

1  
one

# WELCOME

## ABOUT YOU

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ File #: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
LAST FIRST MI

What You Prefer To Be Called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

CITY STATE ZIP

Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

Other Phone #s: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

CITY STATE ZIP

Occupation: \_\_\_\_\_

Status:  Minor  Single  Married  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_

Do you have children?  Yes  No How many? \_\_\_\_\_

two

## INSURANCE INFO

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

Please inform front desk of 2nd. Insurance source.

## REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): \_\_\_\_\_

Please describe the pain & its location: \_\_\_\_\_

When did condition begin? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Is this condition getting worse?  Yes  No  Constant  Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: \_\_\_\_\_

Have you had this or similar conditions in the past?  Yes  No

If so, please explain: \_\_\_\_\_

Have you been treated by a Medical Physician for this condition?  Yes  No

If so, where? \_\_\_\_\_

Have you ever been treated by a Chiropractor before?  Yes  No

If so, whom? \_\_\_\_\_ Phone#: \_\_\_\_\_

three

PLEASE CONTINUE ON BACK

four

IN EVENT OF EMERGENCY

Who should we contact?
Relation:
Home Phone #: Work Phone #:
Who is your Medical Doctor? Phone #:

HEALTH HISTORY

Are you taking any of the following medications?

- ☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants
☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s)

Do you have or ever had any of the following diseases or conditions?

- Y N Heart Attack / Stroke Y N Heart Surg./Pacemaker Y N Heart Murmur
Y N Congenital Heart Defect Y N Mitral Valve Prolapse Y N Artificial Valves
Y N Alcohol / Drug Abuse Y N Venereal Disease Y N Hepatitis
Y N HIV+ / Aids Y N Shingles Y N Cancer
Y N Frequent Neck Pain Y N Emphysema / Glaucoma Y N Anemia
Y N High/Low Blood Pressure Y N Psychiatric Problems Y N Rheumatic Fever
Y N Severe/Frequent Headaches Y N Kidney Problems Y N Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy Y N Sinus Problems Y N Asthma
Y N Diabetes / Tuberculosis Y N Difficulty Breathing Y N Chemotherapy
Y N Lower Back Problems Y N Artificial Bones / Joints Y N Arthritis

Please list any other serious medical condition(s) you have or ever had:

Please list anything that you may be allergic to:

List previous surgeries/treatments with dates:

List any past serious accidents with dates:

Family Health History:

Do you: Take Supplements or Vitamins? ☐ Yes ☐ No / Exercise? ☐ Yes ☐ No

Are you on a special diet: ☐ Yes ☐ No / Since: / /

Do you smoke? ☐ No ☐ Yes / How Much? How Long?

Are you wearing: ☐ Heel Lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

What is the age of your mattress? Is it comfortable? ☐ Yes ☐ No

For women: Are you taking Birth Control? ☐ Yes ☐ No

Are you Pregnant? ☐ No ☐ Yes/How long? Nursing? ☐ Yes ☐ No

five

six

ACCOUNT INFO

Person ultimately responsible for account

Name:

Relation:

Billing Address:

CITY STATE ZIP

SSN:

D.L.#:

Work Phone#:

Payment method: ☐ CASH ☐ Check

☐ Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
■ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
■ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
■ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature Date / /
☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

## **Billing, Insurance, and Collection Policy**

Village Chiropractic Center  
972-317-3146  
972-317-4417 (fax)

2430 F.M. 407  
Ste. B  
Highland Village, TX 75077

This is an agreement between Village Chiropractic Center, a Texas Professional Corporation, as creditor, and the Patient named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient. The word "account" means the account that has been established in your name to which charges are made and payments credited for the services rendered to you by us. The words "we," "us," and "our" refer to Village Chiropractic Center.

**Monthly Statement:** It is our general policy that all charges must be paid for at the time services are rendered. If you have a balance on your account due to insurance claim procedures, we will send you an account statement. It will show separately the previous balance, any new charges to the account, late charges and/or fees, and any payments or credits applied to your account during the month.

**Payment options if you have no insurance:**

- A. You choose to pay by cash, check, or credit card on the day the treatment is rendered.
- B. Pre-Pay

**Payment options if you have insurance:**

- A. You choose to pay your deductible and any out-of-pocket portions at the time the services are rendered by cash, check, or credit card.
- B. You choose to pay all of your treatment by cash, check, or credit card. You will be responsible for filing with your insurance.
- C. Pre-Pay co-pays or get authorization to charge your credit card.

**Payments:** Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within thirty (30) days.

**Charges to Account:** We shall have the right to cancel your privilege to make charges against your account at any time without notice. Future visits would then need to be paid at the time service is rendered.

**Insurance:** Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of you eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it and failure to

obtain the referral and/or preauthorization will not relieve you of your obligation to make full payment to us for the services rendered.

**Late Charge:** A one time late charge will be imposed if payment is not received within thirty (30) days of the statement. The “overdue balance” of your account is calculated by taking the balance owed thirty (30) days ago, then subtracting any payments or credits applied to your account during that time. The minimum late charge is \$10.

