Fort Worth Chiropractic Clinic
Derek L. Page, D.C.
2920 Oak Park Circle, Ste 101
Fort Worth, Texas 76109
(817) 737-7243 * Fax (817) 924-0284
fwcc@flash.net

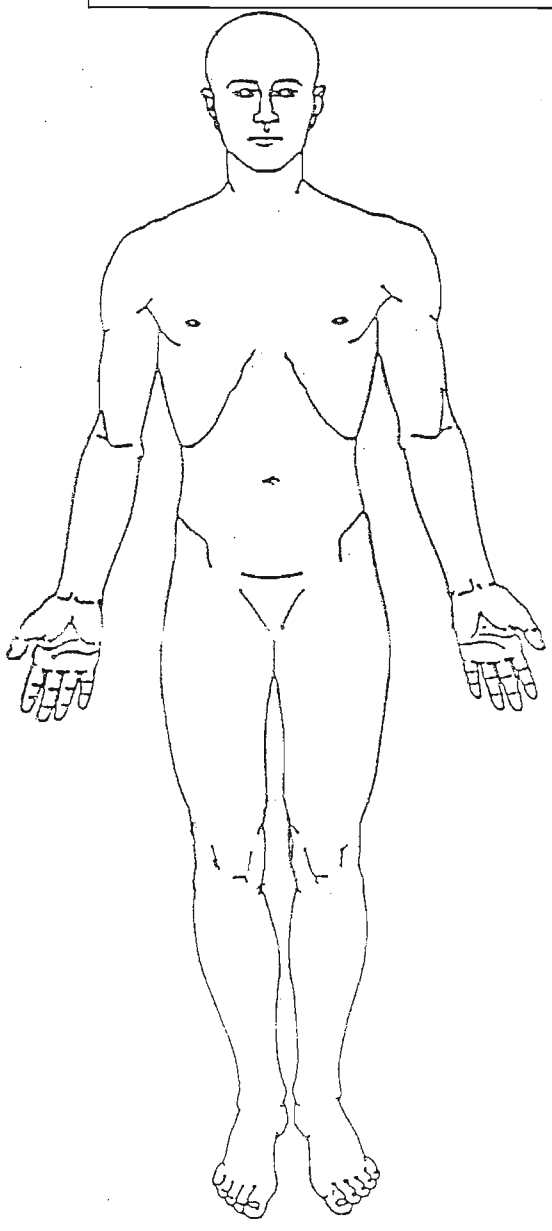
Pain Questionnaire

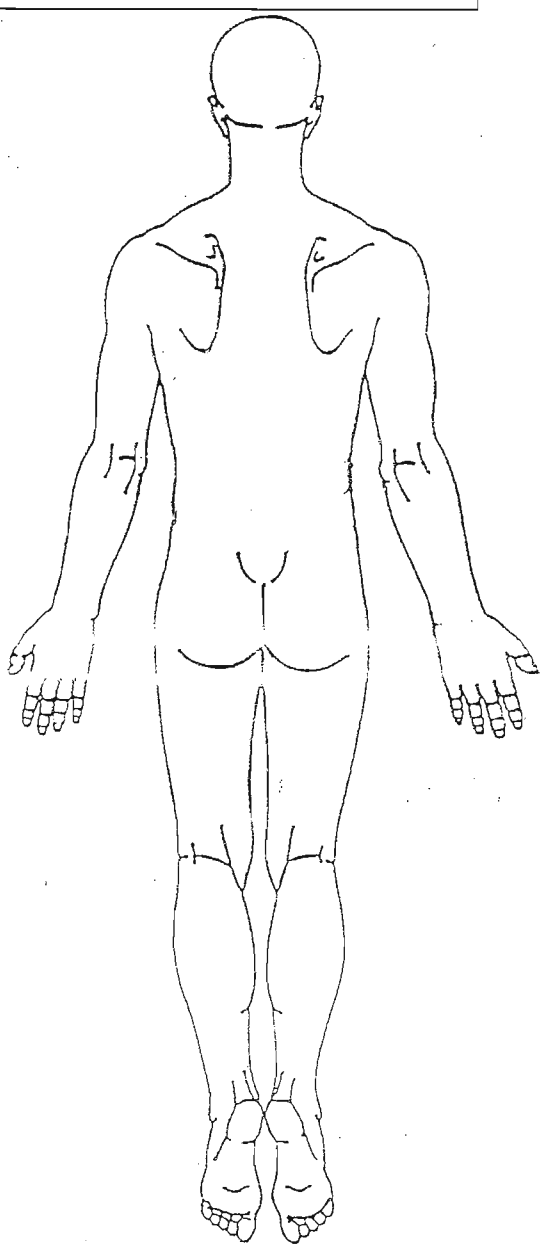
Name: Date:

Use the letters below to indicate the type and location of your sensations you are feeling right now.

(Put letters on diagram below)

A = Aches	B = Burning	P = Pins & Needles
N = Numbness	S = Stabbing	O = Other





Fort Worth Chiropractic Clinic

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: _____ _____ Fort Worth Chiropractic Clinic.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____ _____ _____

Signature: ____ _____ _____ _____ Date: __/__/__

PATIENT INFORMATION FORM

Name: _____ Today's Date: _____

Chart #: _____ X-RAY#: _____ Birth Date: _____

Social Security Number ☐☐☐☐☐☐☐☐☐ Age: _____ Gender: F M

If you are under 18 years of age, who are your legal parents or guardian?

Parent/Guardian: _____ Date of Birth: ___/___/___ Phone: (_____) _____

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single How many children? _____

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (_____) _____ Email: _____

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street _____

City _____ State _____ Zip _____

Phone (_____) _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (_____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (_____) _____

Spouse is a student at _____ ☐ FULL-TIME ☐ PART-TIME

Who should we contact in the event of an emergency? _____Phone: (_____) _____

Were you referred by someone or how did you learn about us? _____

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO Please check ALL that apply.

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO

Are you planning to file on your Personal Injury Protection from your auto insurance? ☐ YES ☐ NO

Do you need information on Personal Injury Protection to make your decision? ☐ YES ☐ NO

If using PIP, what is the name of your insurance company? _____

Phone (_____) _____ Address: _____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

_____

What was the date of the auto accident or approximate date of injury? _____

Describe your condition, symptoms, or the purpose of this appointment: _____

_____

Have you ever had the same or similar condition? ☐ YES ☐ NO If yes, when and describe: _____

_____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Date of last physical examination? _____

What operations have you had? _____ When? _____

Serious illnesses or conditions? _____ When? _____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: _____

What medications or drugs are you taking? _____

Have you ever suffered from:

☐ Dizziness	☐ Arthritis	☐ Digestive Disorders
☐ Backaches	☐ Headaches	☐ Nervousness
☐ Heart Trouble	☐ Numbness	☐ Sinus Trouble
☐ Diabetes	☐ Asthma	☐ Anemia
☐ Hernia	☐ Neuritis	☐ Cancer

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Do you have health insurance? ☐ YES ☐ NO Company: _____

ID#: _____ Phone: (____) _____ Full Name of Policy holder:_____

Policy Holder's DOB: _____ Does the policy holder have the insurance through his/her employer? ☐ YES ☐ NO

If yes, who is the employer? _____

****

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated copay at the time services are rendered, including any deductibles, and further understand that the estimated copay is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual copay as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: _____

PIP / Medpay Information Sheet

A lot of people have personal injury protection ("PIP") or medical payments benefits ("medpay") included in their automobile policies, and do not even realize it. Our office recommends that you use these benefits, if you have them, in the event that you've been injured in an auto accident, regardless of who was at fault. Here are some of the reasons why:

1. **Filing Claims With PIP / Medpay Does Not Mean That Your Rates Are Going to Increase.** The Texas Department of Insurance has published a very helpful document on its web site which addresses this exact issue – "Automobile Insurance Made Easy," located at *www.tdi.state.tx.us*." According to the TDI publication, a carrier *"can add penalties - called surcharges - to your premium for ... accidents resulting in property damage of $1,000 or more."* The carrier can apply surcharges in the amount of 15%-20% for one accident (provided you are deemed to be at-fault) and 35% or more if you are involved in two or more accidents.

2. **Filing Claims With PIP / Medpay Does Not Mean That Your Insurance is Going to Be "Non-Renewed."** According to the same TDI publication, *"In Texas, a company cannot refuse to renew your policy because of ... claims or accidents that cannot reasonably be blamed on you, unless you have more than one of these claims in a 12-month period."*

3. **Filing Claims With PIP / Medpay Does Not Relieve the Other Party From Having to Pay in-Full for Your Loss.** If you were involved in an accident caused by the driver of another vehicle, the liability coverage associated with that other party is *supposed* to pay the damages you suffer regardless of whether you have medical insurance or PIP insurance. The fact that you have PIP coverage or file claims with PIP coverage does not relieve the other liability carrier from its responsibilities.

