ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI)_____ **Today's Date:** _____

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- **Was anyone else in the vehicle with you?** ☐ **No** ☐ **Yes** - *(Number of people)* _____
- **You were?** ☐ **Front seat** – *Driver / Passenger* ☐ **Rear Seat**– Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row
- **Name of Driver**, *if not self*: _____ **Name of Driver of other vehicle:** _____
- **Did airbags deploy?** ☐ **No** ☐ **Yes** **Did Police arrive?** ☐ **No** ☐ **Yes** **Using Seatbelt?** ☐ **No** ☐ **Yes**
- **Did you strike the windshield or object in car?** ☐ **No** ☐ **Yes** - *(Describe)* _____
- **Were you knocked unconscious?** ☐ **No** ☐ **Yes** *(How long?)* _____
- **Where was your vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Where was the other vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Your Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:**_____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____
- **Other's Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:**_____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: _____ **Occupation:** _____ **Claim #:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Contact Person: _____ **Phone:** _____ **Email:** _____

GENERAL ACCIDENT/INJURY INFORMATION – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

Date of Accident: ____/____/_____ **Time**: ___:_____ AM / PM

Please describe the accident in as much detail as possible? _____

_____

_____

_____

Before the accident/injury:

- **Have you ever had any complaints in the involved area before?** ☐ **No** ☐ **Yes**
  - *If yes* - **Were they present at the time of the accident/injury?** ☐ **No** ☐ **Yes**
    - *If yes* - **Summarize these complaints prior to the accident:** _____
- **Were you capable of performing all of your work activities without restriction?** ☐ **No** ☐ **Yes**

At the time of the accident/injury:

- **Did you feel pain immediately after the accident?** ☐ **No** ☐ **Yes** ☐ **Later that day** ☐ **Next day** ☐ **When?** _____
- **Were you taken anywhere after the accident?** ☐ **No** ☐ **Yes** ☐ **Later that day** ☐ **Next day** ☐ **When?** _____
  - *If yes*, **How?**_____ **Where?**_____
  - *If yes*, **Did you receive treatment?** ☐ **No** ☐ **Yes** - *(Describe)* _____

Since the accident/injury:

- **Are your symptoms:** ☐ **Improving?** ☐ **Getting Worse?** ☐ **The Same?**
- **Are your work activities restricted as a result of this accident/injury?** ☐ **No** ☐ **Yes** - *(How?)* _____
- **Have you missed any work since this accident?** ☐ **No** ☐ **Yes** - *(Dates?)* _____
- **Have you retained an Attorney?** ☐ **No** ☐ **Yes - Name:**_____ **Phone:** _____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

Patient No: _____

INTRODUCTION PATIENT CASE HISTORY

Today's Date: ____/____/_____

PATIENT INFORMATION

Name: *(First MI Last)* _____ **Preferred Name**: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female **Social Security #**:_____

Home: _____ **Mobile:** _____ **Work:** _____

Email: _____

Preferred Method of Contact: ☐ Text ☐ Email ☐ Phone - *Home, Mobile, or Work* ☐ Other: _____

***Referred By:** *(Name)* _____

☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor ☐ Other: _____

Race & Ethnicity: *(Choose up to 2)*

- ☐ African American or Black
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Decline

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other: _____
- ☐ Decline

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* _____ **Primary Care Physician:** _____

Home: _____ **Mobile:** _____ **Doctor's Phone:** _____

Relationship:

☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

FINANCIAL INFORMATION

Is today's visit the result of an accident?

☐ No ☐ Auto ☐ Work ☐ Other: _____

Will we be working with insurance? ☐ No ☐ Yes *(Details)*

Primary: _____ *ID#:* _____

Secondary: _____ *ID#:* _____

Where would you like statements sent?

