WELCOME

one ABOUT YOU

Today's Date: ____/____/____ File #: ____

Patient Name: ____
LAST FIRST MI

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: ____ SS#: ____

Mailing Address: ____

CITY STATE ZIP

Home Phone #: (____) ____

Work Phone #: (____) ____ Ext: ____

Cell Phone #: (____) ____

E-mail Address: ____

Referred By: ____

Employer: ____ How Long? ____

Employer's Address: ____

CITY STATE ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

two INSURANCE INFO

Primary Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

Secondary Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

three ACCOUNT INFO

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____

CITY STATE ZIP

SS #: ____

Drivers License #: ____

Work Phone #: (____) ____

Payment method: ❑ Cash ❑ Check

____

❑ Credit Card -

____ I hereby authorize assignment of my insurance
Initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

four IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

PLEASE CONTINUE ON BACK

five 5 REASON FOR VISIT

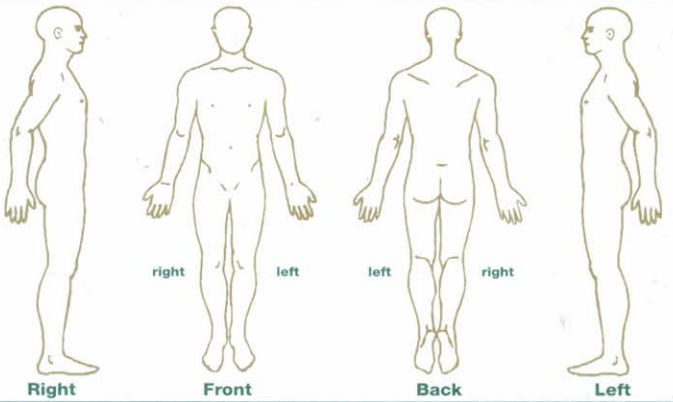
Reason for today's visit: ❑ Emergency ❑ New injury ❑ Old injury ❑ Chronic pain ❑ Wellness
Are you in pain: ❑ Yes ❑ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense
Did your injury occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity
When did your condition/accident occur? ___/___/___ Where did your injury occur? _____
Please explain what happened: _____
Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes.
Is your condition interfering with your: ❑ Work ❑ Sleep or ❑ Daily routine? If so, how: _____

Has this or something similar happened in the past?
❑ Yes ❑ No Explain: _____

Using the adjacent body charts, please circle all affected areas.

Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where? _____

Have you ever been treated by a Chiropractor? ❑Yes ❑No
Clinic or Dr's name: _____
Clinic phone#: _____



six 6 HEALTH HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers(including aspirin) ❑ Muscle relaxers
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N HIV+ / AIDS / ARC
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Anemia / Diabetes
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe / Frequent Headaches	Y N Kidney Problems
Y N Ulcers / Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema / Asthma	Y N Tuberculosis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/Implants	Y N Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____
List any past serious accidents with dates: _____
Please list anything that you may be allergic to: _____
Family Health History: _____
Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you exercise? ❑ No ❑ Yes _____ hours per week
Do you smoke? ❑ No ❑ Yes How much? _____ How long? _____
Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports Are you dieting: ❑No ❑Yes Since: ___/___/___
For woman: Are you taking Birth Control? ❑ Yes ❑ No
Are you Nursing? ❑ Yes ❑ No Are you Pregnant? ❑ No ❑ Yes If so, how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials	Date	Comments
	___/___/___	
	___/___/___	
	___/___/___	

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient Name_____ **Date** _____

1. Type of Vehicle YOU were in

☐ Car ☐ Pickup ☐ Van
☐ Truck ☐ Bus ☐ Station Wagon
☐ Other _____

2. Vehicle Size

☐ Subcompact ☐ Compact ☐ Full-Size
☐ Mini ☐ Light ☐ Mid-Size
☐ Other_____

3. What was your location in the Vehicle?

☐ Driver ☐ Front Passenger
☐ Rear Right ☐ Rear Left ☐ Rear Middle
☐ Other_____

4. What was the vehicle you were in doing?

a. Vehicle stopped for:

☐ Traffic Light ☐ Intersection
☐ Stop Sign ☐ Traffic ☐ Parked
☐ Other_____

b. Vehicle slowing down for:

☐ Traffic Light ☐ Intersection
☐ Stop Sign ☐ Traffic ☐ Turning
☐ Other_____

c. Vehicle moving:

☐ Slowly ☐ Moderate ☐ Fast
☐ MPH_____ ☐ Accelerating
☐ Other_____

d. Vehicle doing other

☐ Other_____

5. What damage did your vehicle sustain?

☐ Minimal ☐ Moderate ☐ Extensive
☐ Totaled ☐ Other_____

6. First Vehicle to strike you

a. Vehicle Type

☐ Car ☐ Truck ☐ Station Wagon
☐ Bus ☐ Pick-up
☐ Other_____

b. Vehicle Size

☐ Subcompact ☐ Compact ☐ Full-Size
☐ Mid-Size ☐ Mini ☐ Light
☐ Other_____

c. How did this vehicle strike you?

