Chiropractic Associates, Inc.
3… NE Loop 286 Ste.A, Paris, TX …460
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? ______________________________

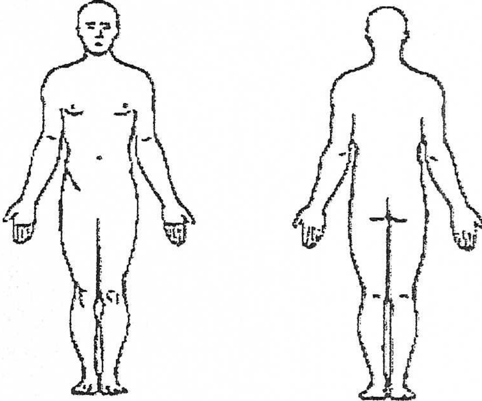
2. Please list ALL symptoms you are having in order of severity:

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.____

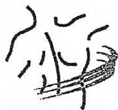
4.____

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, Inc.

Dr. Gregory Thompson Dr. Brandi Baggett Dr. Sean Welborn

ACCIDENT INFORMATION SHEET

1. Are your visits due to an accident? YES NO

   If yes, what was the date of the accident? ______________________

   Please give a brief description of the accident:______________________

   ____

   ____

   ____

   ____

2. Are you presently covered by any insurance? YES NO

   If yes, please circle the types of insurance coverage you have:
   (PLEASE CIRCLE ALL THAT APPLY)

   PIP Auto Coverage   Under Insured Auto Coverage

   Health Insurance   Medicare

   Medicaid   Other:______________

3. Have you seen any other doctors since the accident? YES NO

   If yes, please list the doctor's name and facility where you were seen:

   ____

   ____

   ____

4. Most every licensed driver in the state of Texas is covered by PIP insurance which will pay for your medical bills. Are you covered by PIP or Personal Injury Protection? YES NO

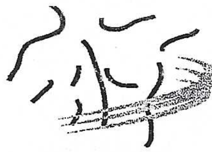
   If you are not sure, please ask the front desk for more information.

Name: (please print)______________________________

Signature of Patient:______________________ Date:______________

3305 NE Loop 286, Suite A Paris, Texas 75460

Phone: 903.785.5551 chiropracticparistexas.com Fax: 903.784.4188



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:______________________

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 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 ______________

1500

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; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

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

SECOND FOLD

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. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

FIRST FOLD WHCF-10-ENV / WHCH-10-ENV-SS

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	

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.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS