H A R P E R

WELLNESS & REHAB CENTER

Phone: (713) 622-3456 ♦ Fax: (713) 622-6408

CONFIDENTIAL AUTO ACCIDENT PATIENT HISTORY

Please Print

Date:_____ *Date of Accident*:_____

First Name:_____ Last Name:_____ Preferred Name:_____

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

Primary Phone:_____ Secondary Phone:_____ Cell Phone:_____

Sex: ❑ M ❑ F Marital Status: ❑ M ❑ S ❑ W ❑ D Birth Date:_____ Age:_____

Social Security #:_____ Spouse's Name:_____

Home Email Address:_____ Work Email Address_____

Work Status: ❑ Employed ❑ Full-Time Student ❑ Part-Time Student Other:_____

Employer:_____ Occupation:_____ Phone:_____

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

Race (check one) ❑White ❑Black/African American ❑Hispanic ❑American Indian/Alaskan Native ❑Asian ❑Asian Indian ❑Chinese ❑Filipino ❑Japanese ❑Korean ❑Vietnamese ❑Native Hawaiian or other Pacific Island ❑Guamanian or Chamorro ❑Samoan ❑Other ❑I choose not to specify

Multi-Racial (check one) ❑Yes ❑No ❑Unknown

Ethnicity (check one) ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language (check one) ❑English ❑ Spanish ❑American Sign Language ❑Chinese ❑ French ❑German ❑Tagalog ❑Vietnamese ❑Italian ❑Korean ❑Russian ❑Polish ❑Arabic ❑Portuguese ❑Japanese ❑French Creole ❑Greek ❑Hindi ❑Persian ❑Urdu ❑Gujarati ❑Armenian ❑I choose not to specify

Verification Question? (choose only one question, then give the answer to that question)

❑ What is the name of your favorite pet? ❑What city were you born in? ❑What high school did you attend?
❑What is your favorite movie? ❑What street did you grow up on? ❑What is your favorite color?

Verification Answer to the chosen question *(MUST BE AT LEAST 6 CHARACTERS)*: _____

FINANCIAL AND INSURANCE INFORMATION

NOTE: We will file on your own personal injury protection (PIP) insurance only. We do not file third party insurance. We will assist you in third part billing, but you must pay in full at the time of service, file major medical health insurance or file on your own personal injury protection (PIP) insurance policy.

Have you reported physical injuries to your insurance carrier? ❑ Yes ❑ No Are you the insured? ❑ Yes ❑ No

Name of your personal injury protection insurance (PIP):_____

Address of Insurance Co.:_____ City:_____ State:_____ Zip:_____

Policy or Group#:_____ Policy Effective Date:_____ Ins. Co. Phone #:_____

Name on Policy:_____ Policyholder SS#:_____ Adjuster's Name:_____

Policyholder Employer:_____ Employer Phone #:_____

Policyholder Employer Address:_____ Claim #:_____

Name of your Health Insurance Company:_____

Address of Insurance Co.:_____ City:_____ State:_____ Zip:_____

Policy or Group#:_____ Policy Effective Date:_____ Ins. Co. Phone #:_____

Name on Policy:_____ Policyholder SS#:_____ Policyholder Birthdate:_____

Policyholder Employer:_____ Employer Phone #:_____

Policyholder Address:_____

Past Medical History

*Please list any conditions you have been treated for prior to this occurrence. List the **dates,** the type of **treatment** received along with **who performed the treatment**, and any **residual effects** you are still experiencing.*

Surgeries ❑ _____

Fractures ❑ _____

Serious Injuries ❑ _____

Work Injuries ❑ _____

Personal Injuries or Motor Vehicle Injuries ❑ _____

Briefly list your main health problems(s):

_____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Never been a smoker ❑ Former smoker

If yes, how often do you smoke: ❑Current everyday smoker ❑Current someday smoker

If yes, what is your level of interest in quitting smoking? 0 1 2 3 4 5 6 7 8 9 10 N/A