☐ Rear-End ☐ Head On ☐ Left
☐ Right ☐ Left side-swiped
☐ Right side-swiped
☐ Other_____

d. What damage did this vehicle sustain?

☐ Minimal ☐ Moderate ☐ Extensive
☐ Totaled ☐ Other_____

7. Second Vehicle to strike your vehicle

a. Vehicle Type

☐ Car ☐ Truck ☐ Station Wagon
☐ Bus ☐ Pick-up
☐ Other_____

b. Vehicle Size

☐ Subcompact ☐ Compact ☐ Full-Size
☐ Mid-Size ☐ Mini ☐ Light
☐ Other_____

c. How did this vehicle strike you?

☐ Rear-End ☐ Head On ☐ Left
☐ Right ☐ Left side-swiped
☐ Right side-swiped
☐ Other_____

d. What damage did this vehicle sustain?

☐ Minimal ☐ Moderate ☐ Extensive
☐ Totaled ☐ Other_____

8. Describe any other vehicles to strike you.

9. Citations issued

☐ Driver of Other Vehicle ☐ Driver of your vehicle
☐ You ☐ No citations issued ☐ Unsure

10. What time of day did the accident occur?

☐ Day ☐ Dawn ☐ Dusk ☐ Night
☐ Other_____

11. What was the condition of the road?

☐ Dry ☐ Damp ☐ Wet ☐ Snow Covered
☐ Icy ☐ Other_____

12. What was the visibility at impact?

☐ Good ☐ Fair ☐ Poor

13. If visibility was poor, why?

☐ Sun Light ☐ Darkness ☐ Rain ☐ Snow
☐ Fog ☐ Traffic
☐ Other_____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

14. Were you prepared for the accident?
☐ Complete Surprise ☐ Aware of collision
☐ Aware and Brace for impact

15. Was your foot on the brake?
☐ Yes ☐ No
If yes, was your foot knocked off pedal? ☐ Yes ☐No

16. Were you wearing your restraint belt?
☐ Yes ☐ No

a. What type of restraint?
☐ Shoulder- Lap belt ☐ Lap belt
☐ Shoulder belt

17. What position was the headrest in?
☐ Low ☐ Middle ☐ High ☐ Don't Know

18. Was your vehicle equipped with air bags?
☐ Yes ☐ No ☐ Don't Know

a. Did air bag deploy?
☐ Yes ☐ No

19. What was your body position at impact?
☐ Straight ☐ Slouched Forward
☐ Rotated Right ☐ Rotated Left ☐ Don't Know
☐ Other_____

20. What direction was your body thrown?
☐ Forward/Backward ☐ Backward/Forward
☐ Sideways ☐ Don't Know
☐ Other_____

21. What position was your Head & Neck in?
☐ Straight ☐ Tilted Forward ☐ Rotated Right
☐ Rotated Left ☐ Don't recall ☐ Other_____

22. What motion did your head & neck go in?
☐ Forward/Backward ☐ Backward/Forward
☐ Sideways ☐ Don't Know
☐ Other_____

23. Which objects in the vehicle did the force of the collision cause your body to strike?

a. Head
☐ Steering Wheel ☐ Dashboard ☐ Windshield
☐ Headrest ☐ Arm Rest ☐ Ceiling
☐ Right side door ☐ Left side door ☐ Console
☐ Right Window ☐ Left Window ☐ Shift Level
☐ Rear View Mirror ☐ Front Seat
☐Other_____

b. Right Upper Extremity (Arm)
☐ Steering Wheel ☐ Dashboard ☐ Windshield
☐ Headrest ☐ Arm Rest ☐ Ceiling
☐ Right side door ☐ Left side door ☐ Console
☐ Right Window ☐ Left Window ☐ Shift Level
☐ Rear View Mirror ☐ Front Seat
☐Other_____

c. Left Upper Extremity (Arm)
☐ Steering Wheel ☐ Dashboard ☐ Windshield
☐ Headrest ☐ Arm Rest ☐ Ceiling
☐ Right side door ☐ Left side door ☐ Console
☐ Right Window ☐ Left Window ☐ Shift Level
☐ Rear View Mirror ☐ Front Seat
☐Other_____

