

How has this affected your Life? Circle one

Have you missed work? _____ YES NO

Has the quality of your work been affected? _____ YES NO

How? _____

Can you work with the pain? _____ YES NO

Are you able to do household chores? _____ YES NO

Has this problem interfered with your social life? _____ YES NO

Has it interfered with spending time with family and friends? _____ YES NO

Has it interfered with your recreational activities (Exercise, Hobbies, Golf, Tennis, etc...) YES NO

Has it affected your life in any other way? _____

PLEASE LIST ALL SURGERIES YOU HAVE HAD:

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

PLEASE LIST ALL PREVIOUS ACCIDENTS AND FALLS:

What _____ When _____

What _____ When _____

Remarks _____

PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU TAKE ON A REGULAR BASIS:

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

DISABILITY:

Do you have a permanent disability rating? _____ Date received _____ Rating Percentage: _____

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD:

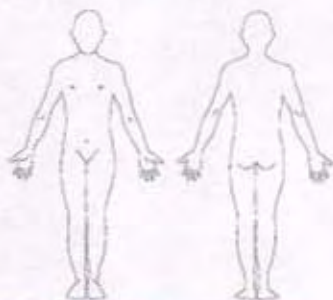
- | | | | | |
|---|--|---|------------------------------------|--|
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypersensitivity | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Small Pox | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcers | |

Any other past medical history that the doctor should be aware of? _____

Patient Name: _____

Date: _____

Please accurately mark the areas
where you have symptoms



CONSENT TO TREATMENT:

Patient Signature

X-RAY CONFIRMATION

This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant. I consent to radiographic pictures if necessary.

Patient Signature

Date

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

Patient Signature

Date

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic at this facility.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I understand that results are not guaranteed.

I have read, or have had read to me, the about consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature

Date

If this is an accident related injury, please fill out the Accident Form. Thank you.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctors 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 on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid to the Doctor for X-rays is for examination only, and the X-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient Signature

Date _____

Guardian or Spouse's

Signature Authorizing Care _____

Date _____

HATMAKER

CHIROPRACTIC

1021 61st St., Ste. 200, Galveston, TX 77551

P: (409)740-6800 F: (409)740-6894

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

For the purposes of this Consent Form, "Office" shall refer to: **Hatmaker Chiropractic**

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____

Signature: _____ Date: ___/___/___

PARTIAL ASSIGNMENT OF THE CAUSES OF ACTION, ASSIGNMENT OF PROCEEDS
CONTRACTUAL LIEN & AUTHORIZATION

(*Assignment* or *Assignment / Lien* - Revised 05-15-06)

Purpose. The purpose of this Assignment is to improve the ability of the Office to collect my Charges directly from various Payers. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to HATMAKER CHIROPRACTIC CLINIC; "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 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 coverages: 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, regardless of whether such Proceeds relate directly to my Charges or not; "Charges" shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony), any Collection Costs incurred by the Office, interest and delinquency penalties to the extent permitted by law, 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 of 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 from any Payer.

Partial Assignment of the Causes of Action, Assignment of Proceeds, and Contractual Lien. I hereby assign to the Office, insofar as permitted by law, but only to the extent of my Charges, all of my rights, remedies, and benefits relating to any Payer, including without limit my right to receive Proceeds from any Payer now or in the future, and any and all causes of action that I might have against any Payer now or in the future, 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 grant a contractual lien to the Office with respect to my Charges. I further intend for this Agreement to create a secured interest under the applicable Uniform Commercial Code and hereby direct the Office to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such lien. Consistent with these provisions, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the extent of my Charges.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I hereby 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 agree that the purpose of any Proceeds received by the attorney is to pay my Charges.

Other Disclosure Authorization. I hereby direct all Payers to release to the Office any pertinent information regarding any coverage I may have including without limit the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize and direct the Office to release any information regarding my treatment or pertinent to my case(s), including without limit a copy of my Charges and a copy of this Assignment, to all Payers in order to facilitate collection of my Charges.

Miscellaneous Provisions. Except as provided in this paragraph, this Assignment shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment. I agree that each and every provision of this Assignment is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Assignment 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 Assignment shall, nevertheless, remain in full force and effect. This Assignment shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens as such term is defined by law. I further waive any statute of limitations which may apply in any action based upon this Assignment.