Please list any medications including dosage and frequency, if known_____

_____

List any allergies that you have to any medication_____

_____

Has any doctor diagnosed you with Diabetes presently? ❑Yes ❑No If yes, what kind? ❑Type I ❑Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑Yes ❑No ❑ Not Sure

Has any doctor diagnosed you with Hypertension presently? ❑Yes ❑No If yes, describe_____

Briefly list your activities at work_____

Briefly list your leisure activities_____

Do you sleep on your ❑ Stomach ❑ Side ❑ Back ❑ Toss & Turn Age of Mattress _____ ❑ Comfortable ❑ Uncomfortable

Do you use a bed board? ❑ Yes ❑ No

HAVE YOU EVER	***YES***	***NO***	***DESCRIBE BRIEFLY***
Been knocked unconscious?	❑	❑	
Been treated for a spine or nerve disorder?	❑	❑	
Been hospitalized for other than surgery?	❑	❑	
Taken vitamins or minerals?	❑	❑	
Had an allergy to any medication?	❑	❑	
Have you seen a chiropractor in the past?	❑	❑	DC Name:

Reason for treatment: Date of Treatment:

DATE OF LAST:	***Less than 6 months***	***6-18 months***	***Over 18 months***	***Never***
Spinal Examination	❑	❑	❑	❑
Physical Examination	❑	❑	❑	❑
Blood test	❑	❑	❑	❑
Chest X-Ray	❑	❑	❑	❑
Spinal X-Ray	❑	❑	❑	❑

Have you had an X-ray or CT scan or MRI of your **low back** spine in the past 28 days? ❑Yes ❑No

HABITS:	***Heavy***	***Moderate***	***Light***	***None***	***DESCRIBE BRIEFLY***
Alcohol	❑	❑	❑	❑	How many drinks per week?
Coffee	❑	❑	❑	❑	How many cups per week?
Water	❑	❑	❑	❑	How many glasses per week?
Recreational/Illegal Drugs	❑	❑	❑	❑	What kind? How often?
Exercise	❑	❑	❑	❑	How many times per week?
Sleep	❑	❑	❑	❑	How many hours per night?
Appetite	❑	❑	❑	❑	
Soft Drinks	❑	❑	❑	❑	How many drinks per week?

Family Health History

Relation (father, mother, sibling, child, etc) Past & Present Health Conditions

_____ / _____

_____ / _____

_____ / _____

_____ / _____

NATURE OF ACCIDENT

Date of accident:_____

City and State of accident:_____ Street and/or intersection:_____

Time: ❑ Day ❑ Night ❑ Dawn ❑ Dusk _____:_____ ❑ AM ❑ PM

Were you the: ❑ Driver ❑ Passenger If you were the passenger, were you in the: ❑ Front Seat ❑ Back Seat

How many people were in the vehicle with you?_____

List the Year, Make and Model of the vehicle you were in: Year:_____ Make:_____ Model:_____

Was your vehicle stopped at the time of impact? ❑ Yes ❑ No If "No", please estimate the speed of the vehicle you were in:_____mph

Road conditions (at the time of the accident) were: ❑ Wet ❑ Dry ❑ Icy ❑ Foggy ❑ Other:_____

Were you wearing your seat belt? ❑ Yes ❑ No

Did you have a shoulder harness on? ❑ Yes ❑ No

Was there a headrest behind your head? ❑ Yes ❑ No

Was the headrest in the up position at the time of the accident? ❑ Yes ❑ No

What direction was your head facing at the time of impact? ❑ Front ❑ Right ❑ Left

If you were the driver, were both hands on the steering wheel? ❑ Yes ❑ No

Were the brakes applied during impact? ❑ Yes ❑ No

Were you struck from: ❑ Behind ❑ Front ❑ Right ❑ Left

Were you aware of the approaching collision prior to impact? ❑ Yes ❑ No Was the impact a surprise? ❑ Yes ❑ No

Was there a second collision involving the vehicle you were in? (I.e. Did your vehicle go on to hit another vehicle?) ❑ Yes ❑ No