d. Torso
☐ Steering Wheel ☐ Dashboard ☐ Windshield
☐ Headrest ☐ Arm Rest ☐ Ceiling
☐ Right side door ☐ Left side door ☐ Console
☐ Right Window ☐ Left Window ☐ Shift Level
☐ Rear View Mirror ☐ Front Seat
☐Other_____

e. Right Lower Extremity (Leg)
☐ Steering Wheel ☐ Dashboard ☐ Windshield
☐ Headrest ☐ Arm Rest ☐ Ceiling
☐ Right side door ☐ Left side door ☐ Console
☐ Right Window ☐ Left Window ☐ Shift Level
☐ Rear View Mirror ☐ Front Seat
☐Other_____

f. Left Lower Extremity (Leg)
☐ Steering Wheel ☐ Dashboard ☐ Windshield
☐ Headrest ☐ Arm Rest ☐ Ceiling
☐ Right side door ☐ Left side door ☐ Console
☐ Right Window ☐ Left Window ☐ Shift Level
☐ Rear View Mirror ☐ Front Seat
☐Other_____

24. Did your body strike any other objects?

25. Any additional information:

Signature_____

Date _____

ACCIDENT / INJURY QUESTIONNAIRE

PATIENT NAME_____

Date of Accident _____/_____/_____
Time of Accident_____**am/pm**

1. **Description of Accident / Injury**
   - ☐ Auto Accident
   - ☐ Worker's Compensation
   - ☐ Slip/Fall Accident ☐ Pedestrian Accident
   - ☐ Other_____

   a. **What was the cause of your Accident?**

   b. **Describe in your own words what happened:**

2. **Did you lose consciousness?**
   ☐ Yes ☐ No ☐ Don't Know

3. **How did you feel?**
   ☐ Confused ☐ Dazed ☐ Dizzy
   ☐ Nervous ☐ Weak
   ☐ Other_____

4. **Where did you immediately develop pain?**

☐ Head	R L	Shoulders	R L	Buttocks
☐ Neck	R L	Arms	R L	Hips
☐ Mid-Back	R L	Elbows	R L	Thighs
☐ Low Back	R L	Forearms	R L	Knees
☐ Pelvis	R L	Wrists	R L	Legs
☐ Chest	R L	Hands	R L	Ankles
☐ Abdomen			R L	Feet

   ☐ Other_____

5. **Were there any lacerations (cuts)?**

☐ Head	R L	Shoulders	R L	Buttocks
☐ Neck	R L	Arms	R L	Hips
☐ Mid-Back	R L	Elbows	R L	Thighs
☐ Low Back	R L	Forearms	R L	Knees
☐ Pelvis	R L	Wrists	R L	Legs
☐ Chest	R L	Hands	R L	Ankles
☐ Abdomen			R L	Feet

   ☐ Other_____

6. **Describe any other significant injury:**

7. **Did you receive emergency care?**
   ☐ Yes ☐ No

8. **What type of emergency care?**
   ☐ Bandages ☐ Splints ☐ Brace
   ☐ Neck Collar ☐ Other_____

9. **Where did you go after the accident?**
   ☐ Hospital ☐ Home ☐ Work
   ☐ School ☐ Other_____

10. **By whom were you driven?**
    ☐ Myself ☐ Ambulance ☐ Family Member
    ☐ Friend ☐ Other_____

11. **If you did go to the Hospital, When?**
    ☐ Immediately ☐ Later that day ☐ Next Day
    ☐ Days Later ☐ Date_____

12. **Hospital Name**_____

13. **Examined by Doctor**_____

14. **Admitted?** ☐ Yes ☐ No

15. **Date Discharged**_____

16. **If x-rays were taken, what body parts?**

☐ Head	R L	Shoulders	R L	Buttocks
☐ Neck	R L	Arms	R L	Hips
☐ Mid-Back	R L	Elbows	R L	Thighs
☐ Low Back	R L	Forearms	R L	Knees
☐ Pelvis	R L	Wrists	R L	Legs
☐ Chest	R L	Hands	R L	Ankles
☐ Abdomen			R L	Feet

    ☐ Other_____

17. **If a CAT Scan was performed, what body parts?**
    ☐ Head ☐ Mid-Back ☐ Chest
    ☐ Neck ☐ Lower Back ☐ Abdomen
    ☐ Other_____

18. **If a MRI was performed, what body parts?**
    ☐ Head ☐ Mid-Back ☐ Chest
    ☐ Neck ☐ Lower Back ☐ Abdomen
    ☐ Other_____

