MEYER CHIROPRACTIC CENTER

Confidential Patient Record

Patient Information

Name: _____

Address: _____

City: _____State: _____ Zip: _____

SSN #: _____

Home #: _____ Cell: _____

Email: _____

Can we text and email you? ☐Yes ☐No

Gender: ☐M ☐F Age: _____ DOB: ____/____/_____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

# of Children: ____ Who referred you? _____

Occupation: _____

Employer: _____

Emergency Contact

Name: _____ Relationship: _____

Home #: _____ Cell: _____

Insurance Information

Subscriber: _____

Relationship: _____ DOB: _____/_____/_____

Insurance Company: _____

ID#:_____GRP#: _____

Is patient covered by additional insurance? ☐Yes ☐No

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to the doctors of Meyer Chiropactic Center all insurance benefits, if any, otherwise payable to me for services rendered. I clearly understand and agree that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Patient or Responsible Party's Signature

_____

Relationship **Date**

HIPAA Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Meyer Chiropractic Center 'Notice of Privacy Practices'. This Notice describes how Meyer Chiropractic Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. Your information will be disclosed to your insurance company and physician for billing purposes and to federal and state reporting agencies. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on the consent.

Informed Consent

I hereby authorize the doctor to examine and treat my conditions deemed appropriate through the use of chiropractic care, and I give authority for those procedures to be performed. I understand that chiropractic is not an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses judgment to anticipate or explain risks and complications and an undesirable result does not indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests. I further understand that there are certain degrees of risks associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

Authorization

I give Meyer Chiropractic Center the right to release any records, and pertinent material to any third party. I hereby instruct, direct, and authorize my insurance company to pay directly to Meyer Chiropractic Center, for any professional services.

MY SIGNATURE IS AN ACKNOWLEGEMENT THAT I HAVE READ AND UNDERSTAND THE POLICIES ABOVE AND AGREE TO ABIDE BY SAME

_____ _____ _____

Patient or Responsible Party's Signature **Witness Signature** **Date**

MEYER CHIROPRACTIC CENTER

Confidential Patient History

Major symptoms/complaints: _____

How did your symptoms start? _____ **Date condition began:** _____/_____/_____

Describe the nature of your symptoms: ☐Sharp ☐Burning ☐Radiating ☐Shooting ☐Stabbing
☐Throbbing ☐Tightness ☐Tingling ☐Dull ☐Numb ☐Other: _____

How often do you experience your symptoms? ☐Constantly (76-100% of the time) ☐Frequently (51-75% of the time)
☐Occasionally (26-50% of the time) ☐Intermittently (0-25% of the time)

Average pain intensity:
Last 24 Hours no pain 1 2 3 4 5 6 7 8 9 10 worst pain
Past Week no pain 1 2 3 4 5 6 7 8 9 10 worst pain

How much have your symptoms interfered with your usual daily activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

In general, how would you say your overall health is right now?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Other doctors or therapists who have treated THIS condition: _____

Major injuries or surgeries: _____

Medications & Usage: _____

Family doctor: _____ Are you pregnant? ☐Yes ☐No Date of last menstrual cycle: _____

Have you been in an auto accident or any other personal injury? When? Describe: _____

_____

Review of Systems

Please check conditions or symptoms you currently have or have had in the past:

☐AIDS/HIV	☐Epilepsy	☐High Blood Pressure	☐Multiple Sclerosis	☐Scarlet Fever
☐Arthritis	☐Eye Problems	☐High Cholesterol	☐Nausea	☐Spinal Conditions
☐Asthma	☐Goiter	☐Jaw Pain/TMJ	☐Neurological Problems	☐Stroke
☐Balance Impaired	☐Gout	☐Kidney Disease	☐Osteoporosis	☐Thyroid problems
☐Burning Eyes	☐Headaches	☐Knee Pain	☐Pacemaker	☐Tuberculosis
☐Cancer	☐Hearing Problems	☐Lightheadedness	☐Parkinson's	☐Tumors/growths
☐Depression	☐Heart Attack	☐Liver Disease	☐Pinched Nerve	☐Ulcers
☐Diabetes	☐Heart Disease	☐Loss of Grip	☐Pneumonia	☐Varicose Veins
☐Dizziness	☐Hepatitis	☐Loss of Concentration	☐Polio	☐Whiplash
☐Drug Use	☐Hernia	☐Loss of Memory	☐Prostate problems	☐Other _____
☐Eating Disorder	☐Herniated Disc	☐Menstrual Problems	☐Psychiatric	_____
☐Elbow Pain	☐Herpes	☐Mononucleosis	☐Rheumatoid Arthritis	_____

Exercise
☐None ☐Daily
☐Moderate ☐Heavy

Work Activity
☐Sitting ☐Light Labor
☐Standing ☐Heavy Labor

Lifestyle
☐Smoking Packs/Day ___ ☐Coffee/Caffeine Cups/Day_____
☐Alcohol Drinks/Day ____ ☐High Stress Level Reason: _____