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

Patient Name (print): _____

Patient Signature: _____ Date: ____/____/____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

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

Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: We need this information because we care enough to want to know, and your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name _____ Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Who referred you to our office? _____
(Indicate if child, student, housewife, unemployed, retired)

Social Sec. # _____ Business Phone _____ Company Name _____ Location _____
Spouse's First Name _____ Spouse's Soc. Sec. # _____ Spouse's Employer _____ Location _____

Please explain in detail how your accident happened _____

Insurance Co. _____ Policy No. _____ Claim No. _____
Driver of other vehicle (if any)

Name _____ Insurance Company _____ Policy No. _____
Driver of vehicle in which you were injured (if applicable)

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? Yes No

If so, his name and address _____

You were heading North East South West on _____ (street or highway)

Other vehicle was headed North East South West on _____ (street or highway)

Were police notified? Yes No

Were you knocked unconscious? Yes No If so, for how long? _____

You were struck from Behind Front Left side Right side

You were Driver Passenger Front seat Back seat Using seat belts Other protective devices

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

What treatment was given? _____

Was any other doctor consulted after your accident? Yes No

If so, what was the doctor's name? _____ D.O., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? Yes No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? Yes No

Are your work activities restricted as a result of this accident? Yes No

Since this injury are your symptoms Improving? Getting worse? Same?

HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes: 1—never had; 2—previously had; 3—presently have.

MUSCULO-SKELETAL SYSTEM

- Low back problems
- Pain between shoulders
- Neck problems
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Ruptures
- Broken bones

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on breast
- Are you pregnant?
 - Yes
 - No

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO-VASCULAR-RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose Veins

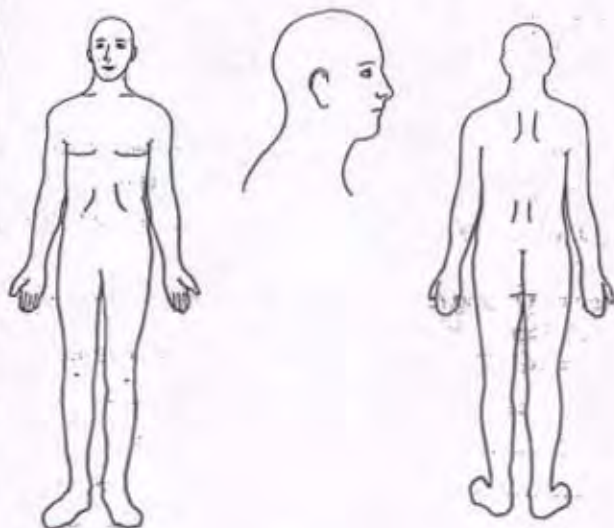
EYE, EAR, NOSE, AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing thru nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech

NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression

Please mark your areas of pain on the figures below.



Patient's Signature

..... DO NOT WRITE BELOW THIS LINE

.....
.....
.....
.....

Patient accepted? Yes No Doctor's signature _____

HATMAKER CHIROPRACTIC

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: 04/04/2003

(must be on or after the date of first printing or publication)

Under Federal Law, How Might Your Protected Health Information Need to Be Used / Disclosed by Our Office for Treatment, Payment, or Health Care Operation Purposes?

Generally, your protected information may be used or disclosed by our clinic for treatment, payment, or specific health care operations. These three words or phrases are defined by Federal Law, 45 CFR s 164.501 and other regulations as follows:

Treatment. *Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.*

Payment. *The activities undertaken by us to obtain or provide reimbursement for the provision of health care. Such activities include without limit determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts); adjudication or subrogation of health benefit claims; billing, claims and practice management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing, analysis and aggregation; provider accreditation; review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and contacting your employer, or you through your employer, for reasons consistent with this paragraph including without limit to obtain current group benefits and effective dates. For the purposes of this Privacy Notice, activities undertaken to properly obtain or provide reimbursement may include without limit disclosures to accountants, attorneys, management consultants, financial consultants, organizations providing data aggregation and other like services, professional associations, and other similar entities, including their agents and subcontractors, where confidentiality is expressly agreed to or normally inferred. Such activities shall also include disclosures to state and federal agencies, officials, and employees for the purposes of enforcement of, and oversight over, payer responsibilities and obligations.*

Other Health Care Operations. 45 CFR s 164.501 and .520(b)(1)(iii) outline several other purposes for which our practice may use or disclose protected information. For example, our practice may use or disclose protected information for the purposes of (1) conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, (2) providing appointment reminders to patients, (3) providing treatment alternatives or other health-related benefits and services that may be of interest to patients, and (4) contacting patients to raise funds.

In addition to those operations listed above, our office may send you welcome cards as well as birthday cards to your attention by mail which may include the actual date of your birthday. Furthermore, for those patients who indicate who referred them to our clinic, our office may send you "Thank You" cards to the referring person. Our office also regularly disburses newsletters, special offers, follow-up surveys and mailings, to our current and past patients.