19. **What was the diagnosis given?**

ACCIDENT / INJURY QUESTIONNAIRE

20. What treatment was administered at the hospital?

☐ Oral Medication ☐ Sutures ☐ Splint
☐ Collar ☐ Injection ☐ Ice Packs
☐ Hot Packs ☐ Cast ☐ Brace
☐ Bandages ☐ Surgery ☐ Topical Cream
☐ Surgery ☐ Other_____

21. Who were you told to see when you were discharged?

☐ General Practitioner ☐ Internist ☐ Orthopedist
☐ Neurologist ☐ Chiropractor ☐ Surgeon
☐ Physical Therapist ☐ Other_____
☐ None

22. What recommendations were made?

☐ No Further Care ☐ No Follow-up Instructions
☐ Observation ☐ Rest ☐ Ice
☐ Heat ☐ Collar ☐ Support
☐ Time off Work ☐ Other_____

23. Were medications prescribed?

☐ Pain ☐ Anti-inflammatory ☐ Antibiotic
☐ Nervousnesss ☐ Other_____

24. Since your accident / injury have you suffered from?

☐ Blurred Vision ☐ Chest Pain ☐ Nausea
☐ Double Vision ☐ Difficulty Breathing ☐ Vomiting
☐ Reduced Vision ☐Palpitations ☐ Constipation
☐ Frequent Urination ☐ Painful Urination ☐ Diarrhea
☐ Inability to hold Urine ☐ Impaired Hearing
☐ Ringing in Ears ☐ Other_____

25. Have you experienced any of the following?

☐ Anxiety ☐ Convulsions ☐ Restlessness
☐ Depression ☐ Dizziness ☐ Insomnia
☐ Mood Swings ☐ Headaches ☐ Light Sensitive
☐ Nervousness ☐ Fainting ☐ Weakness
☐ Poor Memory ☐ Loss of Balance☐ Weight Gain
☐ Weight Loss ☐ Tension ☐ Fatigue
☐ Other_____

26. Are you restricted in any of the following areas?

☐ Daily Living ☐ Work ☐ Recreation
☐ Other_____

27. Have you missed work due to injury?

☐ Yes ☐ No

Dates Missed_____

28. List all medical care you seeked after your accident / injury:

Name_____
Specialty_____
Diagnosis_____
Treatment_____

Name_____
Specialty_____
Diagnosis_____
Treatment_____

Name_____
Specialty_____
Diagnosis_____
Treatment_____

29. Insurance Information

Company_____
Phone_____
Adjuster_____
Claim Number_____

30. Attorney Information

Attorney Name_____
Address_____
City_____
State_____Zip_____
Phone_____

Additional Information:

Signature_____

Date_____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____ _____ _____

Printed Name Signature Date

WITNESS:

_____ _____ _____

Printed Name Signature Date

X-RAY CONSENT FORM

Patient: _____ Date: _____

During your examination, the doctor may feel that x-rays will be needed in order to diagnosis your condition. We would like to make you aware that x-rays may be required, in order, to administer treatment. In order to perform x-rays on any patient our office requires the patients consent for such tests to be performed.

Please Choose One:

_____ I understand that my doctor may need x-rays in order to diagnosis my condition and I give permission of all needed diagnostic tests.

_____ I understand that my condition may require my doctor to take x-rays to further diagnosis my symptoms. I choose not to have any x-rays at this time and release my doctor of all liabilities.

Signature:_____ Date: _____

FEMALES ONLY:

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

I am pregnant	_____yes	_____no	_____ don't know
I could be pregnant	_____yes	_____no	_____ don't know
My menstrual period is late	_____yes	_____no	_____ don't know
I have an IUD	_____yes	_____no	
I have had a tubal ligation	_____yes	_____no	
I have had a hysterectomy	_____yes	_____no	
I have irregular menstrual periods	_____yes	_____no	
My last menstrual period began	_____		
I have begun menopause	_____yes	_____no	

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by my doctor.

Signature: _____ Date: _____

North Decatur Chiropractic Clinic

Financial Agreement
Personal Injury

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policies of our office, I would like to explain how your medical bills will be handled.

Party Responsibility

If you were involved in an auto accident and are the owner of the vehicle, we will bill the medical insurance portion of your own automobile insurance policy. If you were a passenger in some else's car, we will bill the driver's auto insurance company. (These policies will be billed in addition, and prior to, any claim that your attorney may be presenting to an insurance company on your behalf.)

If you were a passenger in a vehicle which was not insured, but you own a car which has medical coverage, the insurance company which carries your policy will be responsible to pay your medical bills.

