PATIENT INFORMATION PERSONAL INJURY

PATIENT'S NAME: ________________________________ CIRCLE: MALE / FEMALE

ADDRESS: ____

CITY: __________________________________ STATE: ______ ZIP: _______________

PHONE: _____-_____-_______ CELL: _____-_____-_______ SS#: ______-______-________

D.O.B. _____/_____/_______ E MAIL ADDRESS:_______________________________________

EMERG. CONTACT: ______________________ EMERGENCY #: _____-_____-________

EMPLOYER: ____

EMPLOYER ADDRESS: ____

CITY: ________________________________STATE: _______ ZIP: __________________

EMPLOYER'S #: ______-_____-________ EMPLOYER'S FAX: _____-_____-________

DATE OF INJURY/ ACCIDENT: ______/______/__________

BODY PARTS INJURED:____

ACCIDENT INFORMATION: FILL OUT ALL THAT APPLY

LAW FIRM:____

LAWYER PH.: _____-_____-_______ EXT: _______ FAX: _____-_____-_______

YOUR INSURANCE CO.: ___________________________ CLAIM #: ________________________

ADDRESS: ____

CITY: ________________________________ STATE: ________ ZIP: __________________

INSURNACE PH.: ______-______-__________ FAX: ______-______-_________

ADJUSTER'S NAME: ________________________________PH & EXT: ____________________

THIRD PARTY INSURANCE CO.: ___________________________ CLAIM #:_________________

ADDRESS: ____

CITY: ________________________________ STATE: ________ ZIP: __________________

INSURNACE PH.: ______-______-__________ FAX: ______-______-_________

ADJUSTER'S NAME: ________________________________PH & EXT: ____________________

HEALTH COMPLAINTS

Are you here because you were injured in a motor vehicle accident, while working or because of another traumatic incident? □Yes □No

What is your primary complaint?

____

____

How long have you been experiencing this complaint? __________________________________

Describe the quality of you primary complaint.
□Sharp □Dull/achy □Numb □Tightness □Tingling □Burning □Cold □Weakness

How often do you experience this complaint? □Constantly □Intermittent

Have you missed work because of your primary complaint? □Yes □No

Treatment thus far for your primary complaint:

____

Have you ever had this complaint before? □Yes □No
If yes, what treatment was used?

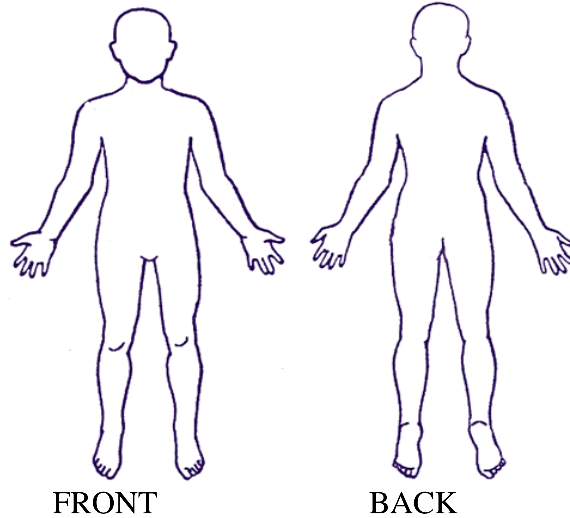
____

Please list any other health complaints:

____

____

Please mark areas of all your complaints on the diagrams below:



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 chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician LMS Chiro. Inc and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with the doctor 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 (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician 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 an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

____
Patient Name (Printed)

____
Patient Signature

____/_____/______
Date

Physician Signature ________________________________ Date _____/_____/________

Height: ____________ Weight: ________________

List any past diseases including those from childhood____

____

____

List any surgeries, major traumas (including concussions and broken bones), illnesses, recent immunizations, or other hospitalizations____

____

____

Have you ever been diagnosed with a spondylolisthesis, compression fracture, or other spinal fracture? Have you had any imaging (X-ray, MRI, CT. etc.) for this problem? Did you seek treatment for this condition? What kind? Explain:

____

____

____

List any medical allergies____

____

List all medications you are currently on or have recently taken__________________________________

____

Circle one:

YES **NO** Are you currently taking NSAIDS (Ibuprofen, Acetaminophen, etc) How often? __________

YES **NO** Do you drink alcohol? If yes how many drinks and how often? _______________________

YES **NO** Do you smoke? How many packs a day? __________ How many years? _______

YES **NO** Do you have difficulties sleeping soundly through the night?

HIGH **MED** **LOW** What is your level of stress?

