



# Bee Cave Chiropractic and Acupuncture

## Patient Health Questionnaire

Date: \_\_\_\_\_

Patient Name (Legal): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Preferred Name (If any): \_\_\_\_\_ SSN #: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt.#: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ May we contact you at work?  Yes  No

Marital Status:  Single  Married  Divorced  Widowed

Name of Spouse: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Who is responsible for payment?  Insurance  Self  Spouse  \_\_\_\_\_

Insurance Carrier (If applicable): \_\_\_\_\_

Who is your family doctor? \_\_\_\_\_ Phone Number: \_\_\_\_\_

How were you referred to our clinic? \_\_\_\_\_

E-mail Address: \_\_\_\_\_

By providing your e-mail address you will receive our E-health letters, specials and announcements.  
(Approximately 1 e-mail per month; your e-mail address is strictly used for our office only.)

### FINANCIAL/INSURANCE POLICY

I understand and agree that health/accident insurance policies are an agreement between an insurance carrier and myself. I understand that my insurance will be billed for services rendered in this office and that I am responsible for any services not paid and/or not covered by my insurance. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and any fees for collection of past due accounts. I also understand that if I suspend or terminate my care and treatment, fees for professional services rendered to me will be immediately due and payable.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# History of Present Injury

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. List Your Current Complaints (from most to least severe) & Rate Your Pain Intensity (scale of 0 – 10 with 10 being the worst)

#1.) \_\_\_\_\_ Pain Rating \_\_\_\_\_ #2.) \_\_\_\_\_ Pain Rating \_\_\_\_\_  
#3.) \_\_\_\_\_ Pain Rating \_\_\_\_\_ #4.) \_\_\_\_\_ Pain Rating \_\_\_\_\_

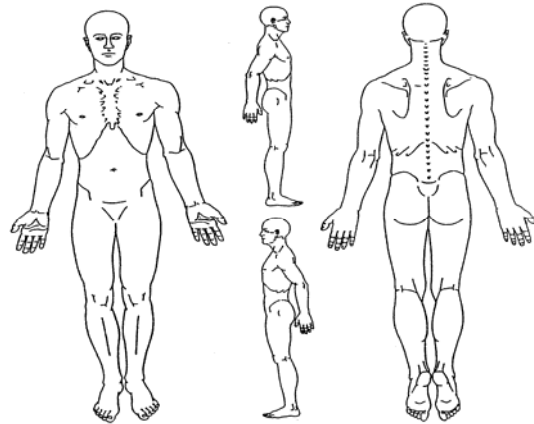
**a. Quality of Pain**

- Sharp
- Dull
- Achy
- Numb
- Tingling
- Shooting
- Weakness
- Gripping
- Burning
- Throbbing

**b. Frequency**

- Constant (76-100%)
- Frequent (51-75%)
- Occasional (26-50%)
- Intermittent (25% or less)

➔  
**MARK ON THE PICTURE  
WHERE YOU HAVE PAIN  
OR RELATED SYMPTOMS.**



c. Are your symptoms?  Increasing  Decreasing  Not Changing  
d. What time of day are your symptoms worse?  Morning  Afternoon  Night  Same All Day  \_\_\_\_\_

2. When did your problem begin? (Specific date if possible) \_\_\_\_\_ Describe how your problem began \_\_\_\_\_

3. What makes your problem **BETTER**?  Nothing  Rest  Walking  Standing  Sitting  Movement/Exercise  \_\_\_\_\_

4. What makes your problem **WORSE**?  Nothing  Rest  Walking  Standing  Sitting  Movement/Exercise  \_\_\_\_\_

5. Have you been treated elsewhere for **THIS EPISODE**?  Yes  No  
If yes, by whom?  Chiropractor  M.D.  Osteopath  Physical Therapist  Massage Therapist  Other \_\_\_\_\_  
What treatment was performed? \_\_\_\_\_ Did it help?  Yes  No  Somewhat  
What was their diagnosis? \_\_\_\_\_

6. Have you taken any medications for this condition? \_\_\_\_\_  
Have they helped?  Yes  No  Somewhat

7. **IN THE PAST**, have you been treated for a same or similar problem?  Yes  No  
If yes, by whom?  Chiropractor  M.D.  Osteopath  Physical Therapist  Massage Therapist  Other \_\_\_\_\_  
When and what treatment did you receive? \_\_\_\_\_

8. What would you rate your general stress level?  Little or no stress  Minimal stress  Moderate stress  Greatly stressed

9. Are your complaints affecting your ability to be active?  
 No effect  Some physical restrictions (able to perform light work and household tasks)  
 Need limited assistance with common everyday  Need assistance often  
 Have a significant inability to function without assistance  Totally impaired/disabled, cannot care for self

10. General physical activity level:  No exercise  Light exercise program  Moderate exercise program  Strenuous exercise program

11. Occupation: \_\_\_\_\_  FT  PT Has your work status changed because of this complaint?  Yes  No

12. Physical activity at work:  Sitting more than 50% of workday  Light manual labor  Heavy manual labor  Repeated motion

# 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

# 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**

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is moderate and does not vary much.
- Ⓔ The pain comes and goes and is very severe.
- Ⓟ The pain is very severe and does not vary much.

## **Sleeping**

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓔ Because of pain my normal sleep is reduced by less than 75%.
- Ⓟ Pain prevents me from sleeping at all.

## **Sitting**

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓜ Pain prevents me from sitting more than 1 hour.
- Ⓨ Pain prevents me from sitting more than 1/2 hour.
- Ⓔ Pain prevents me from sitting more than 10 minutes.
- Ⓟ I avoid sitting because it increases pain immediately.

## **Standing**

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer than 1 hour without increasing pain.
- Ⓨ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓔ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓟ I avoid standing because it increases pain immediately.

## **Walking**

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓔ I cannot walk more than 1/4 mile without increasing pain.
- Ⓟ I cannot walk at all without increasing pain.

## **Personal Care**

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓔ Because of the pain I am unable to do some washing and dressing without help.
- Ⓟ Because of the pain I am unable to do any washing and dressing without help.

## **Lifting**

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor.
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓔ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓟ I can only lift very light weights.

## **Traveling**

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓔ Pain restricts all forms of travel except that done while lying down.
- Ⓟ Pain restricts all forms of travel.

## **Social Life**

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓜ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- Ⓔ Pain has restricted my social life to my home.
- Ⓟ I have hardly any social life because of the pain.

## **Changing degree of pain**

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- Ⓔ My pain is gradually worsening.
- Ⓟ 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

## Past Medical History

If you have ever had a listed condition in the past, please check it in the Past column. If you are presently troubled by a particular condition, check it in the Present column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain (723.1)
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain (719.41)
<input type="checkbox"/>	<input type="checkbox"/> Pain in Upper Arm or Elbow (719.42)
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain (719.44)
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain (719.43)
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain (724.1)
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain (724.2)
<input type="checkbox"/>	<input type="checkbox"/> Pain in Upper Leg or Hip (719.45)
<input type="checkbox"/>	<input type="checkbox"/> Pain in Lower Leg or Knee (729.5)
<input type="checkbox"/>	<input type="checkbox"/> Pain in Ankle or Foot (719.47)
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain (526.9)
<input type="checkbox"/>	<input type="checkbox"/> Swelling/Stiffness of Joint
<input type="checkbox"/>	<input type="checkbox"/> Fainting (780.2)
<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances (368.9)
<input type="checkbox"/>	<input type="checkbox"/> Convulsions (780.3)
<input type="checkbox"/>	<input type="checkbox"/> Dizziness (780.4)
<input type="checkbox"/>	<input type="checkbox"/> Headache (784.0)
<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination (781.3)
<input type="checkbox"/>	<input type="checkbox"/> Tinnitus (Ear Noises) (388.30)
<input type="checkbox"/>	<input type="checkbox"/> Rapid Heart Beat (785.0)
<input type="checkbox"/>	<input type="checkbox"/> Chest Pains (786.50)
<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite (783.0)
<input type="checkbox"/>	<input type="checkbox"/> Anorexia (307.1)
<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight
<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst (783.05)
<input type="checkbox"/>	<input type="checkbox"/> Chronic Cough (786.2)
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis (473.9)
<input type="checkbox"/>	<input type="checkbox"/> General Fatigue (780.7)
<input type="checkbox"/>	<input type="checkbox"/> Irregular Menstrual Flow (626.04)
<input type="checkbox"/>	<input type="checkbox"/> Profuse Menstrual Flow (626.7)
<input type="checkbox"/>	<input type="checkbox"/> Breast Soreness/Lumps (611.72)
<input type="checkbox"/>	<input type="checkbox"/> Endometriosis (617.9)
<input type="checkbox"/>	<input type="checkbox"/> PMS (625.4)
<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control (788.30)
<input type="checkbox"/>	<input type="checkbox"/> Painful Urination (788.1)
<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination (788.41)
<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain (789.0)
<input type="checkbox"/>	<input type="checkbox"/> Constipation/Irregular bowel habits (564.0)
<input type="checkbox"/>	<input type="checkbox"/> Difficulty in Swallowing (787.2)
<input type="checkbox"/>	<input type="checkbox"/> Heartburn/Indigestion (787.1)
<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash (692.9)
<input type="checkbox"/>	<input type="checkbox"/> Depression (311)

Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Aortic Aneurysm (441.50)
<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure (401.9)
<input type="checkbox"/>	<input type="checkbox"/> Angina (413.9)
<input type="checkbox"/>	<input type="checkbox"/> Heart Attack (410.9)
<input type="checkbox"/>	<input type="checkbox"/> Stroke (435)
<input type="checkbox"/>	<input type="checkbox"/> Asthma (493.9)
<input type="checkbox"/>	<input type="checkbox"/> Cancer (199.1)
<input type="checkbox"/>	<input type="checkbox"/> Tumor (229.9)
<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems (601.9)
<input type="checkbox"/>	<input type="checkbox"/> Blood Disorder (790.6)
<input type="checkbox"/>	<input type="checkbox"/> Emphysema (chronic lung disorder) (526.9)
<input type="checkbox"/>	<input type="checkbox"/> Arthritis (716.9)
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis (714.0)
<input type="checkbox"/>	<input type="checkbox"/> Diabetes (250.0)
<input type="checkbox"/>	<input type="checkbox"/> Epilepsy (349.5)
<input type="checkbox"/>	<input type="checkbox"/> Ulcer (556.9)
<input type="checkbox"/>	<input type="checkbox"/> Liver (573.9)/Gallbladder (575.9) Problems
<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones (592.0)
<input type="checkbox"/>	<input type="checkbox"/> Hepatitis (573.3)
<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection (595.9)
<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders (by condition)
<input type="checkbox"/>	<input type="checkbox"/> Colitis (558.9)
<input type="checkbox"/>	<input type="checkbox"/> Irritable Colon (564.1)
<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS (042)
<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Other _____
<input type="checkbox"/>	<input type="checkbox"/> Other _____

If a family member has had any of the following please mark the appropriate box.

<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Chronic Back Pain
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic Headache
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Lupus
<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Other _____
<input type="checkbox"/> High Blood Pressure	_____

Do you have a permanent disability rating?  Yes  No  
 Location \_\_\_\_\_  
 Date rating received \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Rating Percentage \_\_\_\_\_%

Please check any of the following that apply to you.

Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Pregnancy (V22.2)
<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Hormonal/Estrogen Replacement
<input type="checkbox"/>	<input type="checkbox"/> Medications (list if not listed elsewhere)
	_____
	_____
<input type="checkbox"/>	<input type="checkbox"/> Hospitalization/Surgical Procedures (If not described elsewhere) _____
	_____

Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Tobacco (305.1)
<input type="checkbox"/>	<input type="checkbox"/> Alcohol (305.0)
<input type="checkbox"/>	<input type="checkbox"/> Drug or Alcohol Dependence (303.9)
<input type="checkbox"/>	<input type="checkbox"/> Coffee/Tea/Caffeinated Soft Drinks:
	cups/cans per day _____
	_____