4. **There is No Guarantee That the Other Party's Liability Policy Will Cover Your Medical Bills.** Although filing claims with PIP / Medpay does not relieve the other party from being responsible for payment, this does not necessarily mean that the liability coverage of the at-fault party will pay. Filing your claims with PIP / Medpay will help to ensure that you are not left to pay the medical bills out of your own pocket.

5. **Under Law, There May Be Time Deadlines for Filing Your Claims with PIP / Medpay.** Depending on applicable law, you may only have months in which to file your claims with PIP / Medpay, or forever be barred from utilizing these benefits.

6. **Filing Claims With Your PIP Coverage Does Not Mean That the PIP Carrier Will Request a Refund When Your Case Settles.** Texas Insurance Code, Article 5.06-3(c) appears to address this very question. The section provides in part: *"...[PIP] benefits ... shall be payable without regard ... to any collateral source of medical ... benefits. An insurer paying [PIP] benefits ... shall have... no claim against any other person or insurer to recover any such benefits by reason of the alleged fault of such other person in causing or contributing to the accident."*

7. **Our Clinic Does Not Charge a Fee for Filing Your Medical Bills With the PIP / Medpay Carrier.** Our office does not charge for filing your PIP. We file the claims as a service to you. In many instances, your right to PIP benefits may not be disputed. Filing and obtaining PIP benefits may be as simple as filling out and submitting a claim form with the carrier. Before having someone else file claims for you, we recommend that you ask whether there will be a charge for such service and how much.

8. **If You Have Medpay or PIP Coverage and Choose Not to File It, Then You May Be Paying for an Option, but Not Receiving Any Benefit.**

As long as our office is filing your PIP / Medpay and health insurance, and these companies are continuing to cover your charges, we will delay collection of payment at the time of service. If we receive overpayment on your account, we will be happy to refund you the difference, provided we are not under a duty to refund the health insurance carrier.

Fort Worth Chiropractic Clinic
2920 Oak Park Circle, Suite 101
Fort Worth, TX 76109
Tel: 817-737-7243
Fax: 817-924-0284

Personal Injury Election Form

Do You Wish For Us to Treat Your Case as a Personal Injury Case

or as a Health Insurance Case?

I, the below-signed, agree to pay a $50 filing fee and have read and understood the following, and wish for your Office to treat my accident case as a (select one):

___ **Health Insurance Case.** Please file any Charges I incur at your Office primarily with my health insurance, health benefits plan, Medicare, Medicaid, or other form of group or individual health insurance ("Health Insurance Payer"). Please do not file my claims with any other Payer until you have first attempted to collect from my Health Insurance Payer. I agree that I am personally, fully, and immediately responsible for copays, co-insurance, deductibles, and other items for which I am responsible as agreed elsewhere. I understand, for instance, that my Health Insurance Payer may totally Deny Payment for my Charges based on the fact that I was injured in an accident and may have other coverages available such as medical payments benefits, personal injury protection, liability insurance, uninsured motorist coverage, and other forms of coverage. I understand that your Office has no obligation to await payment on such items.

___ **Personal Injury Case.** Please file any Charges I incur at your Office with all Payers with whom I have established claim numbers ("Established Means of Payment") or as otherwise directed in writing. I understand that in choosing to treat my case as a personal injury matter, your Office will agree to delay in collecting copays, co-insurance, deductibles, and any Charges which the Payer Denies Payment until other Established Means of Payment have been reasonably attempted, or 1 year has elapsed from the date of my (the patient's) signature, whichever occurs sooner. In electing to treat my case as a personal injury matter, I am authorizing and directing your Office to collect up to the highest of the fee schedule amounts allowed by any one Payer as discussed in your Financial Policy and that your agreement to delay collecting the patient-portion due as discussed above serves as additional consideration for this direction.

I have read and understood the above information and agree to its terms.

