ☐ ***Slip and Fall*** ☐ ***Other Accident (describe below)***

Date of Accident_____Place (City/State)_____

Auto/Work Insurance Company_____Insured's Name and DOB

If Auto Injury, have you reported the accident to your insurance company? ☐ No ☐ Yes Claim #_____

If Work Injury, have you reported the accident to your supervisor/boss? ☐ No ☐ Yes Claim #_____

If Slip and Fall or Other Type of Injury, please describe:_____

*Do you have an **Attorney** for your Auto or Work Comp. injury* ☐ Yes ☐ No

Please provide Attorney Name, address and phone # _____

Current complaint

I. Please list your **worst** complaint:_____How long have you had it:_____

How did it start?_____ ***A) Is it:*** ☐ *Improving* ☐ *Worsening* ☐ *Staying the Same* ***B) Is it:*** ☐ *Mild* ☐ *Moderate*

☐ *Severe* ***C) What worsens it:*** ☐ *General activity* ☐ *Moving Wrong* ☐ *Bending* ☐ *Lifting* ☐ *Walking* ☐ *Sports* ☐ *Getting up from a chair*

☐ *Using a computer/desk work* ☐ *Other:*_____ ***D) What makes it better:*** ☐ *Rest* ☐ *General Activity* ☐ *Ice Packs*

☐ *Heating Pad* ☐ *OTC Meds* ☐ *Rx Meds* ☐ *Massage* ☐ *Chiropractic* ☐ *Other:*_____ ***E) Is it worse in the:*** ☐ *AM* ☐ *PM*

☐ *After day wears on* ☐ *Steady* ☐ *Off and on* ***F) Is the symptom:*** ☐ *Dull and Achy* ☐ *Tight and Stiff* ☐ *Sharp and Stabbing*

☐ *Numb and Tingly* ☐ *Shooting* ☐ *Burning* ☐ *Cramping*

II. Please list your **2nd worst** complaint:_____How long have you had it: _____

How did it start? _____ ***A) Is it:*** ☐ *Improving* ☐ *Worsening* ☐ *Staying the Same* ***B) Is it:*** ☐ *Mild* ☐ *Moderate*

☐ *Severe* ***C) What worsens it:*** ☐ *General activity* ☐ *Moving Wrong* ☐ *Bending* ☐ *Lifting* ☐ *Walking* ☐ *Sports* ☐ *Getting up from a chair*

☐ *Using a computer/desk work* ☐ *Other:*_____ ***D) What makes it better:*** ☐ *Rest* ☐ *General Activity* ☐ *Ice Packs*

☐ *Heating Pad* ☐ *OTC Meds* ☐ *Rx Meds* ☐ *Massage* ☐ *Chiropractic* ☐ *Other:*_____ ***E) Is it worse in the:*** ☐ *AM* ☐ *PM*

☐ *After day wears on* ☐ *Steady* ☐ *Off and on* ***F) Is the symptom:*** ☐ *Dull and Achy* ☐ *Tight and Stiff* ☐ *Sharp and Stabbing*

☐ *Numb and Tingly* ☐ *Shooting* ☐ *Burning* ☐ *Cramping*

Current Health

• Name and phone number of family doctor: _____

• List all CURRENT illnesses or diseases you have been diagnosed with (cancers, tumors, infections, diabetes, aneurysms, etc.):

_____

• If you are currently taking any prescription or nonprescription medications, please list them below with dosages:

Medication:_____Dose:_____Medication:_____Dose: _____

Medication:_____Dose:_____Medication:_____Dose: _____

• Please list any medications you are allergic to: _____

• Please indicate your height and weight_____

Health History

• List any operations, surgeries or medical procedures:

Date:_____Procedure:_____Date:_____Procedure: _____

Date:_____Procedure:_____Date:_____Procedure: _____

• If you have ever had in the past or currently have any serious illnesses or injuries, please list:

Date:_____Condition:_____Date:_____Condition: _____

Date:_____Condition:_____Date:_____Condition: _____

Any current loss of bowel or bladder control: ☐Yes ☐No Any current seizures, paralysis, speech, vision problems: ☐Yes ☐No

Any unexplained recent weight loss: ☐Yes ☐No Current fever: ☐Yes ☐No Current nutritional problems: ☐Yes ☐No

• Please list any significant family illnesses_____

• Have you had spinal X-Rays within the past 5 years? If yes, when and where _____

• **Do you have a pacemaker? ☐Yes ☐No If yes, please ALERT our doctor and/or chiropractic assistant**

• Do you have any blood/lymph disorders? ☐Yes ☐No If yes, please list _____

• Do you have osteoporosis or rheumatoid arthritis? ☐Yes ☐No

• Please list any other electrical device that you currently wear_____

• Please select one: ☐ I have never smoked ☐ Former smoker ☐ Current smoker, if so how much:_____pk./day_____pk./wk.

• Please select one: ☐ I don't drink alcohol ☐ Rarely drink ☐ Social drinker ☐ Heavy drinker (_____oz. per day/week)

• Have you ever had chiropractic care ☐Yes ☐No If yes, last date of treatment_____ By whom: _____

Similar or difference condition:_____Results: _____

What are your overall expectations from your treatment with our doctor: _____

I, the undersigned, hereby give my consent for the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic care. I also give my consent to the doctor to order x-rays (if needed) or to perform other diagnostic aids as he/she deems appropriate in my case.

• ***WOMEN ONLY*** *I hereby declare that to the best of my knowledge* ☐ ***I am*** ☐ ***I am not pregnant****. If there is a chance that I may be pregnant, I will inform the doctor prior to my examination.*

Patient Signature_____

(Parent/Guardian signature if under 18 years of age)

FightDoc
Zuber Physical Medicine & Rehab
8765 Stockard Drive Ste 303
Frisco, TX 75034

ASSIGNMENT OF PROCEEDS, LIEN, AGREEMENT AND AUTHORIZATIONS

Patient hereby irrevocably acknowledges full financial responsibility for all services provided to patient by Provider as consideration for such Provider services. Patient irrevocably assigns to Provider any and all benefits payable by or from any insurance or health care plan(s) coverage maintained by Patient as consideration for the total fee for those charges incurred by Patient as a result of those services rendered by Provider. Patient also assigns to Provider: (i) any and all benefits payable by or from any automobile medical payment coverage maintained by Patient or any party under whose policy of insurance Patient may have a lawful right of recovery, (ii) any and all benefits payable by or under any third party liability insurance coverage to which Patient may have a right of recovery due to the injuries for which Patient has sought Provider's health care services, and (iii) a "common law lien interest" in, and all contractual rights and claims to, any and all future insurance proceeds Patient has against any insurance company, health care benefit plan, or any other party contractually liable to Patient for payment of all or any portion of the health care services rendered by Provider, and the resultant charges therefore, to the Patient as a result of the injuries sustained by Patient. This irrevocable assignment of benefits, conveyance of lien interest and contractual rights to and for those charges attributable to Provider's health care services shall extend to, but not be limited to, Provider's entitlement to any and all insurance proceeds remitted as a result of any insurance claim for damages by the Patient which has given rise to the above referenced health care services provided by Provider.

I hereby authorize and direct all insurance carriers, attorneys, agencies, government departments, companies, individuals, and/or other legal entities ("payers"), which may elect or become obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, for which medical treatment or medical services were rendered hereunder ("condition") to pay directly and exclusively in the name of FightDoc such sums may be owing to FightDoc for charges incurred by me at FightDoc relating to my condition ("charges"), with such payments to be made exclusively in the name of FightDoc. I further grant a lien to FightDoc, in accordance with the definitions, rights, and remedies of Texas law including specifically, but not limited to, Texas Business & Commerce Code §9.102 and the comments thereunder, with respect to my outstanding medical balance. This lien shall apply to all payers and to the full extent of Texas law. For the purposes of this medical assignment and medical lien, "benefits" shall include, but no be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeding or recovery obtained as result of commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no fault coverage, uninsured and underinsured motorist coverage, third-party liability distribution, or disability distribution.