Insurance Rates

It is important to remember that when a medical claim is submitted to the "medical payments" portion of your insurance policy, your standing with the insurance company will not be affected, and your rates will not normally be increased, unless the accident is determined to be your fault.

Billing Other Insurance Policies

It is also to your advantage for our office to bill your own health insurance policy and/or automobile medical policy for your medical bills, providing your policy does not state otherwise. Any money received above and beyond your total bill in this office will be refunded to you.

Responsibility for Payment

As courtesy to you, we will gladly submit your medical bills to your insurance company and/or your attorney; however, all services rendered by this office will be charged directly to you, and, ultimately, you will be personally responsible for payment for these bills regardless of any settlement you may or may not receive.

We hope this answers any questions you might have concerning the financial policies of this office. Once again, we welcome you to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

_____ _____

Patients Signature Date

Financial Agreement

Figuring out who will pay for your bills following an injury can often take some time and be confusing. We understand.

If you have been injured in an accident and do not carry medical coverage on your automobile insurance, this office will extend you interest free credit and wait until your settlement is obtained. We will work with you and be patient; but ultimately you are responsible for your bills. Many health insurance policies will not cover care due to a car accident or work injury. IF YOU PLAN ON USING HEALTH INSURANCE PLEASE TELL US TODAY & PROVED THE INORMATION ON THE FRONT SHEET. In cases where the insurance company pays you directly or you have not met your deductibles, or if a co-pay applies, you will be responsible for payment on the balance owed. In cases where the insurance company denies the charges for any reason, you understand that you will personally be responsible for all the charges. Communication is extremely important so please ask questions.

Extension of Credit, Insurance Assignment of Benefits Attorney Security Agreement, Personal Guaranty & Contractual Lien

We will provide you the needed service now and wait to get paid at a later date.
We are extending interest free credit to you.

In consideration for this office providing services to me, and because I do not have sufficient insurance or funds available to pay in advance for care, I hereby seek credit and grant a lien to this office against any and all settlement proceeds resulting from and arising out of the negligence of a third party, causing injuries and the need for reasonable and necessary health care, which this office, shall provide. Because services are to be rendered in reliance upon this agreement, I agree this agreement shall be irrevocable after being signed. In the event I change or substitute my attorney, this lien shall be binding upon any subsequent attorney upon being furnished a copy of this agreement.

I direct my attorney and / or claims adjuster, to pay any outstanding bills out of my settlement or med pay benefits, in effect; protecting any such balance and pay this money directly to this office. I assign proceeds from my claim to North Decatur Health Care, Inc., (Tax ID 01-0723774) to pay for treatment and services rendered by this Clinic. I direct any insurance company, attorney or other person who holds or later holds proceeds from my claim to apply it directly to my account at this clinic. I hereby make these instructions to be irrevocable and direct all others now or at a later date to honor this agreement as well.

If using an attorney, now or in the future, I irrevocably direct them to follow State Bar of Georgia - RULE 1.15(I) SAFEKEEPING PROPERTY – GENERAL, and direct them to honor all debts to this clinic. They can negotiate on my behalf but my attorney is not to release funds directly to me without honoring this debt. My lawyer has a duty under applicable law to protect such third-party claims against wrongful interference by their client (me), and accordingly may refuse to surrender the property to me until an agreement is made concerning my debt to this clinic. If my attorney violates this they will not be acting in my best interest and in fact may cause future harm to me.

I further personally guarantee payment and give lien to this office against the proceeds of any settlement, judgment or verdict. I also understand that I am responsible for all collection and court cost associated with collecting this debt. This lien does not remove my own responsibility for outstanding bills, but is given as security and protection of payment. Payment is not contingent on receipt of proceeds; outstanding fees are due upon request. I realize that I am responsible to make sure payment is made to your office and I will update your office once a month concerning the status of my case. I have read this entire contract and fully understand & agree to it.

Signature: _____ Date: _____

Printed Name: _____ Staff Witness _____

Attorney Name: _____ Phone: _____

Insurance Company: _____ Claim#: _____

Insurance Phone # : _____ Adjuster: _____

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____

Patients SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **North Decatur Health Care** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- ❑ I give permission to **North Decatur Health Care** to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.

- ❑ I give **North Decatur Health Care** permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.

- ❑ By signing this form you are giving North Decatur Health Care permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire on the following date: _____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **North Decatur Health Care**. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by **North Decatur Health Care** for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **North Decatur Health Care** will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

- * A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU * *

Print Name of Patient:_____

Signature of Patient:_____

Date:_____

Signature of Personal Representative:_____

Description of Representative's Authority To Act for Patient:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

_____ _____

Patient Signature Date