Please estimate the damage sustained to the vehicle you were in:_____

Describe, in your own words, the nature of the accident_____

_____

_____

_____

_____

_____

_____

List the Year, Make and Model of the other vehicle involved in the accident: Year:_____ Make:_____ Model:_____

Was the other vehicle moving at the time of the accident? ❑ Yes ❑ No If "Yes", what was its approximate speed? _____mph

Were the police notified? ❑ Yes ❑ No Was an accident report filed by the police? Yes ❑ No

On what part of the vehicle did the following body parts impact?:

My head hit:_____ My Right / Left Hip hit:_____

My Chest hit:_____ My Right / Left Leg hit:_____

My Right / Left Shoulder hit:_____ My Right / Left Knee hit:_____

My Right / Left Arm hit:_____ Other:_____

Did you lose consciousness? ❑ Yes ❑ No If "Yes", how long?_____

Did you sustain any abrasions (cuts) during the accident? ❑ Yes ❑ No If "Yes", where?:_____

Did you sustain any contusions (bruises) during the accident? ❑ Yes ❑ No If "Yes", where?:_____

YOUR SYMPTOMS

What were the first symptoms you felt as a result of this accident? ❑ Headache ❑ Dizziness ❑ Disorientation ❑ Shock

❑ Painful / Stiff Neck ❑ Painful / Stiff Back ❑ Painful / Stiff Low Back ❑ Other:_____

When did the symptoms first appear? ❑ Immediately ❑ Hours after accident ❑ Days after accident

Where did you go after the accident? ❑ Hospital ❑ Doctor ❑ Home ❑ Other:_____

_____

_____

Please list physicians you have seen as a result of this accident, the type of treatment you received and the dates you received treatment:_____

_____

_____

Have you lost time from work due to the accident? ❑ Yes ❑ No Please list dates:_____

_____

List your duties at work:_____

List your leisure activities:_____

Did you notice any activity restrictions as a result of this accident? ❑ Yes ❑ No

Please describe in detail:_____

_____

Please check any symptoms you have noticed since the accident:

❑ Headache	❑ Irritability	❑ Numbness in Toes	❑ Flushed Face	❑ Cold Feet
❑ Neck Pain	❑ Chest Pain	❑ Shortness of Breath	❑ Bussing in Ears	❑ Cold Hands
❑ Stiff Neck	❑ Dizziness	❑ Fatigue	❑ Loss of Balance	❑ Upset Stomach
❑ Sleeping Problems	❑ Head seems too heavy	❑ Depression	❑ Fainting	❑ Constipation
❑ Back Pain	❑ Pins & Needles in Arms	❑ Light Sensitivity	❑ Loss of Smell	❑ Cold Sweats
❑ Nervousness	❑ Pins & Needles in Legs	❑ Loss of Memory	❑ Loss of Taste	❑ Fever
❑ Tension	❑ Numbness in Fingers	❑ Ringing in Ears	❑ Diarrhea	❑ _____

Complaint #1_____ Have you had this condition in the past? ❑ Yes ❑ No

Is this condition progressively worse? ❑ Yes ❑ No

Is Condition: ❑ Constant (75-100% of time) ❑ Frequent (50-75% of time) ❑ Occasional (25-50% of time) ❑ Intermittent (random)

Does the pain spread? ❑ Yes ❑ No Where?_____

Please indicate the intensity of your pain: ❑ Severe (Incapacitating) ❑ Moderate (Marked Impairment) ❑ Slight (Mild Impairment) ❑ Mild (Annoyance No Impairment)

Please indicate the character of your pain: ❑ Dull ❑ Sharp ❑ Deep ❑ Surface ❑ Aching ❑ Knife-like ❑ Burning ❑ Pin & Needles ❑ Tingling ❑ Numbness

Please indicate the onset of your condition: ❑ Immediate ❑ Gradual

Please indicate activities that make your condition worse:

❑ Sitting	❑ Standing	❑ Coughing	❑ Sneezing	❑ Kneeling	❑ Bowel Movement
❑ Laying Down	❑ Twisting	❑ Bending	❑ Lifting	❑ Stooping	❑ Other:_____
❑ Pushing	❑ Pulling	❑ Walking	❑ Climbing	❑ Gripping	_____

In general, is your pain worse when you are moving about or when you are not moving?_____

Please indicate what helps you to alleviate the pain:

❑ Laying Down ❑ Sitting ❑ Walking ❑ Standing ❑ Resting ❑ Cold Packs ❑ Hot Packs ❑ Nothing

❑ Other:_____ ❑ Medications:_____

_____ _____

Is your condition better in the ❑ Morning or at ❑ Night? Is your condition worse in the ❑ Morning or at ❑ Night?

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routines ❑ Other:_____

_____

Complaint #2_____ Have you had this condition in the past? ❑ Yes ❑ No

Is this condition progressively worse? ❑ Yes ❑ No

Is Condition: ❑ Constant (75-100% of time) ❑ Frequent (50-75% of time) ❑ Occasional (25-50% of time) ❑ Intermittent (random)

Does the pain spread? ❑ Yes ❑ No Where?_____

Please indicate the intensity of your pain: ❑ Severe (Incapacitating) ❑ Moderate (Marked Impairment) ❑ Slight (Mild Impairment) ❑ Mild (Annoyance No Impairment)

Please indicate the character of your pain: ❑ Dull ❑ Sharp ❑ Deep ❑ Surface ❑ Aching ❑ Knife-like ❑ Burning ❑ Pin & Needles ❑ Tingling ❑ Numbness

Please indicate the onset of your condition: ❑ Immediate ❑ Gradual

Please indicate activities that make your condition worse:

❑ Sitting	❑ Standing	❑ Coughing	❑ Sneezing	❑ Kneeling	❑ Bowel Movement
❑ Laying Down	❑ Twisting	❑ Bending	❑ Lifting	❑ Stooping	❑ Other:_____
❑ Pushing	❑ Pulling	❑ Walking	❑ Climbing	❑ Gripping	_____

In general, is your pain worse when you are moving about or when you are not moving?_____

Please indicate what helps you to alleviate the pain:

❑ Laying Down ❑ Sitting ❑ Walking ❑ Standing ❑ Resting ❑ Cold Packs ❑ Hot Packs ❑ Nothing

❑ Other:_____ ❑ Medications:_____

_____ _____

Is your condition better in the ❑ Morning or at ❑ Night? Is your condition worse in the ❑ Morning or at ❑ Night?

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routines ❑ Other:_____

Complaint #3_____ Have you had this condition in the past? ❑ Yes ❑ No

Is this condition progressively worse? ❑ Yes ❑ No

Is Condition: ❑ Constant (75-100% of time) ❑ Frequent (50-75% of time) ❑ Occasional (25-50% of time) ❑ Intermittent (random)

Does the pain spread? ❑ Yes ❑ No Where?_____

Please indicate the intensity of your pain: ❑ Severe (Incapacitating) ❑ Moderate (Marked Impairment) ❑ Slight (Mild Impairment) ❑ Mild (Annoyance No Impairment)

Please indicate the character of your pain: ❑ Dull ❑ Sharp ❑ Deep ❑ Surface ❑ Aching ❑ Knife-like ❑ Burning ❑ Pin & Needles ❑ Tingling ❑ Numbness

Please indicate the onset of your condition: ❑ Immediate ❑ Gradual

Please indicate activities that make your condition worse:

❑ Sitting ❑ Standing ❑ Coughing ❑ Sneezing ❑ Kneeling ❑ Bowel Movement
❑ Laying Down ❑ Twisting ❑ Bending ❑ Lifting ❑ Stooping ❑ Other:_____
❑ Pushing ❑ Pulling ❑ Walking ❑ Climbing ❑ Gripping _____

In general, is your pain worse when you are moving about or when you are not moving?_____

Please indicate what helps you to alleviate the pain:

❑ Laying Down ❑ Sitting ❑ Walking ❑ Standing ❑ Resting ❑ Cold Packs ❑ Hot Packs ❑ Nothing

❑ Other:_____ ❑ Medications:_____

_____ _____

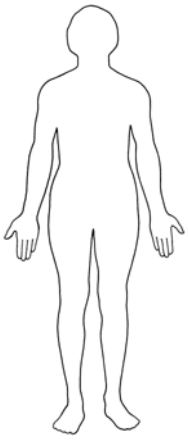
Is your condition better in the ❑ Morning or at ❑ Night? Is your condition worse in the ❑ Morning or at ❑ Night?

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routines ❑ Other:_____

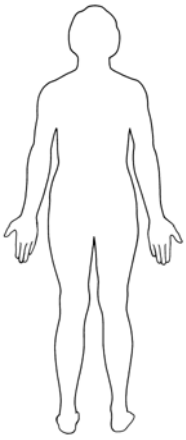
_____

On the diagrams below, please indicate where you are experiencing pain right now. Please mark the exact location of your pain on the diagrams using the following abbreviations:

PAIN = P **TINGLING = T** **NUMBNESS = N** **BURNING = B** **STIFFNESS = S**



FRONT



BACK

FEMALES ONLY

X-rays may be taken of your spine. When was your last period? _____ Are you pregnant? ☐ Yes ☐ No ☐ Maybe

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. I also understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due.

Patient Signature_____ Date:_____

Guardian or Spouse's
Signature Authorizing Care_____ Date:_____

IN CASE OF EMERGENCY: (Please list name of a relative or close friend we may contact in case of emergency)

NAME:_____ PHONE: _____

Harper Wellness & Rehab Center

(713) 622-3456

TREATMENT AGREEMENT

PARTIAL ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS AND CONTRACTUAL LIEN

(Herein, Agreement, Rev. 11-11-03)

Consideration. In consideration for the Office's services, I, the undersigned, agree to the following:

Definitions. For the purposes of this Agreement, the following terms shall have the following meaning: Office shall refer to: Harper Wellness and Rehab Center; Payer shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, tortsfeasor, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for any reason; Proceeds shall include, without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits, plans, or coverage; individual and group health plan benefits, Medicare, Medicaid, workers compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; Charges shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, depositions and testimony), any Collection Costs incurred by the Office, interest to the extent permitted by law, and any other charges incurred by me at the Office; Collection Costs shall include, without limit, court costs and attorney fees incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Partial Assignment of the Cause of Action, Assignment of Proceeds, and Contractual Lien. I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to the Office, as well a any and all causes of action that I might have now or in the future against any Payer to the extent of my Charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further assign my right to receive any Proceeds from any Payer to the Office. I further grant a contractual lien to the Office with respect to my Charges, however, nothing in this Agreement shall be construed as an election or waiver by the Office to any protection under any statutory lien law. Consistent with these rights, I hereby direct any and all Payers, to pay the Proceeds directly to, and exclusively in the name of, the Office in the amount of my Charges.

Other Terms. I understand that I remain personally responsible for my Charges and that nothing in this Agreement requires the Office to await payment for my Charges. I agree to pay the full amount of my Charges to the Office upon its demand. I understand that at any time, I can request a copy of my total Charges. I hereby waive any statute of limitations which may apply to the collection of my Charges.

In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I direct each attorney to issue an irrevocable letter of protection to the Office regarding my Charges. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office.

I authorize and direct the Office to submit my Charges to any and all Payers, including, without limit, my health benefit plan. I understand, however, that in the event that my Charges are submitted to more than one Payer, I hereby authorize and direct the Office to apply any Proceeds received from one Payer to and reductions, write-offs, or discounts, issued by another.

I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

This Agreement shall not be modified or revoked without the written mutual consent of the Office and myself. I hereby revoke the terms of any previously signed documents to the extent those terms conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (Please Print):_____

Patient Signature:_____ Date:_____ / _____ / _____

Name of Custodial Parent or Legal Guardian, on the behalf of the Patient (Please Print):_____

Parent / Guardian Signature:_____ Date:_____ / _____ / _____

PATIENT CONSENT FOR TREATMENT

CONSENT FOR TREATMENT (All Patients):

I voluntarily consent to the rendering of care, including chiropractic, physical therapy and physician treatment, and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and/or physical therapist and it is the responsibility of the staff to carry out the instructions of such clinician(s).

