

Please Print

NEW PATIENT INFORMATION

Name _____ Age _____ Sex _____ Date _____
 Address _____ City _____ Zip _____
 Phone _____ Work _____ Cell _____
 E-mail _____
 Social Security # _____ Birthdate _____ Family Doctor _____
 - Married - Single -Sep -Divorced -Widowed
 Employer _____
 Employer Address _____
 Employer Phone _____
 Parent's Employer If Patient Is Minor / Child _____
 Parents Social Security # If Patient Is Child _____
 Emergency: Who Do We Call? _____ Relationship _____
 Name of Relative or Friend Not Living with You _____ Phone _____

REFERRAL INFORMATION

WHO recommended you to our office? My Doctor Family / Friend _____
 Name _____ Address or Phone _____

ACCIDENT INSURANCE INFORMATION

Name of YOUR Auto Insurance Company _____
 Agent Name _____ Adjuster's Name _____
 Accident Claim Number _____ Phone Number _____
 Name of LIABLE Insurance Company _____ Adjuster's Name _____
 Claim Number _____ Phone Number _____
 Attorney Name _____ Phone Number _____

WORK OR INJURY INSURANCE INFORMATION

Employer or Responsible Party _____
 Contact Person _____ Phone Number _____

Please provide the receptionist with your driver's license & insurance card to be photocopied for your permanent medical record.

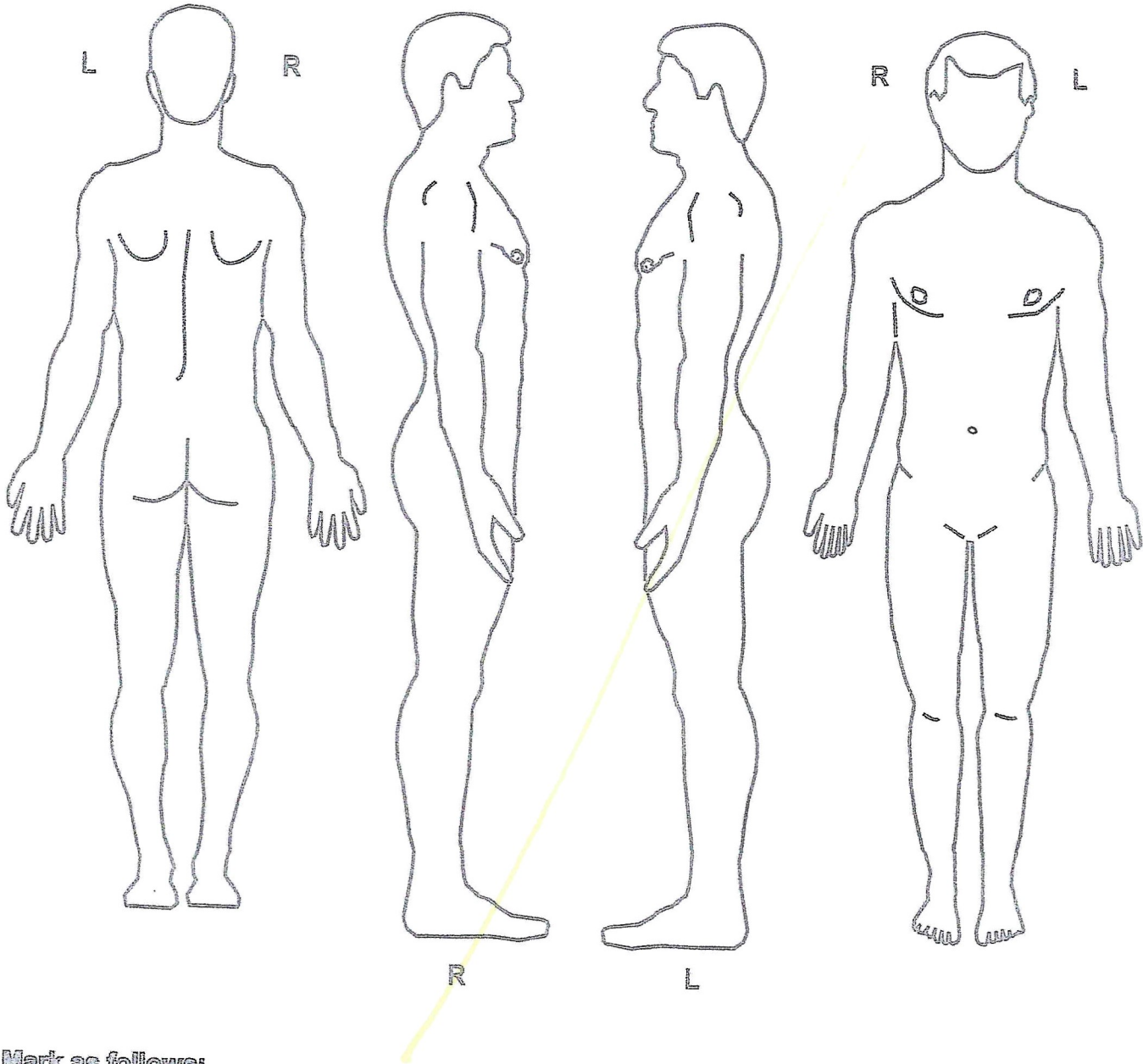
Welcome to our multi-specialty group practice, offering family practice & pain management medical care, chiropractic, physical therapy, rehabilitation, acupuncture, massage therapy, nutritional & psychological counseling. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice. This Notice is detailed on page -3- of this document. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff.

Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or all staff of this Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities. Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. If you must miss an appointment please notify us. If you do not show up for your scheduled appointment you will be charged \$15.00 as a missed appointment fee that you must pay before you are seen or treated again. We are available to immediately see new patients the same day or through our 24 hour - 7-day emergency service. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.

PAIN DRAWING

Name _____ Date _____



Mark as follows:

A - Ache B - Burning N - Numbness P - Pins & Needles
S - Stabbing O - Other - Describe _____

Patient Questionnaire – Auto-Accident

Patient Name: _____

Today's Date: ___/___/___

Date of Exam: ___/___/___ Provider: _____

New Patient Yes No

Basic Information about the Accident:

Date Accident Occurred or Started: ___/___/___

Time of Day when Accident Occurred or Started: ___:___ AM / PM

Describe how the Accident took place: _____

Describe the condition or symptoms caused by the Accident: _____

Auto-Accident Specific Information:

Were you the: Driver Passenger Pedestrian

Automobile you were in: Year _____ Make _____ Model _____

Damage to your car: Front Rear Pedestrian Driver Side Passenger Side Bumper Fender

Damage Amount Estimate: \$ _____ : Minor Major Totaled

Other Automobile: Year _____ Make _____ Model _____

Damage to other car: Front Rear Pedestrian Driver Side Passenger Side Bumper Fender

Minor Major Totaled

Where did the accident happen? Street Names: _____ City/State _____

Was it? Controlled Intersection Uncontrolled Not Intersection

Was there a traffic light? None Green Red Turn Arrow Stop Sign

Were you: Slowly Moving Moving Stopped

Weather Conditions: Sunny Rainy Cloudy

Street Surface: Dry Wet Slick Icy Pavement Other _____

Type of Impact: Rear end Front Side Impact Roll Over

Brakes on Impact: Locked Tight Loosely Applied Foot not on brake

How far did your car move? Did not move Moved 1-5 ft Moved 6-10 ft Moved over 10 ft

Where were you seated in the vehicle: _____ Wearing Seat belt? Yes No

Shoulder harness: Yes No Headrest: Yes No Headrest Position: Up Down

Is the car equipped with airbags? Yes No Did they deploy? Yes No

Did you see the impact coming? Yes No Did you brace yourself for impact? Yes No

On impact, your head was looking: Ahead Behind Up Down To the Right To the Left

On impact were you: Thrown forward Thrown backwards Thrown sideways Other _____

Did your body hit anything inside the car? Yes No Body Part: _____

What did it hit? _____

Head trauma? Yes No Loss of Consciousness? Yes No For how long? _____

Do you remember the accident happening? Yes No

Hospital? Yes No Name of hospital: _____ How long there? _____

Taken by ambulance? Yes No

X-rays taken? Yes No X-ray areas: Neck Mid-back Low-back Other X-rays _____

Medication Given? Yes No RX: _____

Other instruction: _____ Follow-up: _____

Additional Information Related to the Condition:

Describe your pain: Burning Sharp Dull Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? Yes No

When? ___/___/___

Describe: _____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Please check any of the following symptoms you are now experiencing:

- Headache
- Loss of Memory
- Hands Cold
- Numbness in arms/hands
- Cold Sweats
- Irritability
- Loss of strength - arms
- Dizziness
- Clumsiness
- Sleeping Problems
- Buzzing in Ears
- Tension
- Loss of Smell
- Burning muscle pain
- Light Bothers Eyes
- Feet Cold
- Tingling in legs/feet
- Constipation
- Shortness of Breath
- Chest pain/rib pain
- Loss of strength - legs
- Diarrhea
- Neck Stiff
- Face Flushed
- Nervousness
- Fainting
- Pain in arms/hands
- Difficulty swallowing
- Head seems too heavy
- Tingling in arms/hands
- Nausea
- Numbness in legs/feet
- Fever
- Pain in legs/feet
- Sharp/shooting pain
- Neck Pain
- Ears Ring
- Back Pain
- Loss of Balance
- Fatigue
- Jaw pain

Other _____

Have you experienced changes to:

- Eyes (sight)
- Ears (hearing)
- Nose (smell)
- Mouth (taste)
- Bladder
- Bowels
- Sleep
- Emotion
- Appetite

Please Explain: _____

Have you missed work or school due to your injuries? Yes No

Do you smoke? Yes No Number of packs: _____

Do you drink alcohol? Yes No Number of Drinks _____

Notes: _____

Medical History:

Have you ever been in our office before? Yes No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

- 1) _____ / /
- 2) _____ / /
- 3) _____ / /

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

Do you now or have you ever had:

- | | | | | | |
|--|--|--|---------------------------------|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Prostate Disorder | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizure Disorder |

Other: _____

HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT – ASSIGNMENT OF BENEFITS – AUTHORIZATION & LIEN

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility.

Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility.

Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility.

I understand that this Facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur.

I further understand that in the practice of medicine, chiropractic, psychological counseling, massage therapy & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions & reactions and/or other injuries or side effects which cannot be pre-determined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility.

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

- Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay.
- Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
- Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
- All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
- A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy.
- A service charge is computed by a 'periodic rate' of 1 1/2 % per month - 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee's. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a \$30.00 charge.
- Patients are eligible for a maximum \$250 personal credit limit when approved. For your convenience we accept most major credit & debit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Name of Patient

X

Signature

Date

Fields Chiropractic Clinis
2143 Gilmer Rd. – Longview, TX 75604
Phone:903-234-2886 Fax: 903-234-2451

Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to David H. Collum, DC, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct my carrier to make all checks payable to Collum Auto Injury Clinic, and send to PO Box 167682 Irving, TX, 75016.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Collum Auto Injury Clinic, and to send any and all checks to PO Box 167682 Irving, TX, 75016.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

Signature of Patient and/or Responsible Parties:

Date: _____

AUTHORIZATION FOR Medical Records Release

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I authorize the following party : _____

to use or disclose the following health information.

- All of my health information
- My health information covering the period from visit on or around _____

The above party may disclose this health information to the following recipient:

Fields Chiropractic Clinic
2143 Gilmer Rd.
Longview, TX
Phone: 903-234-2886 Fax: 903-234-2451 Email: fccfrontdesklongview@gmail.com

The purpose of this authorization is:

- At my request for continued treatment and expires on _____
- Other: _____

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature of Patient: _____ **Date:** _____

If the patient is a minor or unable to sign, please complete the following:

- Patient is a minor: _____ years of age
- Patient is unable to sign because: _____

Signature of Authorized Representative: _____ **Date:** _____

- Parent - Legal Guardian - Court Order - Other: _____