

Patient History
Welcome to Hatmaker Chiropractic

Name: _____ Today's Date: _____
Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Marital Status: S M D Other _____
Cellphone/Pager: _____
Date of Birth: _____ SS#: _____
Email: _____ Can we email you special announcements and Newsletters? Yes No
Occupation: _____ Work Phone: _____
Emergency Contact: _____
Insurance Company: _____ Policy #: _____
Insurance Company Address: _____ Group #: _____
Have you ever been to another doctor for this problem? _____ Who? _____
Have you been treated by a chiropractor before? _____

COMPLAINT: _____

*Date when symptoms first appeared _____

Is the condition? Job Related Auto Related Home injury Fall Other

Did it begin: Gradual? ___ Sudden? ___ Slowly over time? ___

How often do you experience the symptoms?

- Constant 100% Frequent 75%
 Intermittent 50% Occasional 25% Rare 10%

Describe how the injury occurred _____

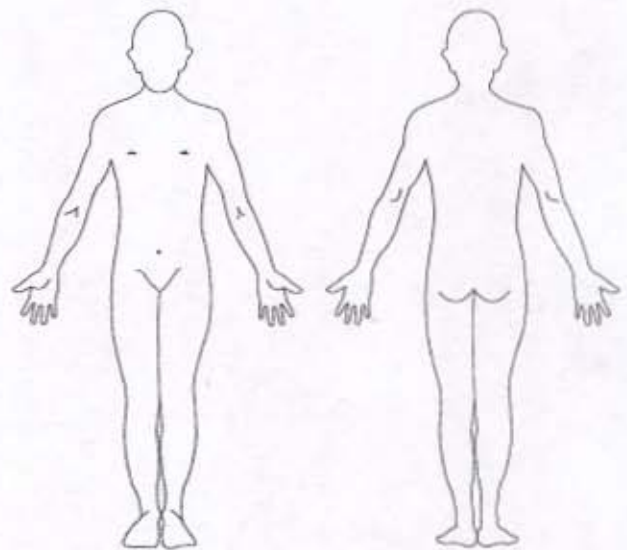
What makes symptoms worse? _____

What gives relief of symptoms? _____

Type of Pain:

- Sharp Dull Aching Burning
 Throbbing Numb Other _____

please mark your areas of pain or
tingling on the figures below.



How bad is your pain? (Please
indicate 0 for no pain to 10
unbearable pain)

Does the pain radiate into the legs or arms? Yes No

If yes, where does it radiate? _____

0-----5-----10

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:

- HIV Positive Diabetes Anemia Gout Polio
- Appendicitis Heart Disease Hepatitis Eczema Miscarriage
- Arteriosclerosis Herpes Multiple Sclerosis Arthritis High Blood Pressure
- Stroke Cancer Hypersensitivity Pleurisy Tuberculosis
- Small Pox Allergies Asthma Ulcers

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

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

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: ___/___/___

NOTICE TO MEDICARE - PART B BENEFICIARIES

ADVANCE NOTICE OF NON-COVERED SERVICES

PLEASE BE AWARE OF THE FOLLOWING MEDICARE REGULATIONS CONCERNING CHIROPRACTIC CARE.

In accordance with the Medicare Act, Section 1842(i), this letter is to advise you that Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862(a)(1) of the Medicare Act. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary", under Medicare program standards, Medicare will deny payment for that service.

Medicare limits chiropractic reimbursement to manual manipulation. Reimbursement is based on medically necessary correction care only, maintenance care is not covered.

Medicare *DOES NOT* reimburse for charges of exams, x-rays, therapy, supplements or supports from a chiropractor.

X-rays may be required to update your condition should a new course of treatment be initiated.

Medicare patients will be responsible for deductible amounts, non-covered charges and any denied visits which exceed Medicare guidelines.

Medicare Supplemental Policies and or Major Medical Policies may be affected by Medicare denials.

Yes Our office agrees to **Accept Assignment**
You will be responsible for 20% co-payment on the allowable charge for manual manipulation in addition to those charges not covered which are listed above.

_____ Our office **DOES NOT ACCEPT ASSIGNMENT**
You will be responsible for all charges incurred. Charges for manual manipulation will be assessed at Medicare's Limiting Charge. Our office will file your claims for you and reimbursement from Medicare will be based on 80% of the allowable charge for manipulation only.

I have read and understand the limitations of my Medicare coverage and the affects it may have on any supplement or secondary policies. I am aware that I will be responsible for any charges that Medicare denies or deems over "reasonable and necessary".

Signature of Patient

Date

HATMAKER CHIROPRACTIC CLINIC

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

(409) 740-6800 Fax: (409) 740-6894

Patient Name: _____

Chart Number: _____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for the items and services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items and services below.

Items and Services	Reason Medicare May Not Pay	Estimated Cost
<input type="checkbox"/> Manual Manipulation of Spine	Medicare NEVER pays for maintenance Care	\$15-\$45
<input type="checkbox"/> Examination (E/M)	These are NON-Covered items and Services under Medicare when ordered and/or delivered by a chiropractic doctor.	\$50-\$200
<input type="checkbox"/> X-ray		\$80-\$160
<input type="checkbox"/> Physical Medicine (e.g. Massage)		\$10-\$50
<input type="checkbox"/> Durable medical Equipment		Various
<input type="checkbox"/> Vitamins and Analgesic Creams		\$10-\$65

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the items and services listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

OPTION 1. I want the items and services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I **can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the items and services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I **cannot appeal if Medicare is not billed.**

OPTION 3. I don't want the items and services listed above. I understand with this choice I am **not responsible for payment, and I cannot appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature: _____

Date: _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/08)

Form Approved OMB No. 0938-0566

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 make 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 amend protected health information as

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

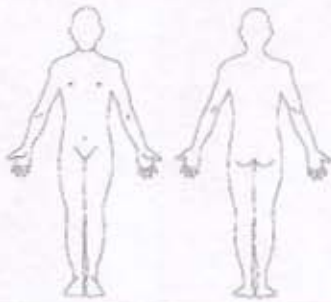
Date

Staff Signature

Patient Name: _____

Date: _____

Please accurately mark the areas
where you have symptoms



CONSENT TO TREATMENT:

Patient Signature