Patient's Signature: _____ Date: ___/___/___

Patient's Name: _____

Attorney Signature (if applicable): _____ Date: ___/___/___

Attorney's Name: _____

ASSIGNMENT, LIEN, AND AUTHORIZATION

FOR DIRECT PAYMENTS BY MY PAYERS TO Fort Worth Chiropractic Clinic

("Assignment & Lien")

Purpose. The purpose of this Assignment & Lien is to assist the Office in collecting from various Payers who may be responsible for paying on my Charges. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment & Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to **Fort Worth Chiropractic Clinic** located at **2920 Oak Park Circle, Ste 101, Fort Worth, TX 76109**; "Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds, either now or in the future; "Proceeds" shall include without limit the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, the proceeds relating to "health-care-insurance receivables" and/or "payment intangibles" as such are defined by the applicable Uniform Commercial Code, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, errors & omissions, and malpractice; "Charges" shall include without limit the full fees for the Office's services (including without limit treatment, diagnostic services, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony, whether rendered before or after the date of this Assignment & Lien), any Collection Costs incurred by the Office, delinquency penalties and interest to the maximum extent permitted under law or at the annual rate of eighteen percent (18%), whichever is greater, and any other charges incurred by me at the Office; "Collection Costs" shall include without limit any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, fees or costs associated with requests for reconsideration, independent reviews, appeals, mediation, arbitration, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer whether based on this Assignment & Lien or other legal basis.

Assignment and Lien Terms. I hereby assign to the Office to the extent permitted by law, but only to the extent of my Charges, all of my rights, remedies, and benefits relating to any Payer, including without limit a primary, non-contingent right to receive Proceeds from any Payer now or in the future, and any and all causes of action that I might have against any Payer now or in the future, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I agree that this assignment shall be effective as of the date and time my condition first arose. I further intend for this Assignment & Lien to create a secured interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to the Office a primary, non-contingent secured interest in all Proceeds to the extent permitted by law for the purpose of securing payment of my Charges, which secured interest shall attach and also be automatically perfected effective as of the date and time that my condition first arose. I further authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency relating to such secured interests, and to make such filings in all relevant jurisdictions as the Office sees fit in its sole discretion. I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my agreement with the Office, such secured interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Service Certified Mail. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the full extent of my Charges. To the extent that any law, including without limit a lien statute, purports to limit, reduce, or modify the distribution of Proceeds in any manner inconsistent with this Assignment & Lien including without limit through the reservation of a portion of the Proceeds exclusively to me, I hereby waive such limits, reductions, or modifications.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of any Proceeds received by the attorney shall be primarily to pay my Charges. If I have a dispute regarding the Charges, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the Office. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to reduce its Charges or balance by a proportionate or weighted share of my attorney's fees, costs, and other expenses of pursuing collection of my claims, including the Office's Charges.

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

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

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

Patient Name (print): _____

Patient Signature: _____ Date: _____/_____/_____

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

Parent/Guardian Signature: _____ Date: _____/_____/_____

FINANCIAL POLICY AND AGREEMENT

("Agreement" – Rev. 05-03-05)

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Incorporation of Assignment Terms and Definitions. In this Agreement, "Office" and "Clinic" shall refer to [your practice name]. I have reviewed the Office's Assignment form titled in short as "Assignment" or "Assignment / Lien." The terms and definitions contained in the Assignment are incorporated herein by reference.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that any partial payments received by the Office towards my Charges shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full upon demand, and shall not constitute an accord and satisfaction of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). Without limiting the foregoing, I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I further understand that a Payer may require certain Charges to be pre-certified or pre-authorized. I understand that there may be other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office ("Term of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I further agree that should the Office assist me in the verification process, I assume the risk that the Payer and/or the Office may fail to accurately understand or communicate to me the Terms of Non-Coverage. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office liable in any of the foregoing instances.

Collection of Higher of Allowed Amounts When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize and direct the Office to submit my Charges, as well as a copy of an Assignment, to any and all Payers including, without limit, my health benefit plan. I understand that some or all of these Payers may utilize fee schedules to which the Office has agreed or as imposed by law ("allowed fees"). I further understand that the fees allowed or utilized by one Payer may exceed the fees allowed by another Payer. In the event that the fees allowed or utilized by one Payer exceed the fees allowed by another Payer, I hereby authorize and direct the Office insofar as permitted by law to collect its Charges up to, but not in excess of, the higher of the two amounts. In the event that a particular Payer does not utilize any fee schedule at all, I direct the Office to collect up to its full Charges.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office 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. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, my treatment, or my Charges, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens as such term is defined by law. I further waive any statute of limitations which may apply in any action based upon this Agreement, my treatment, or my Charges.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (print): _____

Patient Signature: _____ Date: ___/___/___

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

Parent/Guardian Signature: _____ Date: ___/___/___