**Re-billing Fee:** A re-billing fee of \$5 will be imposed on each account that is over thirty (30) days past due. We determine your account past-due by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

**Credit History:** You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

**Returned Checks:** There is a fee (currently \$30) for any checks returned by the bank for any reason.

**Past due accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If your account is referred to a collection agency or attorney, you agree to pay all of the collection costs which are incurred, including all reasonable attorney’s fees and expenses which we incur plus all court costs. In case a lawsuit for collection of your account is filed, you agree the exclusive venue shall be in Denton County, Texas and you agree that all services were rendered in Denton County, Texas and all invoices are payable in Denton County, Texas.

**Waiver of confidentiality:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment and the type of treatment received at our office may become a matter of public record or disclosed to third parties.

**Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible to us for those subsequent charges.

**Transferring of Records:** You will need to request in writing, and pay a reasonable copying fee (currently \$25) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history and hereby indemnify and hold us harmless for any claims or damages resulting from our providing records pursuant to your request. If you request records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

**Workers Compensation:** We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. Should your claim be denied you will be responsible for payment in full.

**Personal Injury:** If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. Payment of the bill remains the patient's responsibility.

**Liability:** If you are being treated for a 3<sup>rd</sup> party liability claim and do not have an attorney, we will require that you allow us to bill your health insurance or file on your Personal Injury Protection. Upon settlement of your claim, YOU WILL BE RESPONSIBLE FOR ANY BALANCE OWED ON YOUR ACCOUNT REGARDLESS OF THE AMOUNT OF SETTLEMENT YOU RECEIVE FROM THE INSURANCE COMPANY. Please understand upon settlement of your claim, the 3<sup>rd</sup> party carrier will NOT PAY US DIRECTLY; however, you remain fully responsible for payment of your account. If you do not have health insurance or PIP, we must have a letter of protection on file from an attorney. Otherwise, you will be responsible for payment in full at the time services are rendered. We have the right, at our sole discretion, to refuse to accept a letter of protection for payment of your services.

**Co-signature:** If this or another Financial Policy is signed by another person, that co-signature remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

**Authorization for Credit Card Charge:** By signing this agreement, you hereby authorize us to make charges to your credit card now and in the future for services provided to you by us and all related fees and expenses.

**Effective Date:** By signing this agreement, you agree to all of the terms and conditions contained herein and agree that no changes to this agreement will be binding unless such changes are in writing and signed by both parties. In addition, all of the undersigned agree to pay for all services rendered to the patient in accordance with this agreement.

Patient's name: \_\_\_\_\_

Responsible party  
(if not the patient): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Co-Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**INFORMED CONSENT**

- ◆ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- ◆ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, re-billing charges and any other expenses incurred in collecting your account.
- ◆ I authorize the staff of Village Chiropractic Center to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ◆ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. This includes changes of address, telephone numbers, and insurance information.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**CONSENT FOR X-RAY EXAMINATION**

I \_\_\_\_\_ do hereby give my permission to Village Chiropractic Center and its representatives to take X-RAYS as deemed appropriate by the examining doctor. I also hereby declare that to my knowledge, I am not pregnant.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

**CONSENT TO TREAT A MINOR**

I hereby authorize \_\_\_\_\_ and whomever he or she may designate as assistants to administer Chiropractic care as deemed necessary to my \_\_\_\_\_ (indicate relationship of child), \_\_\_\_\_.

Dated at: \_\_\_\_\_, Texas on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Signed: \_\_\_\_\_  
(Parent or Guardian)

Witnessed: \_\_\_\_\_

**PIP/Liability Insurance Information**

Patient: \_\_\_\_\_

DOI: \_\_\_\_\_

**PIP**

Insurance Carrier: \_\_\_\_\_

Address: \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_

Adjuster's Phone #: \_\_\_\_\_

Insured: \_\_\_\_\_

Claim #: \_\_\_\_\_

**Liability**

Insurance Carrier: \_\_\_\_\_

Address: \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_

Adjuster's Phone #: \_\_\_\_\_

Insured: \_\_\_\_\_

Claim #: \_\_\_\_\_

**VILLAGE CHIROPRACTIC CENTER  
NON-RESCINDABLE AGREEMENT LETTER**

This agreement is between \_\_\_\_\_ and Village Chiropractic and any third-party involved in the accident on \_\_\_\_\_.

I, \_\_\_\_\_ do hereby authorize and agree to pay any outstanding balance due on my account at the time of my release from care.

I instruct any monies due from my personal injury protection to be paid directly to my physician. Furthermore, claims shall be paid in accordance with Article 5.06-3, in a timely manner, not to exceed thirty (30) days upon receipt of each claim.

I instruct my attorney to pay in full any outstanding monies due to my physician at the time of settlement with any liability claim that may result from this case. My agreement to offset attorneys fees which my attorney now or hereafter may claim to be owed by me. I instruct my attorney to pay my doctor immediately upon settlement, by way of issuance of a separate draft made payable to the physician/clinic.

I instruct any third-party individual or insurance carrier that may be liable, to pay my physician direct for any outstanding medical bills which are the result of this accident. If payment is not made until time of settlement, I instruct the third party to issue separate draft to be payable to the physician/clinic for the medical bills.