I authorize FightDoc Office and Staff to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Assignment of Lien. I further authorize and direct all payers to release any and all information regarding any coverage or benefits which I may provide for reimbursement to for medical services provided to me including, but not limited to, the amount and type of insurance coverage, the amount paid out on this condition thus far, and the amount of any outstanding claims. I hereby direct FightDoc to file a copy of the assignment and lien with all payers. I hereby authorize FightDoc to file a copy of this assignment and lien with all public records in accordance with Texas law so as to provide public notice of this assignment and lien. In the event I retain one or more attorneys to represent me for the recovery for injuries with sustained which were the basis of the condition on which I sought medical treatment, I direct each and every attorney to issue a letter of protection to FightDoc to protect FightDoc's outstanding medical charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the express written consent of FightDoc.

_____
Patient Initials

ASSIGNMENT OF PROCEEDS, LIEN, AGREEMENT AND AUTHORIZATIONS (cont'd)

I understand that I will become personally responsible should any payer fail to honor this assignment. I understand that my personal responsibility is in addition to the obligation of any other payer, to the extent of my outstanding medical balance, costs, and expenses and enumerated herein, including attorneys fees. I further understand and acknowledge that FightDoc has rendered good and valuable services and consideration for this assignment and lien including forbearance of payment for services rendered for a reasonable period. In the event that FightDoc must take any action to collect an outstanding balance on my account. I acknowledge and agree to be liable to reimburse FightDoc for all costs incurred, including collection costs, court costs, expert witness fees, travel costs, and reasonable attorneys' fees.

This Assignment and Lien constitutes the complete agreement between the parties and revokes any other written agreement or oral agreements between the parties. I acknowledge that I have read this Assignment, Lien, and Agreement and that I acknowledge acceptance of, agreement to and understand that this is a binding legal document and that this Assignment, Lien, Agreement and Authorization affects legal rights that I may have to settlement, judgment, or verdict proceeds as a result of the injuries that I have suffered.

Patient Name (please print) _____

Patient Signature_____

Name of Custodial Parent or Legal Guardian (please print) _____

Parent/Guardian Signature_____

Date_____/_____/_____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any given time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and privacy official has been designated to enforce those procedures at our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. The patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____	_____	_____
Printed Name	Signature of Patient/ Legal Guardian	Date

The material risks inherent is such options and the probability of suck risks occurring include:

- Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work or household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.
- Prescription muscle relaxants and pain killers can produce undesirable side effects and patient dependence. The risk of suck complications arising is dependent upon the patient's general health, severity of the patient's discomfort, pain tolerance and self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks – some with rather high probabilities.
- Hospitalization on conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.
- The risks inherent is surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

- **The risks and dangers attendant to remaining untreated.**

  Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____	_____	_____
Printed Name	Signature of Patient/ Legal Guardian	Date

_____	_____
Signature of Witness	Printed Name of Witness

General/Financial Policy

We strive to provide you with excellent care in a clean, friendly, professional setting and our goal is to make your visits as convenient as possible.

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone changes.
- Your account is to be kept current. All self-pay or insurance copayment, co-insurances or deductibles will be collected at the time of service payable by cash, check, Health Spending Account (HSA), Visa, MasterCard, Discover or American Express.
- If you do not have your payment(s), your appointment may be rescheduled.
- If you are unable to keep a scheduled appointment, please give our office **24** hours before your scheduled time so that we may offer that time to another patient. Failure to give proper notice of cancelations will result in the following charges:
    - One grace period is extended to each patient for missed appointments or last minute reschedules.
    - There will be a $80 charge for missing a Chiropractic appointment
- A returned check will result in a $25 service charge and all future payments being required in the form of cash or credit card.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. **WE ARE HERE TO HELP YOU.**

IF YOU HAVE HEALTH INSURANCE COVERAGE: As a courtesy to you, our office will attempt to pre-verify your primary insurance coverage for your Chiropractic care. Coverage information is obtained from you insurance company using information provided by you prior to your initial visit. **We must emphasize as medical providers, our relationship is with you, not your insurance company.** Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of inquiry.

By signing below you confirm you understand that:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified.
- Not all services are a covered benefit with all insurance plans.
- We will send all required claims forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.

By signing below, you have read and understand the above Financial Policy and agree to meet all financial obligations.

_____	_____	_____
Printed Name	Signature of Patient/ Legal Guardian	Date