one 1

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 2

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.

three 3

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#: ________________

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)

______ Initials 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).

PRINTED ON RECYCLED PAPER

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

- 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

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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 confidentially: 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 3rd 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 FO THE AMOUNT OF SETTLEMENT YOU RECEIVE FROM THE INSUREANCE COMPANY. Please understand upon settlement of your claim, the 3rd 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 anther 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: ________________

Village Chiropractic Center — Consent Form

2430 Hwy 407, Suite B Highland Village, TX 75077 P: 972-317-3146 F: 972-317-4417

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: _______________________

WORKER COMPENSATION INFORMATION

Date____________________

PATIENT INFORMATION

Name____________________ Birthdate__________ Soc. Sec. #__________

Address____________________

Telephone____________________ Occupation____________________

EMPLOYER

Employer Name____________________

Employer Address____________________

Employer Telephone____________________ Injury Verified By (For Office Use)____________________

Contact Person____________________

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier____________________

Carrier Address____________________

Carrier Phone Number____________________ Coverage Verified by____________________

Adjuster's Name____________________ Claim Number____________________

INJURY INFORMATION

Date of Injury____________________ Time__________ ☐ AM ☐ PM

Place of Injury____________________

Accident reported to employer? ☐ Yes ☐ No Name of person you reported accident to____________________

Give full description of how accident happened____________________

Have you lost time from work? ☐ Yes ☐ No How much?____________________

Other doctors seen for this condition:

Doctor's Name____________________ Diagnosis____________________

Were X-Rays taken? ☐ Yes ☐ No Other Tests? ☐ Yes ☐ No

If yes, by whom? Please list test(s) and result(s)____________________

Any previous Worker Compensation injuries? ☐ Yes ☐ No Date(s) of previous injuries____________________

Describe previous Worker Compensation injuries____________________

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied.

Patient's Signature____________________ Date____________________

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