I understand and acknowledge that all charges incurred by me are my responsibility regardless of any settlement made by a third party. I am instructing and agreeing to the above conditions as a safeguard to the physician's right to collect payment. I understand that the physician/clinic has the right to expect good faith payment on my account and that full payment is being deferred only until such time as a third party settlement occurs. If a settlement does not occur within a reasonable amount of time, I agree to make other arrangements to pay my account in full.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT OF RECEIPT OF AGREEMENT**

As the insurance adjuster, or attorney, on this claim, I acknowledge that I have received notice of the patient's agreement and will abide as instructed.

\_\_\_\_\_  
Adjuster/Attorney Signature

\_\_\_\_\_  
Date

# VEHICLE ACCIDENT INFORMATION

## PATIENT INFORMATION

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_  a.m.

p.m.

Please describe the accident in your own words: \_\_\_\_\_

Were you the:  Driver  Front Passenger  Rear Passenger  Pedestrian

How many people were in the accident vehicle? \_\_\_\_\_

## ACCIDENT SITE

Road/Street Name \_\_\_\_\_

City/State \_\_\_\_\_

Nearest intersection with road/street \_\_\_\_\_

Driving conditions  Dry  Wet  Icy  Other \_\_\_\_\_

Which direction were you headed? \_\_\_\_\_

Speed you were traveling? \_\_\_\_\_

## IMPACT

Did your car impact another vehicle?  Yes  No

Did your car impact a structure?  Yes  No

If yes, explain \_\_\_\_\_

Did any part of your body strike anything in the vehicle?

Yes  No If yes, explain \_\_\_\_\_

Was impact from :

Front  Rear  Left  Right  Other \_\_\_\_\_

At the time of impact were you:

Looking straight ahead  Looking to the right

Looking to the left  Looking down

Looking up

Were both hands on the steering wheel?  Yes  No

If no, which hand was on the wheel?  Right  Left

Was your foot on the brake?  Yes  No

If yes, which foot was on the brake?  Right  Left

Were you:  Surprised by impact  Braced for impact

## VEHICLE

Make and model of vehicle you were in: \_\_\_\_\_

Were you wearing a seatbelt?  Yes  No

If yes, what type?  Lap  Shoulder

Was vehicle equipped with airbags?  Yes  No

If yes, did it/they inflate properly?  Yes  No

Did your seat have a headrest?  Yes  No

If yes, what was the position of the headrest?

Low  Midposition  High

## OTHER VEHICLE

(if applicable)

Make and model of other vehicle \_\_\_\_\_

Which direction was other vehicle headed? \_\_\_\_\_

Speed other vehicle was traveling \_\_\_\_\_

## POLICE

Did the police come to the accident site?  Yes  No

Were there any witnesses?  Yes  No

Was a police report filed?  Yes  No

Was a traffic violation issued?  Yes  No

If yes, to whom? \_\_\_\_\_

## PATIENT CONDITION

Were you unconscious immediately after the accident?  Yes  No If yes, for how long? \_\_\_\_\_

Please describe how you felt immediately after the accident:

\_\_\_\_\_  
\_\_\_\_\_

## TREATMENT

Did you go to the hospital?  Yes  No

When did you go?  Immediately after accident  Next day  2 days or more after the accident

How did you get to the hospital?  Ambulance  Private transportation

Name of hospital \_\_\_\_\_ Name of doctor \_\_\_\_\_

Diagnosis \_\_\_\_\_

Treatment received \_\_\_\_\_

X-rays taken \_\_\_\_\_

## SYMPTOMS/INJURIES

Have you been able to work since this injury?  Yes  No How many work days have you missed? \_\_\_\_\_

Prior to the injury were you able to work on an equal basis with others your age?  Yes  No

If you have had any of the following symptoms since your injury, please  check:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Feet/toe numbness    | <input type="checkbox"/> Neck pain           |
| <input type="checkbox"/> Back pain         | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Neck stiff          |
| <input type="checkbox"/> Back stiffness    | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain        | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Sleep difficulty    |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Jaw problems         | <input type="checkbox"/> Stomach upset       |
| <input type="checkbox"/> Ear buzzing       | <input type="checkbox"/> Leg pain             | <input type="checkbox"/> Tension             |
| <input type="checkbox"/> Ear ringing       | <input type="checkbox"/> Memory loss          | <input type="checkbox"/> Vision blurred      |
| <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Nausea               |  |

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

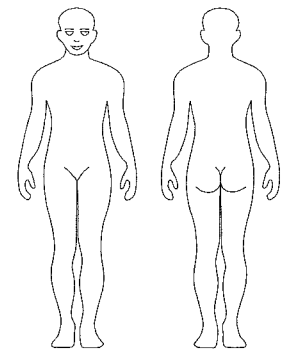
Type of pain:  Sharp  Dull  Throbbing  Numbness  
 Aching  Shooting  Burning  Tingling  
 Cramps  Stiffness  Swelling  Other \_\_\_\_\_

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation

Movements that are painful to perform:  Sitting  Standing  Walking  
 Bending  Lying Down



To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient