ABSOLUTE CHIROPRACTIC & REHAB

Rick Bartlett, D.C., Steve Anderson, D.C.
480 W. Harwood Rd., Hurst, TX 76054
Phone: (817) 428-0801 Fax: (817) 428-0875
www.absolutechirorehab.com

Registration and Confidential Patient Questionnaire

Date _____

Patient last name _____ First name _____ Initial _____ Prefer to be called _____

Address _____ City _____ State _____ Zip _____ Home phone _____

Sex ❑M ❑F Marital status ❑Single ❑Married ❑Widowed ❑Divorced ❑Partnered Cell phone _____

Age _____ Date of birth _____ Number of children _____ Emergency contact/phone _____

SSN _____ Drivers license # _____ Email address _____

Occupation _____ Employer _____ Employer's phone _____

Employer's address _____ City _____ State _____ Zip _____

Spouse's name _____ Occupation _____ Employer _____

How did you hear about us? ❑Attorney _____ ❑Personal referral _____ ❑Insurance ❑Health lecture

❑Mall screening ❑Spinal care class ❑Yellow pages ❑Absolute Chiropractic & Rehab website ❑Other _____

Please list any and all insurance and/or employee health care plan coverage you or your spouse may have

Patient insurance information: Insurance company _____

Policy/group # _____ Effective date _____ ID # _____

Name of insured _____ Date of birth _____ SSN _____

Relationship to insured ❑Self ❑Spouse ❑Child ❑Other _____

Spouse coinsurance information: Insurance company _____

Policy/group # _____ Effective date _____ ID # _____

Name of insured _____ Date of birth _____ SSN _____

Are you present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? If you answer yes, please fill out accident specific form, available at the front desk.

❑Yes ❑No Your initials: _____ Attorney (if applicable) _____ Phone _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee healthcare benefits coverage with the above captioned, and hereby assign and convey directly to **Absolute Chiropractic & Rehab** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and /or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee healthcare plan any claim, chose in action, or other right I may have to such insurance and/or employee healthcare benefits coverage under any applicable insurance policies and/or employee medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurer and/or employee healthcare plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee healthcare plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of insured/guardian Date

What is your major complaint for which you came to our clinic? _____

_____

Please describe in detail how your present illness developed/started from first sign/symptom to the present.

_____

_____

Did symptoms/pain begin ❑Gradually ❑Suddenly

How long have you had these episodes of symptoms? _____

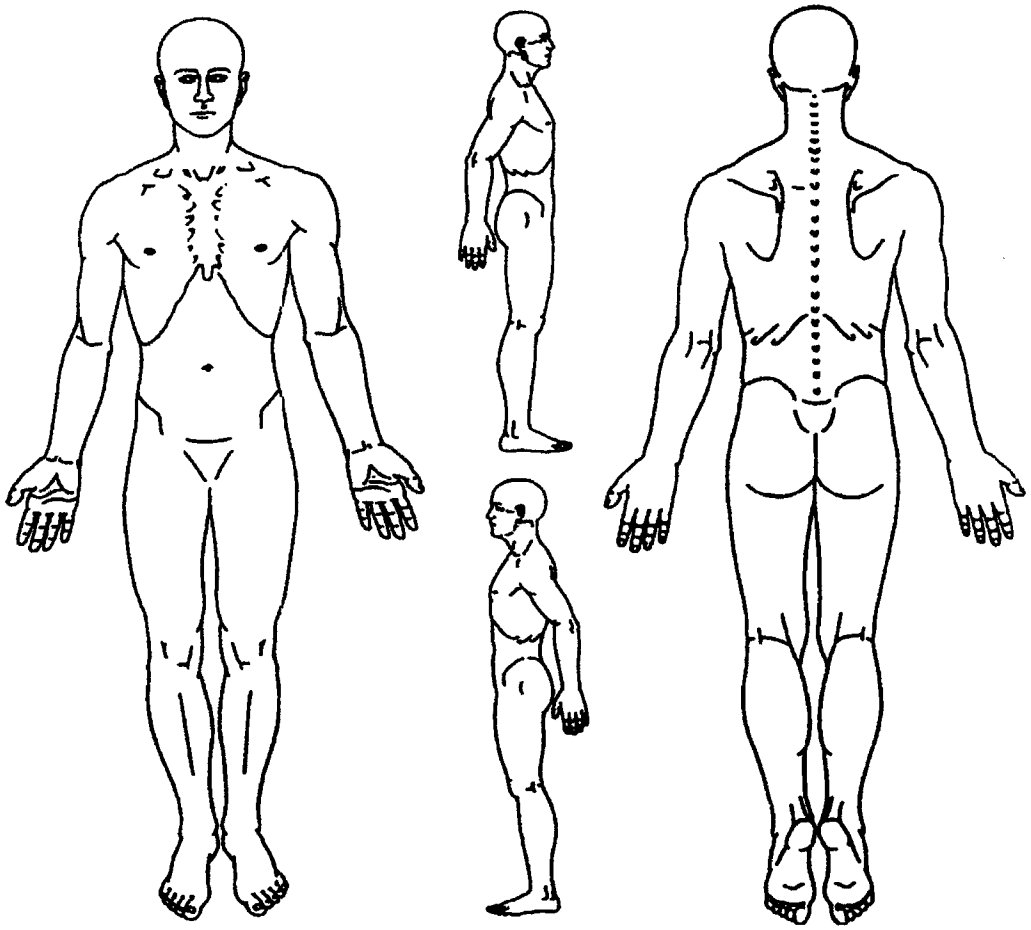
Describe the quality/character of your symptoms. Some words often used include: burning, tingling, aching, tired, numbness, sharp, dull, stabbing, shooting, radiating, pins and needles, etc.