Present Weight \_\_\_\_\_ lbs. Height \_\_\_\_\_ feet \_\_\_\_\_ inches

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Additional Comments/General Health Concerns

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## HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) CONSENT FORM

In the course of your care as a patient at our office, we may use or disclose personal and health related information about you in the following ways: 1.) Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. 2.) Your health records as well as your billing records may be disclosed to another party, such as insurance carrier (HMO, PPO, etc.) or your employer (if they are responsible for payment). 3.) Your name, address, phone number, and your health records may be used to contact you regarding appointment reminder, a message may be left on your answering machine. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you. Under federal law, we are also permitted to use or disclose your health information without your consent or authorization in the following circumstances:

- \* If we are providing health care services to you based on the orders of another health care provider.
- \* If we provide health care services to you in an emergency.
- \* If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- \* If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. By signing below, I acknowledge that I have read the above information and give full disclosure of my information.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### INFORMED CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, laboratory procedure, chiropractic care or any clinic services that he deems necessary in my case; and I further authorize him to disclose all or any part of my (patient's) records to any person or corporation which is or may be liable under a contract to the clinic or the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services, companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer.

It is not enough that you understand the benefits of chiropractic care in restoring normal joint motion and nervous system health, you must also be aware of the existence of inherent risks and limitations to chiropractic care. Every type of treatment (medical, chiropractic or otherwise) carries some form of potential risk associated with it. Risks associated with some forms of chiropractic care include muscular sprain/strain, neurological deficit, osseous fracture and vertebral artery dissection (stroke). While the incidence of injury from chiropractic care is extremely low, and only seldom are the risks great enough to contraindicate care, these facts should be considered in making the decision to receive chiropractic care.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the potential risks of chiropractic care, including the risk that care I receive in this office may not accomplish the desired clinical objective. I have been advised of reasonable alternative treatments, including known risks, consequences, and probable effectiveness of each, and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been provided to me concerning the results of the care I will receive. I knowingly authorize Bee Cave Chiropractic and Acupuncture to proceed with chiropractic care and treatment.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION AGREEMENT

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("condition"), to pay directly to, and exclusively in the name of **Bee Cave Chiropractic** ("office") such sums as may be owing to **Bee Cave Chiropractic** for charges incurred by me at the office ("charges"). I further grant a contractual lien to **Bee Cave Chiropractic** with respect to my charges, applicable to all payers; however, I understand that nothing in this Agreement shall be construed as an election by **Bee Cave Chiropractic** to claim protection under any statutory lien law. For the purposes of the Agreement, "benefits" shall include, but shall not be limited to, disability benefits, worker's compensation benefits, medical payment benefits, personal injury protection, lost wages benefits, lost services benefits, no fault coverage, uninsured and underinsured motorist coverage, third party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay **Bee Cave Chiropractic**, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to **Bee Cave Chiropractic** to the extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name or in the office's name, and to settle or otherwise resolve such causes of action as the office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges, upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without expressed written consent of this office. I further direct each attorney to provide immediate notice to the office regarding any funds received by the attorney relating to my accident, to promptly pay such office and to provide a full accounting of such funds to the office upon its request.

I hereby direct all payers to release to **Bee Cave Chiropractic** any information regarding any coverage or benefits which I may have including, but not limited to, the amount paid thus far, and the amount of any outstanding claims.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this office to file a copy of this Agreement, together with any applicable charges, with any and/or all payers, regardless of whether a claim has been established with said payees. I hereby authorize **Bee Cave Chiropractic** to endorse/sign my name on any and all checks listing me as payee, which are presented to this office for payment of any account relating to me, my spouse, or any of my departments. I further authorize **Bee Cave Chiropractic** to apply any credit balance on charges incurred by me 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.

I understand that I remain personally responsible for the total amounts due **Bee Cave Chiropractic** for their services. This agreement does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **Bee Cave Chiropractic** for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of **Bee Cave Chiropractic** and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations 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 **Bee Cave Chiropractic** 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 Signature: \_\_\_\_\_ Date: \_\_\_\_\_