☐ Self ☐ Other *(Details below)*

Name: _____

Address: _____

Phone: _____ *Email:* _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Account No: _____

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

Major Complaint: _____ **Secondary Complaints:** _____

_____ _____

_____ _____

When did it start? ____/____/_____ **What happened?** _____

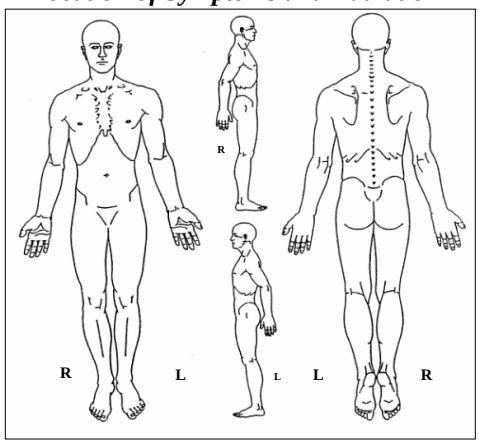
_____

Which daily activities are being affected by this condition? _____

_____

MAJOR COMPLAINT

Location of Symptoms and Radiation



P __ Pain T__ Tender
N __ Numb H__ Hypoesthesia
S __ Spasm

Grade Intensity/Severity:

- ☐ None (0/10)
- ☐ Mild (1-2/10)
- ☐ Mild-Moderate (2-4/10)
- ☐ Moderate (4-6/10)
- ☐ Moderate-Severe (6-8/10)
- ☐ Severe (8-10/10)

Frequency:

- ☐ Off & On
- ☐ Constant

Quality:

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff & Sore
- ☐ Other: _____

Does it radiate?

☐ No ☐ Yes *(Please indicate on drawing)*

Improves with:

- ☐ Ice
- ☐ Heat
- ☐ Movement
- ☐ Stretching
- ☐ OTC Medications: _____
- ☐ Other: _____

Worsens with:

- ☐ Sitting
- ☐ Standing/Walking
- ☐ Lying Down/Sleeping
- ☐ Overuse/Lifting
- ☐ Other: _____

Previous Treatment:

- ☐ None
- ☐ Chiropractor _____
- ☐ Medical Doctor _____
- ☐ Physical Therapy _____
- ☐ ER/Urgent Care _____
- ☐ Orthopedic _____
- ☐ Other: _____

Previous Diagnostic Testing:

- ☐ None
- ☐ X-rays _____
- ☐ MRI _____
- ☐ CT _____
- ☐ Other: _____

Women:** ***Are you pregnant?

☐ No *Last Menstrual Period:* ___/___/____

☐ Yes *Due date:* ___/___/____

Present Illness Comments:

_____

_____

_____

_____

_____

_____

Prescription Medications & Supplements: ☐ None

☐ Yes *(List – Name, dosage, frequency)* _____

_____

_____

_____

_____

_____

Allergies to Medications: ☐ No known drug allergies

☐ Yes *(List - Name and reaction)*_____

_____

_____

_____

_____

_____

PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you *ever* had any of the following? *(Please select all that apply and use comments to elaborate.)*

Illnesses:

- ☐ Asthma
- ☐ Autoimmune Disorder (*Type*) _____
- ☐ Blood Clots
- ☐ Cancer (*Type*) _____
- ☐ CVA/TIA (stroke)
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Other: _____

Injuries:

- ☐ Back Injury
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Falls
- ☐ Other: _____

Hospitalizations: *(Non-surgical with Date)*

_____

_____

Surgeries: *(If yes, provide type & surgery date)*

- ☐ Cancer _____
- ☐ Orthopedic
  - Shoulder – R / L _____
  - Elbow/Forearm – R / L _____
  - Wrist/Hand – R / L _____
  - Hip – R / L _____
  - Knee – R / L _____
  - Ankle/Foot – R / L _____
- ☐ Spinal Surgery
  - Neck: _____
  - Back: _____
- ☐ Other: _____

_____

_____

Medical History Comments:

_____

FAMILY HISTORY *(Please mark **X** to all that apply and use comments to elaborate.)*

☐ Unknown ☐ Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death *(if Deceased)*								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

Family History Comments:

_____

SOCIAL AND OCCUPATIONAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Children: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other:_____

Student Status: ☐ Full Student ☐ Part Student ☐ Non-Student

Highest level of Education: ☐ High School ☐ College Grad.

☐ Post Grad. ☐ Other: _____

Employed: ☐ No ☐ Yes (*Occupation*) _____

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Smoking/Tobacco Use: *If current smoker, amount =* _____

☐ Every Day ☐ Some Days ☐ Former ☐ Never

Alcohol Use:

☐ Every Day ☐ Weekly ☐ Occasionally ☐ Never

Caffeine Use:

☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never

Exercise frequency:

☐ Daily ☐ 3-4xs/week ☐ 2-3xs/week ☐ Rarely ☐ Never

Social History Comments: _____

_____

REVIEW OF SYSTEMS

Many of the following conditions respond to chiropractic treatment.