_____ _____ _____

Printed Patient Name **Patient or Responsible Party's Signature** **Date**

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

MEYER CHIROPRACTIC CENTER

Personal Injury – Patient History Form

Name_____ Date_____

HISTORY OF OCCURRENCE

Date of Accident_____ Time_____ AM PM

What was the approximate damage done to the car you were in? $_____

Visibility at the time of the accident: ☐Poor ☐Fair ☐Good

Type of accident: ☐Head on Collision ☐Broadside Collision
☐Rear-end Collision ☐Front impact, rear-ended car in front

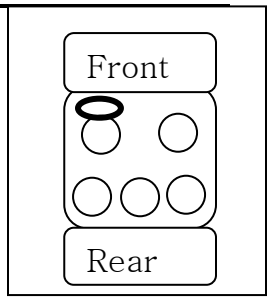
IMPACT / SEAT BELT / SPEED

Describe in your own words what happened to you upon impact:

_____

Where were you seated in the car?_____

Please note in diagram where you were seated in the car at the time of impact:



Did you see the accident coming? Yes No

Did you brace for impact? Yes No

Were seat belts worn? Yes No

How fast would you estimate you were going? _____MPH

What was the position of the headrests compared to your head before the accident?

☐Top of headrest even with bottom of head ☐Top of headrest even with top of head

☐Top of headrest even with middle of neck

HEAD / BODY POSITION / ABLE TO MOVE BODY

Head/Body position at time of impact: ☐Head straight forward ☐ Head looking back

Head turned: ☐Right ☐ Left ☐Body straight in sitting position ☐ Body rotated ☐Right ☐Left

At the time of accident, recall what parts of your head or body hit the inside of your car:

_____

_____

Were you able to get out of the car and walk unaided? Yes No If no, why not?_____

SYMPTOMS FROM ACCIDENT

Check symptoms apparent since the accident:

☐ Headache	☐Dizziness	☐Loss of memory	☐Sleeping problems	☐Eyes sensitive to light
☐ Neck pain/stiffness	☐Fainting	☐Fatigue	☐Numbness in toes	☐Anxious
☐Mid back pain	☐Ringing/Buzzing ears	☐Tension	☐Numbness in fingers	☐ Diarrhea
☐Low back pain	☐Loss of balance	☐Shortness of breath	☐Cold hands	☐Nervousness
☐ Loss of smell	☐ Irritability	☐Cold feet	☐Chest pain	☐ Cold sweats
☐Pain behind eyes	☐ Loss of taste	☐Depression	☐Constipation	☐Other:

WORK STATUS HISTORY

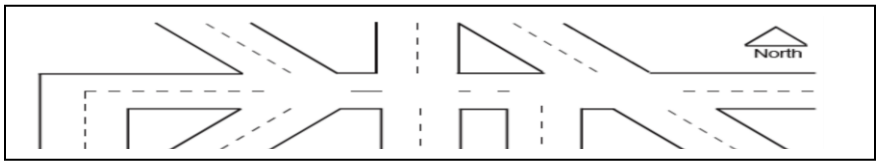
Have you missed time from work? Yes No When?_____

PRIOR SIMILAR SYMPTOMS

PRIOR to this accident, have you EVER had symptoms similar to what you're experiencing now? Yes No

If Yes, explain. List and give dates:_____

INDICATE ON THE DIAGRAM HOW THE ACCIDENT HAPPENED



ATTORNEY ON CASE

Do you have an attorney on this case? Yes No If yes, who? Name_____

Address, City, State, Zip_____

MEYER CHIROPRACTIC CENTER

AUTO ACCIDENT INSURANCE SIGNATURE FORM

Patient Name:_____ Date: _____/____/____ Date of Injury:____/____/____

Accepting assignment means that our office will bill your insurance policies for your chiropractic care which is an advantage to you because payment is not due at the time of service. However, if the total bill is not paid by your insurance companies or a third party (i.e. liability of another driver), you will be personally responsible for total payment of these bills. Meyer Chiropractic Center, PC is willing to accept assignment on your care if you agree to the following criteria. Please check the appropriate box and sign.

1) ☐ Agree ☐ Disagree I understand that the Meyer Chiropractic Center will file and take assignment of benefits on all applicable personal injury protection (PIP) policies to the allowable limits. If you receive any check(s) for PIP, the check(s) need to be endorsed and brought to our office immediately. If this procedure is not followed, the entire balance on your account will be due immediately. This amount will be subject to an 18% annual interest charge.

Signature _____ Date _____

2) Agree Disagree I understand that the Meyer Chiropractic Center will file and take assignment of benefits on all medical and/or group insurance policies to the allowable limits. These types of policies treat accident claims one of three ways.
A) Will pay without requiring repayment upon settlement. B) Will not pay since another insurance is paying.
C) Will pay but require repayment upon settlement.

Signature _____ Date _____

3) Agree Disagree I understand that the Meyer Chiropractic Center will file claims with all liability carriers/parties unless an attorney is involved in the case. If an attorney is involved in the case, all claims will be sent to the attorney to be forwarded by him/her on to the liability carrier/party.

Signature _____ Date _____

4) Agree Disagree I understand that any money received by the Meyer Chiropractic Center above and beyond the total bill, will be refunded back to me or to my insurance company if applicable. (see #2 above). Disbursement to be made after the patient is released.

Signature _____ Date _____

5) Agree Disagree I understand that payment for any outstanding charges is due within 10 days of receipt of my settlement check. After 10 days, an 18% annual interest charge will begin to accrue.

Signature _____ Date _____

6) Agree Disagree I understand that if I choose to discontinue care, all outstanding balances are immediately due and payable within 10 days. After 10 days, an 18% annual interest charge will begin to accrue.

Signature _____ Date _____

7) Agree Disagree I understand that I am ultimately personally responsible for payment of any bills incurred at the Meyer Chiropractic Center regardless of any settlement I may or may not receive.

Signature _____ Date _____

8) Agree Disagree I understand that in the event of default, I am legally liable for any reasonable attorney's fees and/or collection fees and all related costs necessary to remit entire balance to Meyer Chiropractic Center.

Signature _____ Date _____

9) Agree Disagree I understand that the Meyer Chiropractic Center may check my credit in order to extend payments terms.

Signature _____ Date _____

MEYER CHIROPRACTIC CENTER, P.C.
5520 S. COOPER STREET STE. 111
ARLINGTON, TX 76017

ASSIGNMENT OF BENEFITS

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

(Herein "Agreement")

Consideration. In order to facilitate the ability of the Office to collect in Charges directly from various Payers and thereby to enhance the patient provider relationship, I the undersigned, as consideration for the Office's services, agree to the following and direct all Payers as follows.

Partial Assignment of the Cause of Action, Assignment of Proceeds, and Contractual Lien. I hereby assign, in so far as permitted by law, all of my rights, remedies, benefits to the office as well as 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 and further grant a contractual lien to the office with respect to my charges. I further assign my right to receive any proceeds from any payer to the office and further grant a contractual lien to the office with respect to my charges. I understand that these assignments of rights and contractual lien may effectuate, automatically or otherwise, a secured interest under the applicable uniform commercial code. I intend for this agreement to effectuate such a lien and hereby authorize the office to file the form(s) normally filed with the secretary of state and other governmental agency in order to perfect such lien. Except as provided herein, nothing in this agreement shall be construed as an election or waiver by the office to a secured interest under any other statutory lien law. Consistent with these rights, I hereby direct any and all payers, to pay to proceeds directly and immediately to, and exclusively in the name of, Meyer Chiropractic Center, PC in the amount of my charges.

Other Terms. I understand that I remain personally responsible for my charges. Consistent with law or contract, I agree to pay the full amount of my charges of the office upon its demand. Unless mutually agreed to in writing, the receipt ad processing of partial payments by the Office shall not constitute a waiver of the Office's right to receive payment in full upon demand and shall not constitute an accord and satisfaction of my charges, irrespective of any restrictions indicated on any payments. 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 Meyer Chiropractic, PC, 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, as well as a copy of this agreement, to any and all payers including, without limit, my primary health benefit plan. I understand, that some or all of these Payers may utilize a fee schedule to which this office has agreed ("allowed fees"). I further understand that the fees allowed or utilized by one Payer may exceed the fees allowed by another payer. I herby authorize and direct Meyer Chiropractic Center, PC to collect its charges up to but not in excess of the higher of the two amounts. In the event that a particular payer does not utilize a fee schedule at all, I direct the office to collect up to its full charges.
I authorize the office to endorse or sign my name on any and all check 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.
Except as provided in this paragraph, this agreement shall not be modified or revoked without the mutual consent of the office. I hereby revoke with the office's consent, the terms of any previously signed documents to the extent those terms conflict with this agreement. This agreement shall be governed under the laws of the state where the office is located, and performable in the county where the office is located. I hereby consent to personal jurisdiction and venue of any court in said county and waive all objection based on improper jurisdiction, venue, or forum non-conveniens. I agree that each and every provision of the agreement is reasonable necessary for the protection of the rights and interest of the office and myself. However, should any provision of this agreement be found to-be "invalid, illegal and unenforceable, or for any reason cease to be binding on any party hereby, all other portions and provisions of this agreement shall, nevertheless, remain in full force and effect.

Definitions. For the purposes of this Agreement, the following terms shall have the following meaning: "Office shall refer to: Meyer Chiropractic, PC located at 5520 S. Cooper St., Arlington, TX 76017. "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, individual, and any other entity, which may elect to pay 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 payer reimburse, in the proceeds relating to the following benefits, plans, or overages: individual and group health 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 offices services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, depositions, and testimony) any collection costs incurred by the office, 18% interest on outstanding charges, and any other charges incurred by me at the office; "Collection costs" shall include without limit, any pre and post judgment court costs, filing fees, service or process charges, attorneys fees, and any other costs of collection incurred by the office in any effort or action to collect my charges either from me or any payer.

I have read, understood, and agree to the terms of this agreement.

Patient Name: (Print) _____

Patient Signature: _____ **Date:** ___/___/___

Name of custodial Parent or Legal Guardian, on behalf of the patient (Please Print) _____

Parent / Guardian Signature: _____ **Date:** ___/___/___