APPLICATION FOR CARE AT CHIROPRACTIC ASSOCIATES

Today's Date: _____ Whom May We thank for referring you to our office? _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date ____-____-____ Age: _____ ( ) Male ( ) Female

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

Cell Phone: _____Home Phone: _____ Email Address: _____

Social Security # _____ Driver's License # _____

Employer: _____ Employer Address: _____

Occupation: _____ Employer Phone: _____

Person Responsible for payment Name, Number & Social: _____

Marital Status: ( ) Single ( ) Married Spouse's Name & Phone Number: _____

Do you have Insurance? ( ) Yes ( ) No Company: _____

HISTORY OF COMPLAINT

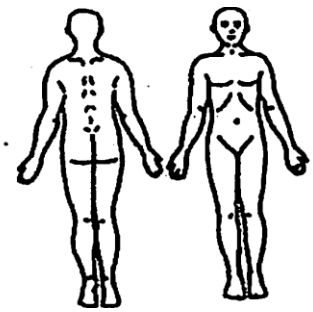
Please identify the condition(s) that brought you into our office: Primarily: _____
Secondarily: _____ Third: _____ Fourth: _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by circling the number:

Primary or chief complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? _____
How long does it last? ( ) It is Constant ( ) It comes and goes daily ( ) It comes and goes throughout the week
How did the injury happen? _____
Condition(s) ever been treated by anyone in the past? ( ) Yes ( ) No
IF YES, when: _____ by whom: _____ How long were you under care: _____
What were the results? _____ Name of previous Chiropractor: _____

*PLEASE MARK the areas on the diagram with the following letters to describe your symptoms:
R = Radiating B = Burning D = Dull A = Aching N = Numbers S = Sharp/Stabbing T = Tingling



What relieves your symptoms? _____
What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL:	USUAL ACTIVITY LEVEL:
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	

Is your problem the result of ANY type of accident? ( ) Yes ( ) No IF YES, please explain: _____
_____

Identify any other injury(s), minor or major, to your spine that the doctor should know about: _____
_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ( ) Yes ( ) No IF YES, how many times? _____
When was the last episode? _____
Have you tried any other forms of treatment? ( ) Yes ( ) No IF YES, please state the type of treatment: _____
_____, who provided treatment: _____ How long ago? _____ What were the results? ( ) Favorable ( ) Unfavorable Please explain: _____
Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body: _____
If you have ever been diagnosed with any of the following conditions, please indicate with a P for PAST, C for CURRENTLY have and N for NEVER have had:
___Broken Bone ___Dislocations ___Tumors ___Rheumatoid Arthritis ___Fracture ___Disability ___Cancer
___Heart Attack ___Osteo Arthritis ___Diabetes ___Cerebral Vascular ___Other serious conditions: _____

Please identify ALL PAST and CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
Injuries	→		
Surgeries	→		
Childhood Diseases	→		
Adult Diseases	→		

SOCIAL HISTORY

1. Smoking: ( ) Cigars ( ) Pipe ( ) Cigarettes How often? ( ) Daily ( ) Weekends ( ) Occasionally ( ) Never
2. Alcoholic Beverage: ( ) Yes ( ) No Consumption Occurs ( ) Daily ( ) Weekends ( ) Occasionally ( ) Never
3. Recreation Drug use: Consumption Occurs ( ) Daily ( ) Weekends ( ) Occasionally ( ) Never
4. How does your present problem affect the following: Hobbies – Recreational Activities – Exercise Regime?

_____

FAMILY HISTORY

Does anyone in your family suffer with the same condition(s)? ( ) Yes ( ) No
IF YES WHOM? ( ) Grandmother ( ) Grandfather ( ) Mother ( ) Father ( ) Sibling ( ) Child
Have they ever been treated for the condition? ( ) Yes ( ) No ( ) I don't know If YES please explain: _____

I hereby authorize payment to be made directly to CHIROPRACTIC ASSOCIATES, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies therof for purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to CHIROPRACTIC ASSOCIATES for any and all services I receive at this office.

_____ _____-_____-_____
Patient or Authorized Person's Signature Date Completed

_____ _____-_____-_____
Doctor's Signature Date Form Reviewed

AUTHORIZATION FOR RADIATION

For Both Female and Males

I understand that my condition may require my doctor to take X-Rays to further diagnose my symptoms and I give my permission for all needed diagnostic test.

Patient/Guardian's Signature _____ Date _____

PREGNANCY WARNING AND CONSENT TO X-RAY FOR FEMALES ONLY!!

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are NOT pregnant at this time?

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.

( ) There is a possibility that I may be pregnant at this time
( ) Yes. I am definitely pregnant at this time.
( ) No. I am definitely NOT pregnant at this time.
( ) I request that x-ray films not be taken because _____.

Date of last menstrual period: _____

Signature _____ Date _____
(FEMALE PATIENTS ONLY)

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. Robert L. Birk and staff to administer treatment as he so deems necessary for my
_____ , _____.
(Child, grandchild, etc.) (Name of Minor Child)

Signature _____ Date _____
Witness _____ Date _____

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information **(PHI)** is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information **(PHI)** for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature _____ Date _____

AUTHORIZATION FOR CARE GENERAL RELEASE AND ASSIGNMENT OF BENEFITS TO BIRK CHIROPRACTIC

AUTHORIZATION FOR CHIROPRACTIC TREATMENT: I, the undersigned, a patient in this Office, hereby authorize Birk Chiropractic, DBA CHIROPRACTIC ASSOCIATES, and all employees (including doctors of chiropractic) to administer such treatment as deemed necessary by the doctor. I also certify that no guarantee or Assurance has been made as to the results that may be obtained. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.
I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

GENERAL RELEASE OF INFORMATION: I hereby authorize any hospital, physician or other person who has examined or attended me, to furnish to CHIROPRACTIC ASSOCIATES or a representative thereof, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. I hereby authorize CHIROPRACTIC ASSOCIATES to release to authorized persons any and all records pertaining to my treatment in said clinic.

ASSIGNMENT OF BENEFITS: I hereby authorize the direct payment to CHIROPRACTIC ASSOCIATES of any sum I now or hereafter owe them by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or them based in whole or in part upon the charges made for their services. I understand that (regardless of my insurance carrier), I am ultimately financially responsible for the balance on my account for any professional services rendered, whether or not paid by said insurance. I understand and agree to allow this office to use the Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will become immediately due and payable in full by you, regardless of any claims submitted.

In consideration of CHIROPRACTIC ASSOCIATES undertaking to treat me, I have read all of the above, understand, and agree to all consents and releases. These consents and releases will remain in effect until revoked by me in writing. A photocopy of this form is to be considered as valid as the original. I also have read all the information on this sheet, have answered all the questions and I certify that it is true and correct to the best of my knowledge. In addition, I declare that I will notify CHIROPRACTIC ASSOCIATES of any changes in my health status or the above information.

Patient Signature: _____ Date: _____
Guardian's Signature Authorizing Care: _____ Date: _____
Witness Signature: _____ Date: _____

Irrevocable Assignment, Security Agreement and Authorization Insurance Benefits and Attorney

I hereby authorize and direct you, (my insurance company, and/or my attorney), to pay directly to Birk Chiropractic, P.A. 3701 Fairway, Ste. 116 Wichita Falls, TX 76310 (the "Provider") such sums as may be due and owing the Provider for health care services rendered me by reason of accident or illness. Further, I authorize and direct you to withhold such sums from any disability benefits, medical payment benefits, no fault benefits, health and accidental benefits, Worker's Compensation benefits, or any other insurance benefits obligated to be paid to me of from any settlement or judgment on my behalf as may be necessary to adequately protect the financial interests of the Provider.

I hereby grant the provider a security interest in any and all insurance benefits, and any and all proceeds of any settlement or judgment which may be payable to me as a result of the injuries or illness for which I have been treated by the Provider.

In the event my insurance company becomes obligated to make payments to me for charges for services rendered by the provider and refuses to make such payments upon demand by the Provider or me, I hereby assign and transfer to the provider any and all causes of action that I may have against such insurance company, and authorize the provider to prosecute said cause of action either in my name or in the Provider's name. Further, I authorize the Provider to compromise, settle or otherwise resolve such claim or cause of action in such manner as the Provider shall determine in his sole discretion.

I understand that I remain personally responsible for the payment of all amounts due the provider for health care services. I further understand and agree that this Assignment, Security Agreement and Authorization does not constitute consideration for the provider to defer collection efforts for payment for health care services and the Provider may, at his option, demand immediate payment from me upon rendering such services.

I hereby authorize the provider to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection of insurance of benefits or the proceeds of any settlement or judgment under this Assignment, Security Agreement and Authorization.

I hereby appoint the Provider as my attorney-in-fact and agent to endorse/sign my name on any and all checks issued by the insurance company to me as payment of any accounts due and payable to the Provider for health care services.

I agree to pay the Provider for all costs of collection efforts, including court costs and attorney's fees, if the Provider must take any action to collect outstanding balance on my account.

_____ _____

Patient Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices for Protected Health Information

If you would like a personal copy of HIPPA PRIVACY NOTICE – as opposed to reading the 9 page form in our office, SIGN HERE: _____ Date: _____

If you should choose not to receive a copy of HIPPA PRIVACY NOTICE please SIGN BELOW:
I acknowledge that I have been given the option to receive Chiropractic Associate's Notice of Privacy for protected health information.

Date: _____ _____
Signature of Patient/Personal Representative

Name of Patient: _____
Print Name