Are you *currently* experiencing any of these symptoms? *(Please select all that apply and use comments to elaborate.)*

Constitutional: *(General)*
- ☐ Fever
- ☐ Fatigue
- ☐ Other: _____
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Joint Pain/Stiffness/Swelling
- ☐ Muscle Pain/Stiffness/Spasms
- ☐ Broken Bones_____
- ☐ Other: _____
- ☐ *None in this Category*

Neurological:
- ☐ Dizziness or Lightheaded
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Other: _____
- ☐ *None in this Category*

Psychiatric: *(Mind/Stress)*
- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ *None in this Category*

Genitourinary:
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Painful or Irregular Periods
- ☐ Other: _____
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains/Tightness
- ☐ Rapid or Heartbeat Changes
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Other: _____
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Other: _____
- ☐ *None in this Category*

Eyes & Vision:
- ☐ Eye Pain
- ☐ Blurred or Double Vision
- ☐ Sensitivity to Light
- ☐ Other: _____
- ☐ *None in this Category*

Head, Ears, Nose, & Mouth/Throat:
- ☐ Frequent or Recurrent Headaches
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Hearing Loss
- ☐ Sensitivity to Loud Noises
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Other: _____
- ☐ *None in this Category*

Endocrine:
- ☐ Infertility
- ☐ Recent Weight Change
- ☐ Eating Disorder
- ☐ Other: _____
- ☐ *None in this Category*

Hematologic & Lymphatic:
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Swollen Glands
- ☐ Other: _____
- ☐ *None in this Category*

Integumentary: *(Skin, Nails, & Breasts)*
- ☐ Rash or Itching
- ☐ Change in Skin, Hair, or Nails
- ☐ Non-healing Sores or Lesions
- ☐ Change of Appearance of a Mole
- ☐ Breast Pain, Lump, or Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Allergic/Immunologic:
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Other: _____
- ☐ *None in this Category*

Review of Systems Comments:

_____

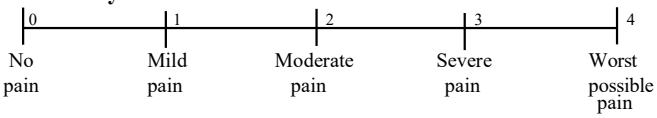
I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature _____ Date_____

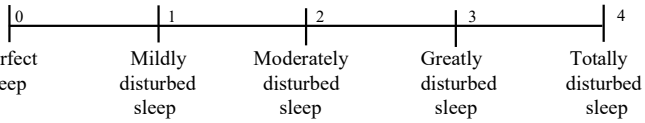
Functional Rating Index

In order to properly assess your condition, we must understand how much your problems have affected your ability to manage everyday activities.
For each item below, **please circle the <u>WHOLE NUMBER</u> which most closely describes your condition.**

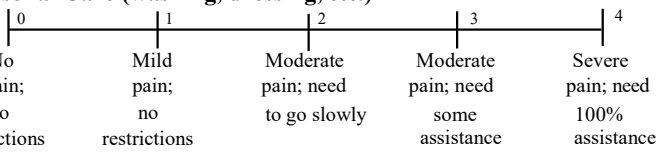
1. Pain Intensity



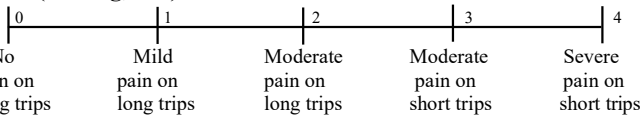
2. Sleeping



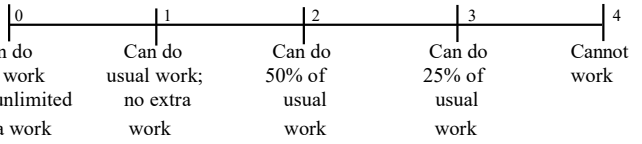
3. Personal Care (washing, dressing, etc.)



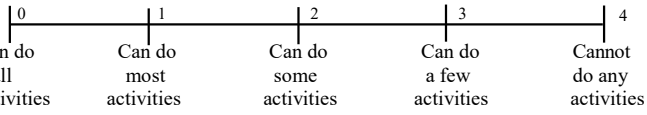
4. Travel (driving, etc.)