Explain____

YES **NO** Have you been to a chiropractor before? If so, why and when? ________________________

____

LMS Chiro Inc.

4632 Camp Bowie Blvd
Ft Worth, TX 76107
PH # (817) 735-3839 FAX # (817) 735-3837

IRREVOCABLE AUTHORIZATION AND ASSIGNMENT OF BENEFITS AND LIEN

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, assigns to the physician or facility named above 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 adjuster, for purposes of processing my claim for benefits and payment of 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, court costs, or other legally compensable amounts by any insurance company, in accordance with **article 21.55** of the Texas Insurance Code or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree 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, you are hereby tended demand to pay in full the bill for services rendered by the physician/facility named above within 21/45 days (electronic/paper) following your receipt of such bill for services to the extent such bills are payable under the terms of demand specifically conforms with **Article 21.55** of the Texas Insurance Code, providing for attorney fees, **18% penalty**, court costs, and interest from judgment, upon violation.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to cut a separate draft to pay in full for all services rendered, payable directly to the physician/facility named above.

STATUE OF LIMITATIONS: I waive my rights to claim and Statute of Limitations regarding claims for services rendered, or to be rendered, by the physician/facility named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instruments representing payment from any insurance company representing payment for treatment and health care rendered by 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 office upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if do not keep appointments as recommended to me by my caring doctor at this chiropractic clinic, he/she has the 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, any insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.
A photo copy of this instrument shall serve as original.

Signature of Patient and/or responsible parties:

____ Date_____/_____/______

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To Whom It May Concern,

I, ____, give authorization and power of attorney for my Third Party Insurance, ____, to pay any and all medical bills related to my injury on ___/___/____ directly to LMS Chiro, Inc. dba Five Stars Personal Injury, LMS Chiro, Inc. dba Natural Health Chiropractic Spine and Sports or Lynn Saul. at the time of the settlement disbursement. This check for medical bills is to need only sole endorsement by LMS Chiro, Inc. and any other monies I may receive not related to their medical bills will not be included in this authorization and should be endorsed only with my name. They are also authorized to negotiate for their medical bills on my behalf as this will stand as a power of attorney for that one purpose only.

The patient hereby irrevocably acknowledges full financial responsibility for all services provided to patient by Provider as consideration for such Provider services. Patient irrevocably assigns to Provider any and all benefits payable by or from any insurance or health care plan(s) coverage maintained by Patient as consideration for the total fee for those charges incurred by Patient as a result of those services rendered by Provider. Patient also assigns to Provider: (i) any and all benefits payable by or from any automobile medical payment coverage maintained by Patient or any party under whose policy of insurance Patient may have a lawful right of recovery, (ii) any and all benefits payable by or under any third party liability insurance coverage to which Patient may have a right of recovery due to the injuries for which Patient has sought Provider’s health care services, and (iii) a “common law lien interest” in, and all contractual rights and claims to, any and all future insurance proceeds Patient has against any insurance company, health care benefit plan, or any other party contractually liable to Patient for payment of all or any portion of the health care services rendered by Provider, and the resultant charges therefore, to the Patient as a result of the injuries sustained by Patient. This irrevocable assignment of benefits, conveyance of lien interest and contractual rights to and for those charges attributable to Provider’s health care services shall extend to, but not be limited to, Provider’s entitlement to any and all insurance proceeds remitted as a result of any insurance claim for damages by the Patient which has given rise to the above referenced health care services provider by Provider.

____ _____/_____/______
Injured Party’s Signature Date

____ _____/_____/______
Lynn Saul Date

____ _____/_____/______
Witness Date

Assignment And Instruction For Direct Payment to doctor for Private, Group, or Accident Health Insurance

I, ______________________________, hereby instruct and direct

____

Insurance Company to make check payable and mail directly to:

Five Stars Personal Injury

4632 Camp Bowie Blvd

Fort Worth, TX 76107

If my current policy prohibits direct payment to the above, then I hereby instruct and direct you to make the check payable to me and mail it as follows:

____

c/o Five Stars Personal Injury

4632 Camp Bowie Blvd

Fort Worth, TX 76107

the benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Dated at __________________________, this _________day of ___________ 20___.

____________________________ ______________________________

Signature of policyholder Signature of Claimant, if other than Policyholder

PRIVACY PRACTICES PATIENT ACCEPTANCE FORM

I have received or reviewed the privacy practice notice (2 pages) for LMS Chiro, Inc, and understand the situation in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in the privacy practices statement.

____
Patient Name (Printed)

____ ____/_____/______
Patient Signature Date