_____

PRINT PATIENT NAME

_____

PATIENT SIGNATURE

_____

IF YOU ARE NOT THE PATIENT, PRINT YOUR NAME AND STATE YOUR RELATIONSHIP TO PATIENT

NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and the methods you can use to request access to this information. Please review this notice carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, personal research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on disclosure on this information. By law, we are not required to grant your request. However, if we decide to grant your request, we are bound by our agreement.

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Harper Wellness & Rehab to use and disclose your protected health information for the purposes of treatment, payment and healthcare operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at (713) 622-3456. You have a right to request a restriction on how we use and disclose your private health information for the purposes of treatment, payment or health care operations. By law, we are not required to grant your request. However, if we decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent that we have already used or disclosed your protected health information in reliance on your consent.

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or any other related Medicare or Medicaid claim.

- √ Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.
- √ You may inspect and receive copies of you records within 30 days of your request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation of your medical records.
- √ You may request changes to your records. Our practice has the right to accept or deny your request.
- √ We maintain a history of protected health information disclosures that is accessible to you.
- √ In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.
- √ Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.
- √ For your convenience, you may obtain an Authorization for Release of Records form on our website at www.harperwellness.com or by calling (713) 622-3456.
- √ You may file a complaint about privacy violations by contacting our Office Manager at (713) 622-3456.

_____

PATIENT SIGNATURE **DATE**

OFFICE FINANCIAL POLICY

Our policy is to extend you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expenses and allows you to place your family under our care.

1. If You Do Not Have Insurance: All payments are due at the time of service or by an authorized payment plan. For bookkeeping purposes, we suggest that you prepay for your scheduled appointments with the doctor. This will greatly reduce your time at the front desk and help us minimize our bookkeeping expenses.

2. If You Have Insurance: All deductibles and co-payments are due at the time of service or by an authorized payment plan. For bookkeeping purposes, we suggest that you prepay for your scheduled appointments with the doctor. This will greatly reduce your time at the front desk and help us minimize our bookkeeping expenses.

- √ You are considered a cash patient until you bring in your completed insurance forms and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but we will be happy to provide you with a claim for your secondary carrier.
- √ Our fees are considered usual, customary and reasonable by most insurance companies and are therefore covered up to the maximum allowance determined by each carrier. This statement does not apply to insurance companies that reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.
- √ If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active role in the recovery of your claim. If your carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.
- √ When your treatment plan is once per month or less in frequency, you insurance carrier may deem your treatment as maintenance and not cover the visit. Charges for services rendered will be due as they are performed or by an authorized payment plan. We will happily provide you with an insurance claim form for these visits.
- √ If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claims already submitted.

Patient's Printed Name:_____

Signature:_____ Date:_____

Finance Counselor:_____ Date:_____

For your convenience, you may retain your credit card number on file with us.

Credit Card #:_____ Exp Date:_____

Your name as it appears on the card:_____

Driving Directions

COMING FROM 290/Katy Freeway
Take 610 and travel south toward the Galleria
Exit San Felipe then turn LEFT under the freeway
Go to the 2nd light which is Briar Oaks, turn LEFT
Briar Oaks dead-ends into Post Oak Place Drive, turn RIGHT
There will be a cul-de-sac in front of you
We're in the last building on the left in the cul-de-sac
Our building # is 4544 and our suite # is 287

COMING FROM 59
Take 610 and travel north toward the Galleria
Exit San Felipe, then turn RIGHT
Go to the 2nd light which is Briar Oaks, turn left
Briar Oaks dead-ends into Post Oak Place Drive, turn RIGHT
There will be a cul-de-sac in front of you
We're in the last building on the left in the cul-de-sac
Our building # is 4544 and our suite # is 287