_____

_____

Mark the areas on your body where you feel pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>>>>	Numbness ======	Pins and Needles ↓↓↓↓↓↓	Burning ××××××
Stabbing ∇∇∇∇∇	Throbbing ~~~~~~	Tingling ++++++	Sharp ↔↔↔↔
Dull 0 0 0 0 0	Soreness ∩∩∩∩∩	Shooting ⊕⊕⊕⊕	Other



Have you experienced any restrictions or difficulties in any **activities of daily living, social and recreational activities** because of your current condition, please describe in detail (such as bathing, grooming, dressing, eating, walking, stooping, bending, grasping, driving, etc.)?
❑Yes ❑No If yes, is the effect ❑Mild ❑Moderate ❑Severe

Please explain: _____

Have you experienced any restrictions or difficulties in performance of your **job duties at work** because of your current condition?
❑Yes ❑No If yes, is the effect ❑Mild ❑Moderate ❑Severe

Please explain: _____

Have you seen a physician or chiropractor outside this clinic for the problems for which you came to this clinic?
❑Yes ❑No If yes, please list each doctor individually.

A. If yes, whom did you see? Doctor's name _____ Specialty _____

Address _____ City _____ State _____ Phone _____

When were you seen? From _____ to _____ Are you still under this doctor's care? ❑Yes ❑No

Were ❑X-ray ❑MRI ❑CAT Scan ❑EMG ❑Bone scan ❑Others _____ taken?

What was diagnosis? _____

What types of treatments were received? Please list in detail all the treatments you received from this doctor (include medications, injections, surgeries, physical therapy and others)

_____

B. If yes, whom did you see? Doctor's name _____ Specialty _____

Address _____ City _____ State _____ Phone _____

When were you seen? From _____ to _____ Are you still under this doctor's care? ❑Yes ❑No

Were ❑X-ray ❑MRI ❑CAT Scan ❑EMG ❑Bone scan ❑Others _____ taken?

What was diagnosis? _____

What types of treatments were received? Please list in detail all the treatments you received from this doctor (include medications, injections, surgeries, physical therapy and others)

_____

C. If yes, whom did you see? Doctor's name _____ Specialty _____

Address _____ City _____ State _____ Phone _____

When were you seen? From _____ to _____ Are you still under this doctor's care? ❑Yes ❑No

Were ❑X-ray ❑MRI ❑CAT Scan ❑EMG ❑Bone scan ❑Others _____ taken?

What was diagnosis? _____

What types of treatments were received? Please list in detail all the treatments you received from this doctor (include medications, injections, surgeries, physical therapy and others)

_____

Have you seen a physical therapist for this problem? ❑Yes ❑No

If yes, whom did you see? Name _____ Address _____

What types of therapies were received? _____

Have you seen a physician, chiropractor or physical therapist for any other problems? ❑Yes ❑No

If yes, please describe _____

_____

Any family history of diseases or death of parents, siblings and children (i.e. heart problems, diabetes, asthma, hereditary disease, etc.)?

❑Yes ❑No If yes, please describe _____

Please list all major past diseases and accidental injuries (include concussions, head injuries, broken bones, high blood pressure, etc.) you may have had which did not require hospitalization (please include dates and any recurring problems)

Illness/injury Date Recurring

Have you ever been involved in injuries from following?

❑Automobile accident ❑Worker's compensation ❑Personal injuries (slip and fall, etc.)

❑Yes ❑No If yes, please list all of them with date, type, and legal status.

Injury Date Settled Not settled Attorney's name

Please list all surgeries/operations you have ever had. Please also list when these were done, where they were done, who the surgeon was, and if you have had any remaining problems associated with these procedures. (Attach separate sheet if necessary)

Date Type of surgery Where Surgeon's name Complications Remaining problems

Are you allergic to anything (medications, lotion, latex, etc.)? ❑Yes ❑No

If yes, please explain _____

Do you smoke or use any tobacco products? ❑Yes ❑No If yes, how much & often? _____

Do you drink alcoholic beverages? ❑Yes ❑No If yes, how much & often? _____

Do you drink caffeinated beverages? ❑Yes ❑No If yes, how much & often? _____

Have you missed any work as a result of this illness/pain? ❑Yes ❑No

If yes, how many days/weeks? _____ Dates of absence _____ to _____

What type of physical activities or postures does your job involve (prolonged sitting, standing, bending, etc.)?

Please list all and any other health problems you have had in the past or have now (such as headache, dizziness, blurred vision, vertigo, heart attack, high blood pressure, stomachache, vomiting, bloody stool, kidney infection, pneumonia, asthma, etc.).

Illness/discomforts Date

Women only

A. *Are you pregnant or think you may be pregnant?* ❑Yes ❑No

B. *Date of last menstrual period* _____

C. *Do you or have you suffered from any menstrual disorders?* ❑Yes ❑No

If yes, please explain _____

Who is filling out this questionnaire? ❑Self ❑Spouse ❑Other _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____

Patient's Signature Date

_____ _____

Doctor's Signature (upon review) Date

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Automobile Accident Questionnaire

Patient's Name: _____ Today's Date: _____

Date of Accident: _____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:
- ❑Car
- ❑Truck
- ❑SUV
- ❑ Other _____
- ❑Van

Vehicle size:
- ❑Compact
- ❑Mid-size
- ❑Full-size _____
- ❑Make _____
- ❑Model _____

Your position in the vehicle:
- ❑Driver
- ❑Passenger
- ❑Other _____

Location:
- ❑Left
- ❑Front passenger
- ❑Middle
- ❑Rear passenger
- ❑Right
- ❑Third seat (rear)

Speed of your vehicle:
- ❑Moving slowly
- ❑Slowing
- ❑Stopped
- ❑Parked
- ❑Moving moderately
- ❑Moving fast
- ❑Moving at apprx ____MPH

Why Vehicle was slowed or stopped:
- ❑Traffic signal
- ❑Pedestrian
- ❑Stop sign
- ❑Parking
- ❑Traffic
- ❑Busy intersection

Collision Type:
- ❑Driver side impact
- ❑Passenger side impact
- ❑Front impact
- ❑Head on collision
- ❑Rear impact
- ❑Pedestrian incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:
- ❑Car
- ❑Truck
- ❑SUV
- ❑ Other _____
- ❑Van

Vehicle size:
- ❑Compact
- ❑Mid-size
- ❑Full-size _____
- ❑Make _____
- ❑Model _____

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...
- ❑Totally unaware that the accident was impending
- ❑Aware that the accident was impending
- ❑Aware that the accident was impending and braced for it

Restraints: (check all that apply)
- ❑Seat belt with shoulder harness
- ❑ No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? ❑Yes ❑No ❑Knocked off by impact

Was the air bag deployed?
- ❑Car not equipped with air bag
- ❑Air bag deployed
- ❑Air bag not deployed

What position was YOUR headrest in?
- ❑High position
- ❑Middle position
- ❑Low position

Damage to vehicle YOU were in:
- ❑Incurred minimal damage (Less than $1,000)
- ❑Incurred moderate damage ($1,000-$2,500)
- ❑Incurred severe damage (More than $2,500)

Were the police called? ❑Yes ❑No
Was a police report filed? ❑Yes ❑No

Position of YOUR head at time of impact?
- ❑Facing straight ahead
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Position of Your body at time of impact?
- ❑Facing straight ahead
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your head thrown...?
- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left
- ❑To the right
- ❑To the left then the right
- ❑To the right, then the left

Was your body thrown...?
- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left
- ❑To the right
- ❑Across the vehicle
- ❑Under the vehicle
- ❑To the left then the right
- ❑To the right, then the left
- ❑Outside the vehicle

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Left arm
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Right arm
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Torso
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Left leg
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Right leg
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?
- ❑Yes
- ❑No

Immediately following the accident, did you feel...?
- ❑Dizzy
- ❑Dazed
- ❑Disoriented
- ❑Weak
- ❑Nervous
- ❑Nauseated

Next day discomfort...?
❑Increased ❑Decreased ❑Same

Did your major complaints exist before the accident?
❑Yes ❑No

Were you able to walk unaided?
- ❑Yes
- ❑No

Where did you go...?
- ❑Drove home
- ❑Was driven home
- ❑Drove to hospital
- ❑Was driven to hospital
- ❑Taken to hospital via ambulance
- ❑Drove to work
- ❑Was driven to work
- ❑Drove to school
- ❑Was driven to school

At the hospital, what areas were x-rayed? Name of hospital?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper/mid back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Low back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Pelvis	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Ribs	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Chest	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Abdomen						

Did you require post-accident hospitalization? ❑Yes ❑No

In what areas did you IMMEDIATELY feel pain?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper/mid back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Low back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Pelvis	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Ribs	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Chest	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Abdomen						

In what areas did you experience lacerations (cuts)?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper/mid back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Low back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Pelvis	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Ribs	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Chest	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Abdomen						

Where did you experience pain on the day FOLLOWING the accident?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper/mid back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Low back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Pelvis	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Ribs	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Chest	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Abdomen						

Check all symptoms you have experienced since the accident.

❑Headache	❑Sleeping problems	❑Lights bother eyes	❑Depression
❑Neck pain	❑Shoulders feel heavy	❑Loss of memory	❑Muscle spasm
❑Neck stiffness	❑Pain/numbness in arms	❑Ears ringing	❑Muscle pain
❑Dizziness	❑Pain/numbness in legs	❑Face flushed	❑Stomach upset
❑Upper/mid back pain	❑Pain/numbness in wrist/hand	❑ Vision loss	❑Constipation
❑Low back pain	❑Pain/numbness in ankle/foot	❑Loss of balance	❑Cold sweats
❑Tension	❑Shortness of breath	❑Fainting	❑Fear of driving
❑Irritability	❑Fatigue	❑Loss of smell	❑Difficulty walking
❑Nervousness	❑Chest pain	❑Loss of taste	

Patient's Signature: _____

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Authorization for the Release of Medical Records

_____ _____
Patient Name Date of Birth

I hereby request and authorize:

Absolute Chiropractic & Rehab
480 W Harwood Rd
Hurst, TX 75064

_____ To disclose information to: _____ To receive information from:

_____
Provider

_____
Address

_____
City/State/Zip

Information to be disclosed include copies of:

_____ Entire record
_____ Progress notes
_____ X-ray reports
_____ X-ray films
_____ Specialized imaging reports
_____ Specialized imaging films
_____ Other, specify: _____

Purpose for disclosure:

_____ Treatment
_____ Other, specify: _____

This authorization will be effective for six months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____ _____
Signature Date

_____ _____
Signature of Parent or Guardian Date

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

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Authorization for Patient Communications

(Circle the correct answer)

May we contact you or send detailed messages related to your treatment/appointments by...

Yes No Home Phone
Yes No Work Phone
Yes No Cell Phone
Yes No Mail
Yes No E-mail at Home E-mail Address_____
Yes No E-mail at Work E-mail Address_____

May we send postcard communications such as scheduling reminders, thank-you cards, sympathy cards, birthday cards, or holiday cards?

Yes No At Home Yes No At Work

May we send you a periodic newsletter?

Yes No E-mail Yes No Mail

May we discuss your treatment with a spouse, parent or friend? Yes No
(Please List names below)

_____

_____

May we discuss your appointment time with a spouse, parent or friend? Yes No
(Please List names below)

_____

_____

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

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Informed Consent

The primary treatment used by doctors of chiropractic is the spinal manipulation, sometimes called spinal adjustment.

- **The nature of the chiropractic adjustment.**
  I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

- **The material risks inherent in chiropractic adjustment.**
  As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

- **The probability of those risks occurring.**
  Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

- **Ancillary treatment.**
  In addition to chiropractic adjustments, various ancillary procedures such as hot or cold packs, therapeutic ultrasound, electric muscle stimulation, and myofascial release may used. These treatments involve the following additional significant risks: skin irritation, burns, or other minor complications.

- **The availability and nature of other treatment options.**
  Other treatment options for your condition include:
  - Self-administered, over-the-counter analgesics and rest
  - Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
  - Hospitalization with traction
  - Surgery

- **The material risks inherent in such options and the probability of such risks occurring include:**

  - Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and 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, his 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 painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks - some with rather high probabilities.

- Hospitalization in 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 in 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. I have discussed it with Rick Bartlett, D.C. or Curtis Begin, D.C. and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____

Printed Name Date

_____

Signature

_____

Signature of Parent or Guardian

ABSOLUTE CHIROPRACTIC & REHAB

Rick Bartlett, D.C., Steve Anderson, D.C.
480 W. Harwood Rd., Hurst, TX 76054
Phone: (817) 428-0801 Fax: (817) 428-0875
www.absolutechirorehab.com

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 Patient Health Information (**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 obligated to agree to those restrictions only to the extent they coincide with state and federal law.
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 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. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in 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.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If 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.

_____ _____

Signature Date

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ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION ["Agreement"]

I hereby direct any all insurance carriers, attorney, agencies, governmental departments companies, individuals, and/or other legal entities ["payors"], which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ["conditions"], to pay directly to, and exclusively in the name of, Absolute Chiropractic & Rehab ["ACR" or "Office"] such sums as may be owing to ACR for charges incurred by me, including, but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the Office ["charges"]. I further grant a contractual lien to ACR with respect to my charges, applicable to all payers; however, I understand that nothing in this Agreement shall be constructed as an election by ACR to claim protection under any statutory lien law. For the purpose of this Agreement, "benefits" shall include, but shall not be limited to proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payment benefits, personal injury protection, lost wages benefits, lost service benefits, no-fault coverage, uninsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or precedes payable to me for the purpose stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payor refuses to pay ACR, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to ACR to extent of my charges, as well as any and all causes of action that I might have against such payor, to prosecute such causes of acting either in my name or in the Office's name, and to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter[s] of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice of to the Office regarding any funds received by the attorney relating to my accident, to promptly pay such Office, and to provide a full accounting of such funds to the Office upon its request.

I hereby direct all payors to release to ACR any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this Office to release any information regarding my treatment or pertinent to my case[s] to all payors as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payors, regardless of whether a claim had been established with said payors. I hereby authorize ACR to endorse/sign my name on any and all checks listing me as a payee, which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize ACR to apply any credit balances on charges incurred by me to any other outstanding charges still owed by my spouse, my dependents, regardless of whether these other charges are related to my condition or me.

I understand that I remain personally responsible for the total amounts due ACR for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse ACR for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of ACR and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interest of ACR and myself. However, should any provision of this Agreement 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 Agreement shall, nevertheless, remain in full force and effect.

_____
Patient Name (Printed)

_____ _____
Patient Signature Date

_____
Name of Custodial Parent or Legal Guardian (Printed)

_____ _____
Parent or Guardian Signature Date

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ASSIGNMENT OF CAUSE OF ACTION AND LIEN AGAINST RESPONSIBLE THIRD PARTIES AND/OR INSURANCE COMPANIES

I, _____ (Name of Patient), hereinafter referred to as "Patient," suffered personal injuries as a result of a motor vehicle accident which I was involved in on _____ (Date). The accident was not my fault and was caused by the reckless and/or negligent conduct of _____ (Name of Reckless/Negligent Party), hereinafter referred to as "Insured." I have requested, and am in the process of receiving medical treatment for my injuries at/from Absolute Chiropractic & Rehab, hereinafter referred to as "Clinic." In consideration for the treatment rendered and to be rendered to me by Clinic, and as compensation for medical services rendered and/or to be rendered, I have agreed to execute this agreement granting the Clinic the following:

- Irrevocable Assignment of Cause of Action (First Party). Patient hereby assigns, sells and conveys to Clinic that part of Patient's cause of action against the Patient's insurance company(s) which covers medical services rendered, or to be rendered, to Patient by Clinic as a result of the above referenced accident. This assignment expressly includes the right to make demand for payment in Patient's name to receive payment for said service, to file suit in Patient's name, and to settle that portion of Patient's claim which relates to Clinic's bills. Patient understands that by signing this agreement he/she assigns a portion of Patient's cause of action against all responsible Insurance Carriers to the extent of Patient's medical bills incurred at clinic. Patient understands that he/she no longer has a right to receive, pursue, or settle that part of Patient's claim which relates to medical bills incurred and owned to Clinic. Further, Patient understands that should he/she receive payment for Clinic's medical bills directly from an insurance company, Patient is obligated to make immediate payment to Clinic. Patient and/or responsible party, further agree to cooperate, provide information as needed, and appear in court if requested, and to assist in the prosecution of such claims for benefits of Clinic.

_____ _____
Patient Signature Date

_____ _____
Clinic Representative Date

APPLICATION FOR BENEFITS – AUTOMOBILE PERSONAL INJURY PROTECTION

NAME AND ADDRESS OF INSURANCE COMPANY				
DATE	OUR POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE TEXAS AUTOMOBILE PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

TO: _____
CLAIM DEPARTMENT

ADDRESS:

YOUR NAME	LENGTH OF TIME IN STATE	PHONE NO.	HOME	BUSINESS

YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH / /	SOCIAL SECURITY NO.

DATE AND TIME OF ACCIDENT / /	AM PM	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT AND AUTOMOBILE YOU OCCUPIED, OR WERE STRUCK BY

OTHER AUTOMOBILES IN YOUR FAMILY	AUTO:	OWNER:	INSURER:
	1	1	1
	2	2	2
	3	3	3

ARE YOU A MEMBER OF OUR POLICY HOLDER'S HOUSEHOLD? ☐ YES ☐ NO

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? ☐ YES ☐ NO IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.
SIGNATURE: _____ DATE: _____

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? ☐ YES ☐ NO	DATE OF 1ST TREATMENT	DOCTOR'S NAME AND ADDRESS

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU: ☐ AN IN-PATIENT ☐ AN OUT-PATIENT	HOSPITAL NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE $	WILL YOU HAVE MORE MEDICAL EXPENSES? ☐ YES ☐ NO	AT THE TIME OF THIS ACCIDENT WERE YOU WORKING FOR YOUR EMPLOYER? ☐ YES ☐ NO
DID YOU LOSE TIME FROM WORK AS A RESULT OF YOUR INJURY? ☐ YES ☐ NO	IF YES, AMOUNT LOST TO DATE $	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $
HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR WAGE LOSS AND/OR MEDICAL BENEFITS UNDER: ANY WORKMENS' COMPENSATION LAW? ☐ YES ☐ NO ANY OTHER SOURCE? ☐ YES ☐ NO (NAME)		IF YES, AMOUNT OF MEDICAL AND WAGE $ ☐ PER WEEK ☐ PER MONTH

LIST NAMES AND ADDRESSES OF YOUR EMPLOYERS AT THE DATE OF THE ACCIDENT OR LAST PREVIOUS EMPLOYER AND GIVE OCCUPATION AND DATES OF EMPLOYMENT.

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO
IF YES, EXPLAIN ON REVERSE SIDE.

SIGNATURE DATE

IMPORTANT:
1. TO PRESENT CLAIM FOR BENEFIT YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

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08/24/2016

As a courtesy to our Employees and Doctors we will no longer treat patients that arrive 15mins prior to our closing time. This includes closing for lunch and for the day. The last patient will be scheduled 30mins prior to closing. There will be no exceptions and this will be effective immediately.
Thank you for your cooperation in this matter.

Thank you,
Management

Patient Signature Date