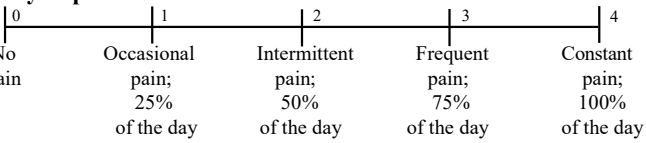
5. Work



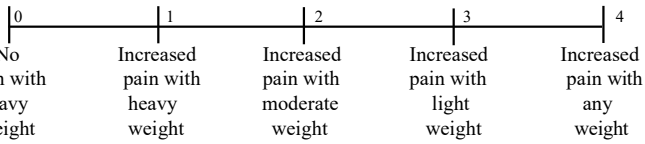
6. Recreation



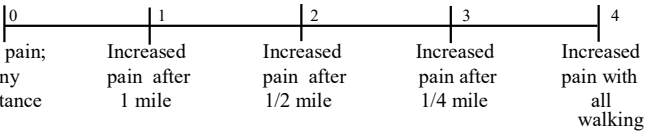
7. Frequency of pain



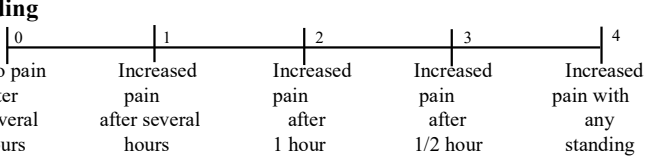
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

NEW LEAF CHIROPRACTIC

Curtis Begin, D.C. • 686 Grapevine Hwy, Hurst, TX 76054 • Phone: (817) 514-1908 • Fax: (817) 514-1941
www.drcurtisbegin.com

Patient Name: _____ DOB: _____ Date: _____

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation and examination on the above.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

CONSENT FOR CHIROPRACTIC SERVICES: I have been made aware: The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound. As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of intersegmental traction. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment. That the chiropractor has made no guarantee of a positive outcome from treatment. I have been afforded ample opportunity for questions and answers. I **consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case. I **consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to be paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "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." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

CLINICAL SUMMARY REPORT (CCR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking New Leaf Chiropractic to save these electronically for me and not print them out after each visit. I understand that upon request these reports are available to be printed or emailed to me for review.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

CONSENT FOR TREATMENT OF MINOR: I, the parent or legal guardian of _____ (minor child's name), hereby give my permission to New Leaf Chiropractic to treat said child.

PRIMARY CARE PHYSICIAN RELEASE: To improve the quality and continuity of your care, do we have your permission to send our notes and reports to your Primary Care Physician (PCP)? ❑ Yes ❑ No

Patient or Parent (Legal Guardian) Signature: _____

AUTHORIZATION TO SEND/RECEIVE APPOINTMENT AND MEDICAL INFORMATION BY EMAIL/TEXT

This practice utilizes email and/or text messaging to communicate with patients.

RISKS: Transmitting information by email/text has a number of risks that patients should consider before using. These include, but are not limited to, the following: Email/text can be circulated, forwarded, and stored in numerous paper and electronic files. Can be immediately broadcast worldwide and be received by many intended and unintended recipients. Can easily misaddress an email or text. Are easier to falsify than handwritten or signed documents. Can be intercepted, altered, forwarded, or used without authorization or detection. Can be used to introduce viruses into computer systems. Can be used as evidence in court. Backup copies of email/text may exist even after the sender or the recipient has deleted his or her copy. Employers and on-line services have a right to archive and inspect emails/texts transmitted through their systems.

CONDITIONS: Because of the Risks outlined above, the practice cannot guarantee the security and confidentiality of email/text communication, and will not be liable for improper use and/or disclosure of confidential information that is not caused by the practice's intentional misconduct. Thus, patients must consent to the use of email/text for patient information. Consent to the use of email/text includes agreement with the following conditions:

1. All emails/texts to or from the patient concerning diagnosis or treatment will be saved as part of the medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails/texts.
2. Although the practice will endeavor to read and respond promptly to an email/text from the patient, the practice cannot guarantee that any particular email/text will be read and responded to within any particular period of time. Thus, the patient shall not use email/text for medical emergencies or other time-sensitive matters.
3. If the patient's email/text requires or invites a response from the practice, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the email/text and when the recipient will respond.
4. The patient should not use email/text for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
5. The patient is responsible for informing the practice of any types of information the patient does not want to be sent by email/text, in addition to those set out in the preceding paragraph.
6. The patient is responsible for protecting his/her password or other means of access to email/text.
7. The practice is not liable for breaches of confidentiality caused by the patient or any third party.
8. The practice shall not engage in email/text communication that is unlawful, such as unlawfully practicing medicine across state lines.
9. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

INSTRUCTIONS: To communicate by email/text, the patient shall:
1. Limit or avoid use of his/her employer's computer.
2. Inform the practice of changes in his/her email address or text number.
3. Put the patient's name in the body of the email/text.
4. Inform the practice that the patient received an email/text from the practice.
5. Take precautions to preserve the confidentiality of emails/texts, such as using screen savers and safeguarding his/her computer password.
6. Withdraw consent only by email or written communication to the practice.
7. Contact the doctor or staff with any privacy concerns before communicating with the practice via email or text message.

PATIENT ACKNOWLEDGMENT AND AGREEMENT
I acknowledge that I have read and fully understand the information the practice has provided me regarding the risks of using email and text messaging. I understand the risks associated with the communication of email and text between the practice and me, and consent to the conditions outlined in this document. In addition, I agree to the instructions outlined above, as well as any other instructions that the practice may impose regarding email or text message communications.

_____ _____
Phone number to be used for appointment text *Email address authorized to be used for sending medical records*

_____ _____ _____
Patient Name *Patient Signature* *Date*

_____ _____ _____
Patient/Guardian Name *Patient/Guardian Signature* *Date*

PINNACLE CHIROPRACTIC SYSTEM
Rev. 1/3/2022

NEW LEAF CHIROPRACTIC

Curtis Begin, D.C. • 686 Grapevine Hwy, Hurst, TX 76054 • Phone: (817) 514-1908 • Fax: (817) 514-1941
www.drcurtisbegin.com

ASSIGNMENT OF BENEFITS: ASSIGNMENT OF CAUSE ON 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 Curtis Begin, D.C., a lien and assignment of any and all claims, causes of actions, 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. A letter of protection issued by an attorney's office will not negate this assignment.

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 my carrier to make all checks payable to New Leaf Chiropractic, and send to 686 Grapevine Hwy, Hurst, TX 76054. I instruct my attorney to provide on request to the above named provider, a settlement breakdown in accordance with the Safekeeping Property Rule, Sec. 1.15.

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 New Leaf Chiropractic, and to send any and all checks to 686 Grapevine Hwy, Hurst, TX 76054.

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 any other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

I declare under penalty of perjury that the forgoing is true and correct. [CPRC: Sec. 132.001(a)]

Patient or Parent (Legal Guardian) Signature: _____ Date: _____

NEW LEAF CHIROPRACTIC
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Auto Accident Payment and Insurance Policy

If you have been injured in a car accident, payment is expected at the time of service. **We do not bill third party auto insurance** (i.e. at fault parties), even if they have already accepted full liability for your case.

Payment/Billing Options:
Please initial and check the box next to the Payment/Billing Option you would like to use.

_____ ❑ **Personal Injury Protection (PIP) or MedPay:** If you have PIP or MedPay coverage on YOUR auto policy, we will help you set up a claim with your carrier. We will submit all of the required paperwork and billing records to your auto carrier at no charge. If you were not-at-fault, your auto insurance rates will not increase for using this coverage. You are responsible for any charges not covered by your PIP or MedPay policy.

As an additional courtesy to you, we will provide you with the required paperwork and billing records so you can submit them to the third party for reimbursement of your medical bills. We will be happy to fax these records to the third party at no charge. You will receive payment from the third party for your medical bills.

_____ ❑ **Attorney's Letter of Protection (LOP):** If you do not have PIP or MedPay coverage, you can still receive treatment that you would otherwise not be able to afford with an Attorney's Letter of Protection. This allows you to get the care you need with no out of pocket expenses until a settlement is reached. New Leaf Chiropractic will get paid for any services rendered at the time of your settlement. We only work with a few select attorneys in the area. The front desk will be happy to provide you with their contact information.

_____ ❑ **Cash:** If you do not have PIP or MedPay coverage and/or do not wish to have an attorney represent you, payment is expected at the time of service. As a courtesy to you, we will provide you with the required paperwork and billing records so you can submit them to the third party for reimbursement. We will be happy to fax these records to the third party at no charge. You will be reimbursed by the third party for your medical bills.

Patient or Parent (Legal Guardian) Signature: _____ Date: _____