Chiropractic Associates, Inc.
3305 NE Loop 286 Ste.A, Paris, TX 75460
903-785-5551

CONFIDENTIAL PATIENT INFORMATION:

DATE:_____

Patient Name:_____
First Middle Last

Address:_____

City:_____ State:_____ Zip:_____

E-Mail Address:_____
(your email will be used for internal notifications only)

Sex: ( ) Male ( ) Female Number of Children_____

Your Date of Birth:_____ Your Age:_____
Month/Day/ Year

Please Check one:
( ) Married ( ) Single ( ) Divorced
( ) Separated ( ) Widowed ( ) Minor

Patient Employer:_____

Occupation:_____

Employer Address:_____

City:_____ State:_____ Zip:_____

Employer Phone Number:_____

Spouse's Name:_____
First Middle Last

Spouse's Date of Birth:_____ Age:_____

Spouse's Employer:_____

Spouse's Employer Phone Number:_____

PHONE NUMBERS:

Cell Phone:_____

Home Phone:_____

Best Time To Reach You:_____
In Case of Emergency Call:

Name:_____

Relationship:_____

Contact Phone Number:_____

INSURANCE INFORMATION:

Who is responsible for this account?_____

Insurance Company:_____

Patient ID #:_____

Group #:_____
Is patient covered by any other Insurance? ( ) YES ( )NO

Subscriber's Name:_____
(This is the person whose name the policy is under)

Relationship to Patient:_____ Date of Birth_____

I Certify that I, and/or my dependent(s) have Insurance coverage with the Insurance I have provided and assign directly to Chiropractic Associates, Gregory Thompson, DC, Brandi Baggett, DC, and/or Sean Welborn, DC. ALL insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named chiropractic doctors my use my healthcare information and my disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for services rendered. This consent will end one year from the date signed below.

PLEASE SIGN AND DATE:

X_____
print name of patient, parent, guardian or responsible party

X_____
signature of patient, parent, guardian or responsible party

Date:_____ Relationship to Patient:_____

Who may we send a thank you card for referring you to our office_____

Or how did you hear about our office?
( ) Google ( ) YellowBook ( ) Yahoo
( ) Bing ( ) Our Sign ( ) Radio/TV
( ) Word of Mouth ( )
Other:_____

PATIENT CONDITION:

1. What is the reason for your visit today? _____

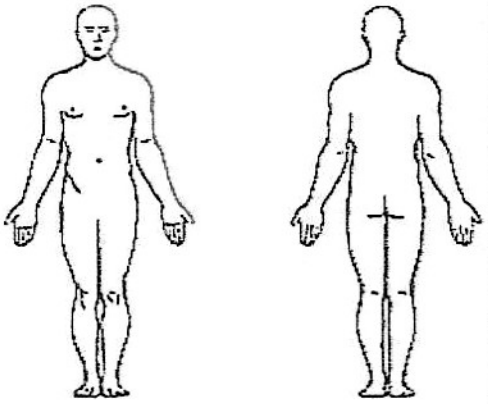
2. Please list ALL symptoms you are having in order of severity:

3. A._____ C._____ E._____

   B._____ D._____ F._____

4. Circle the number that best describes your pain 0 1 2 3 4 5 6 7 8 9 10
   None Mild Medium High Severe

5. Mark an X on the body diagram exactly where you are having symptoms, such as pain, numbness or tingling:



Do not write in box

Doctor Notes:

6. When did your current symptoms first begin? _____

7. What might have caused your symptoms? _____

8. Is the condition getting worse since it first began? ( ) YES ( ) NO

9. How often do you have the pain? ( )Constantly ( )Frequently ( )Occasionally ( ) Intermittently

10. Are your symptoms changing with time? ( )Getting Worse ( )Staying the Same ( )Getting Better

11. Describe the Type of Pain: ( ) Sharp ( ) Dull ( ) Throbbing ( ) Numbness ( ) Aching ( ) Shooting ( ) Burning ( ) Tingling ( )Cramping ( ) Stiffness ( ) Swelling ( ) Sharp with Motion ( )Shooting with Motion ( ) Stabbing with Motion ( ) Electric like with Motion ( ) Other

12. Does the pain travel down your arms or legs? _____

13. Has your condition interfered with your and how much: a. ( ) Work ( ) Daily Routine ( )Recreation ( ) School
    b. ( )Not at all ( )A little bit ( ) Moderately ( ) Quite a bit ( )Extremely

14. Activities that are now difficult: ( ) Sitting ( ) Standing ( ) Walking ( ) Bending ( ) Other:_____

15. What. Aggravates your problem?_____

16. What concerns you the most about your problem and what does it prevent you from doing?_____

17. What do you expect from undergoing chiropractic care? _____

18. Have you been to a Chiropractic doctor in the past? _____

HEALTH QUESTIONARE:

1. Height:_____ Weight_____ Date of Birth_____

2. How would you rate your overall Health? ( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor

3. What type of exercise do you do? ( ) Stenuous ( )Moderate ( ) Light ( ) None

4. What activities do you do at work? ( ) Sit ( ) Stand ( ) Computer Work ( )On the Phone How much of the day?_____

5. Who is your primary medical doctor?_____ Date of last exam?_____

6. Have you ever been hospitalized? ( ) No ( ) Yes If Yes, why_____

7. Have you had significant past trauma? ( ) No ( ) Yes

8. Have you been evaluated by another doctor for your current condition? ( )Chiropractor ( )ER Physician ( )Massage Therapist ( )Neurologist ( )Orthopedist ( )Physical Therapist ( )Primary Care Physician ( )Other ( )No One
If YES, who and when? _____

9. Please check the past or present column if you have and/or had any of the following condition:

Past	Present	Past	Present	Past	Present
	AIDS/ HIV		DIZZINESS		HEADACHE
	ALCHOLISM		FRACTURES		MULITPLE SCLEROISIS
	ANEMIA		SPINAL FRACTURES		OSTEOPOROSIS
	ARTHRITIS		GOUT		PACEMAKER
	ASTHMA		HEART DISEASE		DEFIBRILLATOR
	BLEEDING DISORDER		HEPATITIS A, B, or C		PARKINSON'S
	BREAST LUMP		HIGH CHOLESTERAL		RHEUMATOID
	CANCER		HIGH BLOOD PRESSURE		PINCHED NERVE
	DISC PROBLEMS		LIVER DIESEASE		PREGNANT
	CHICKEN POX		PROSTHESIS		PROSTATE PROBLEMS
	DIABETES		THYROID PROBLEMS		UNDER PSYCHIATRIC CARE
	STROKE		TUMORS / GROWTHS		ULCER
	TUBECULOSIS		HEART ATTACK		CHEST PAINS
	ANGINA		KIDNEY STONES		KIDNEY DISORDERS
	BLADDER INFECTION		PAINFUL URINATION		LOSS OF BLADDER CONTROL
	ABNORMAL WEIGHT GAIN /LOSS		LOSS OF APPETITE		ABDOMINAL PAIN
	GENERAL FATIGUE		MUSCULAR INCOORDINATION		VISUAL DISTURBANCES
	EXCESSIVE THIRST		FREQUENT URINATION		SMOKING/TOBACCO USE
	ALLERGIES		DEPRESSION		SYSTEMIC LUPUS
	EPILEPSY		BIRTH CONTROL		HORMONAL REPLACEMENT
	DERMATITIS/ECZEMA/RASH		UPPER BACK PAIN		MID BACK PAIN
	LOW BACK PAIN		SHOULDER PAIN		ELBOW/UPPER ARM PAIN
	WRIST PAIN		HAND PAIN		HIP PAIN
	UPPER LEG PAIN		KNEE PAIN		ANKLE/FOOT PAIN
	JAW PAIN		JOINT PAIN/STIFFNESS		CHRONIC SINUSITIS
	NECK PAIN		OTHER :		

Please list any other health conditions you may have:_____

_____

Indicate if you have any IMMEDIATE family members with the following: ( ) Rheumatoid Arthritis ( ) Diabetes ( ) Lupus ( ) Cancer ( ) Heart Problems ( ) ALS

HABITS

Do you smoke?	YES / NO	If yes, how many packs per day?_____
Do you drink alcohol?	YES / NO	If yes, how may drinks per week?_____
Do you use illegal drugs?	YES / NO	If yes, what type and how often?_____

Please list your current medications:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

Please list any medicatoions you are allergic to: _____

Please list ALL surgeries you have had:

1. _____

2. _____

3. _____

4. _____

5. _____

Do you have any metal implants related to previous surgery? YES / NO If yes, where? _____

Is there anything else pertinent to your visit today? _____

Patient Signature: _____ Date: _____

CHIROPRACTIC ASSOCIATES

Gregory Thompson, DC Sean Welborn, DC Brandi Baggett, DC

3305 NE Loop 286, Suite A Paris, Texas 75460

Ph. (903) 785-5551 Fax (903) 784-4188

Patient Name: _____ DOB: _____

ADVANCED ACKNOWLEDGMENT OF NON-COVERED SERVICES

IMPORTANT! Insurance companies have increasingly reduced covered benefits for chiropractic services provided. Every insurance company and most often, every policy offered by an insurance company provide different coverage limitations. Your doctor will make recommendations for treatment based upon what he/she feels is best regarding your health care needs, not based upon your individual insurance benefits. In an effort to provide the most affordable care, our office has decided to continue to participate in network with most insurance companies, in spite of continued reductions in insurance fee schedules. Please be aware that **your insurance company will likely not provide coverage for all services provided.** Services may be partially covered or not covered at all. The amount you are charged at the time of service is correct and may not be entirely reflected on your insurance explanation of benefits. Our office will NOT provide refunds for non-covered services that were provided to you at the time of service or services that were provided and never submitted for reimbursement to your insurance carrier. Our office will make every effort to attain accurate insurance benefits from your insurance company. However, we are not liable if the information we are given is not correct. For details regarding your chiropractic benefits or limitations of services, please contact your insurance company. If you are concerned about the reduction in fees and/or reduction in benefits by your insurance company, please contact your insurance customer relations department and recommend they increase the chiropractic benefits they provide. Please ask our staff if you have any questions regarding out-of-pocket expenses or details about this form.

By signing below I acknowledge I have read the above statement and agree to abide by the policies detailed within.

Patient Signature: _____ Date: _____

Chiropractic Associates Inc.
Dr. Gregory Thompson Dr. Brandi Baggett Dr. Sean Welborn
3305 NE Loop 286 Ste. A Paris, Tx 75460
903-785-5551

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractor and / or anyone working in this office authorized by the chiropractor.

I further understand that such chiropractic services may be performed by Chiropractic Associates and/ or other licensed Doctors of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with, Dr. Gregory Thompson, Dr. Brandi Baggett, and/ or Dr. Sean Welborn and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes, transient ischemic attack (TIA's) and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. Further, I wish to rely on the doctor to exercises judgment during the course of the procedure which the doctor feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had and opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommenced by my doctor. I intend this consent form to cover the entire course of treatment for my present condition(s) for which I seek treatment at this facility.

_____
print patient's name

_____ _____
signature of patient Date

_____
print name of guardian

_____ _____
signature of guardian Date

Doctor Signature_____ Date _____

Chiropractic Associates
3305 NE Loop 286 Ste A., Paris, Tx 75460

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

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

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

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

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to **Chiropractic Associates,** and mailed to **3305 NE Loop 286 Ste. A, Paris Tx 75460.**

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to **Chiropractic Associates, and to send any and all checks to 3305 NE Loop 286 Ste A, Paris, Tx 75460.**

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

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

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

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

Signature of Patient and/or Responsible Parties:

_____ Date:_____

Chiropractic Associates
Gregory Thompson, DC Brandi Baggett, DC Sean Welborn, DC
3305 NE Loop 286 Ste A., Paris TX 75460

HIPPA
PRACTICE'S REQUIREMENTS

The Practice:

(A) is required by Federal Law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(B) under the Privacy Rule, may be required by State Law to grant greater access or maintain greater restrictions on the use or release of your PHI that which is provided for under Federal Law.

(C) is required to abide by the terms of this Privacy Notice.

(D) reserves the right to change the terms of this Privacy Notice and to make the New Privacy Notice provisions effective for all of your PHI that is maintains.

(E) will distribute any revised Privacy Notice to you prior to implementation.

(F) will not retaliate against you for filing a complaint.

EFFECTICE DATE

This Notice is in effect as of 4/15/2003

PATIENT ACKOWLEGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Signature of Patient and/or Responsible party:

_____

Date:_____

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

Signature On File for Ins. ↓ ↓ ↓

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ________ DATE ________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ________

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. ____ . ____

2. ____ . ____

3. ____ . ____

4. ____ . ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH. # ( )

a. b.