Disclosures to the Patient by Fax and E-mail; Disclosures Left on Voice Mail.

Periodically, patients request that our clinic transmit protected information to them by means of fax or email, or leave messages on voice mail regarding such information. While we may request specific written authorization from you prior to disclosing protected information through such means, you hereby agree that by providing us with a fax number, email address, or phone number which includes voice mail, you are hereby consenting to disclosures through such means.

Disclosures to "Personal Representatives" at the Patient's Request

Oftentimes, close relatives to our patients will request that we disclose protected health information to them on the patients' behalf or at our patients' request. You hereby agree that if the person you represent as your spouse contacts our clinic regarding your care, we may disclose protected information to them.

Under Federal Law, How Might Your Protected Health Information Need to Be Used / Disclosed in Ways That Don't Require Written Consent or Authorization?

Under certain circumstances, law may require or permit our practice to make use of or to disclose your protected information without your consent or authorization. Such circumstances include:

- a) Uses and disclosures required by law.
- b) Uses and disclosures for public health activities.
- c) Disclosures about victims of abuse, neglect or domestic violence.
- d) Uses and disclosures for health oversight activities.
- e) Disclosures for judicial and administrative proceedings.
- f) Disclosures for law enforcement purposes.
- g) Uses and disclosures about decedents.
- h) Uses and disclosures for cadaveric organ, eye or tissue donation purposes.
- i) Uses and disclosures for research purposes.
- j) Uses and disclosures to avert a serious threat to health or safety.
- k) Use and disclosures for specialized government functions.
- l) Disclosures for workers' compensation.

What Happens If Other Law is More Restrictive Than Federal Law?

In the event other law becomes more restrictive than Federal Law with respect to uses and disclosures of your protected information, our practice will include descriptions of the more stringent requirements in this privacy notice.

All Other Uses / Disclosures Require Your Written Authorization

All other uses and disclosures besides those listed herein and those which require an opportunity to agree or object (see 45 CFR 164.512) will only be made with your written authorization. Once such authorization is granted, you may revoke it at any time as provided by and subject to 45 CFR 164.508(b)(5).

Your Rights and How to Exercise Those Rights

Under Federal Law, you have the following rights. To exercise your rights, you will need to send a written request to the attention of the Privacy Officer of our clinic.

You have the right to request restrictions on certain uses and disclosures of protected health information as provided by s 164.522(a). Please note however that under Federal Law, our clinic is not required to agree to a requested restriction. You have the right to receive confidential communications of protected health information as provided by and subject to 45 CFR s 164.522(b). You have the right to inspect and copy protected health information as provided by and subject to 45 CFR s 164.524. You have the right to sue for damages, costs, and attorneys' fees if you believe your privacy rights have been violated.

provided by and subject to 45 CFR s 164.526. You have the right to receive an accounting of disclosures of protected health information as provided by and subject to 45 CFR s 164.528. You have the right to obtain a copy of this privacy notice.

Duties of Our Clinic

Our clinic is required by law to maintain the privacy of your protected information and to provide you with notice of our legal duties and privacy practices concerning your protected information. Our clinic is required to abide by the terms of this privacy notice currently in effect. Our clinic reserves the right to change the terms of our notice and to make new notice provisions effective for all protected information that our clinic maintains. The revised notice will be made available at the front desk of our clinic for your inspection or copying.

Complaints

Our clinic welcomes any suggestions for amending our privacy practices. If you believe that your privacy rights have been violated, you may file a complaint with the Privacy Officer of our clinic and to the Secretary of Health and Human Services. To file a complaint with our Clinic's Privacy Officer, simply request and complete a copy of our privacy complaint form and submit it to our Privacy Officer. No individual may be retaliated against for filing such a complaint.

Acknowledgement of Receipt

We are required by law to maintain the privacy of and to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information as mandated by the federal Health Insurance Accountability and Portability Act and the Texas Medical Privacy Act. If you have any objection to this form, please speak with our compliance officer in person or by phone at our main phone number (409)740-6800.

Signature below is only acknowledgement that you received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of _____.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization for Assignment will be in continual effect until revoked by both parties.

Date

Patient/Insured Signature

RECORDS RELEASE

To _____, I hereby authorize you to release to _____ any information including the diagnosis and records of treatment or examination rendered to me for all care during the period from _____ to _____.

Date

Patient/Insured Signature

Date

Staff Signature

RELEASE FROM CARE

I, _____ hereby understand that Dr. _____ is releasing me from care, for my accident dated _____, and that I have reached a pre-accident status or maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

Patient Signature

Date

Staff Signature