remove obstacles • restore function • improve performance • maximize potential

Patient Registration

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

clinic id	date

1 PATIENT CONTACT

last name	first name	m.i.

preferred to be called

street

city	state	zip

home phone	mobile phone

work phone	e-mail

2 PATIENT PERSONAL

age	date of birth	social security #	sex ☐ male ☐ female

status ☐ single ☐ married ☐ partnered ☐ widowed ☐ separated ☐ divorced

3 EMERGENCY CONTACT

name	home phone

relationship	work phone

4 SPOUSE OR GUARDIAN

last name	first name	m.i.

employer name

work phone	date of birth	social security #

5 PATIENT EMPLOYMENT

employer name	occupation

street

city	state	zip

Which one of our patients referred you to our clinic?

Today we will conduct a thorough history, consultation, and preliminary screening. If we believe we may be able to help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes. I am requesting these services
- My case may not be accepted for treatment at this clinic
- If the doctors believe that I may respond to their care, additional service may be recommended and I will be advised of applicable cost

patient or guardian signature

date

tailed Case History

We are glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

confidential health information

clinic id | date

1 PATIENT INFORMATION

last name | first name | m.i.

age | date of birth | sex ☐ male ☐ female

2 HEALTH COMPLAINTS

Are you here because you were injured while working, in a motor vehicle collision, or in another accident? ☐ yes ☐ no

What is the reason for your visit?

*If you have a **primary** complaint, please complete all questions related to the **primary** complaint.*

How long have you been experiencing this **primary** complaint?

How does the **primary** complaint feel? ☐ dull/achy ☐ sharp ☐ numb ☐ tingling ☐ burning ☐ cold

How often do you experience the **primary** complaint? ☐ constantly ☐ daily ☐ weekly ☐ monthly ☐ yearly

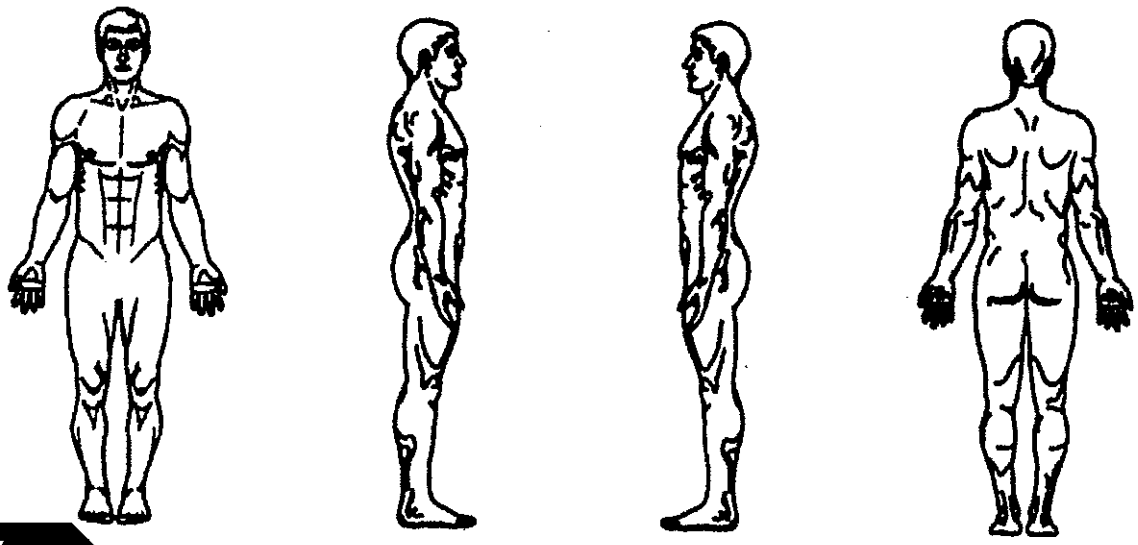
Using the scale below, rate how your **primary** complaint affects your life. (mark only one box below)

[1] no pain or discomfort	[2] slight discomfort	[3] pain that does not affect my activity	[4] pain that affects my daily activities	[5] pain that prevents performing my daily activities	[6] pain that limits my work schedule	[7] pain that prevents working at all	[8] pain that prevents working and all personal activity	[9] pain that that keeps me bed ridden	[10] pain that causes thoughts of suicide

If you have missed work because of your **primary** complaint, what was your last day of work?

What do you believe is causing your **primary** complaint?

Please mark the areas of all of your primary complaint on the diagrams to the right. Include any descriptors or comments, that were not mentioned above.



3 PERSONAL HISTORY

Mark the following conditions as they pertain to you.

joint instability	☐ yes	☐ no	unstable fractures	☐ yes	☐ no	spinal bone tumors	☐ yes	☐ no	bleeding disorders	☐ yes	☐ no
bone demineralization	☐ yes	☐ no	vertebral column infection	☐ yes	☐ no	vertebrobasilar insufficiency	☐ yes	☐ no	cauda equina syndrome	☐ yes	☐ no
artery aneurysm	☐ yes	☐ no	loss of sensation	☐ yes	☐ no	joint disease	☐ yes	☐ no	malignancy	☐ yes	☐ no
neurological deficit	☐ yes	☐ no	HIV positive	☐ yes	☐ no	vascular disease	☐ yes	☐ no	stroke sign/symptom	☐ yes	☐ no

4 LIFESTYLE & HABITS

How often do you exercise?	☐ never	☐ 1x/week	☐ 2x's/week	☐ 3x's/week	☐ NA
How long do your exercise workouts last?	☐ >1 hour	☐ 1 hour	☐ 30 minutes	☐ < 30 minutes	☐ NA
How often do you use tobacco?	☐ never	☐ daily	☐ weekly	☐ monthly	☐ year
How many servings of alcohol do you drink each week?		☐ 0	☐ 1-2	☐ 3-5	☐ >5
How many servings of coffee do you drink each week?		☐ 0	☐ 1-2	☐ 3-5	☐ >5
How many servings of soda you drink each week?		☐ 0	☐ 1-2	☐ 3-5	☐ >5

5 INJURIES

List any **auto collisions** that you were involved in , either as the driver or passenger, below. Begin with the most recent.

type of collision	type of treatment received	date of collision
1.		
2.		
3.		

List any **job, sports, or other injuries** that you experienced, below. Begin with the most recent.

type of injury	type of treatment received	date of injury
1.		
2.		
3.		

6 HOSPITAL / MEDICINE

Have you had breast implant surgery?	☐ yes	☐ no
Have you had knee or hip replacement surgery?	☐ yes	☐ no
Do you have a pacemaker?	☐ yes	☐ no
Do you have any other implantable medical devices in your body?	☐ yes	☐ no

Have you ever had a lapse of memory? ☐ yes ☐ no Were you ever knocked unconscious? ☐ yes ☐ no

List any broken bones or dislocations that you had.

List any surgeries that you had.

Have you ever had a spinal tap or spinal injection? ☐ yes ☐ no

7 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

cardiovascular disease	[n][p][c]	mother	[n][p][c]	father	[n][p][c]	brother	[n][p][c]	sister
diabetes	[n][p][c]	mother	[n][p][c]	father	[n][p][c]	brother	[n][p][c]	sister
cancer	[n][p][c]	mother	[n][p][c]	father	[n][p][c]	brother	[n][p][c]	sister
stroke	[n][p][c]	mother	[n][p][c]	father	[n][p][c]	brother	[n][p][c]	sister

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services
- It is my responsibility to complete the clinic's forms accurately
- It is my responsibility to notify the doctor if any of my information has changed or requires updating
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request

patient or guardian signature

date

Advanced Chiropractic
&
Spinal Rehab

Doctor-Patient Agreement

Welcome to Advanced Chiropractic & Spinal Rehab

The purpose of this agreement is to allow us to serve you more completely and to get the best results in the shortest amount of time. It is our experience that those patients who adhere to the following agreements get the best results.

Signing In
When you arrive at our office, please sign in. For legal and bookkeeping purposes, we need your signature entered legibly on the Daily Sign-In Sheet every time you visit the office. One family member can sign in for the rest of the family. Patients are not seen on a first-come, first-served basis. Schedule appointment times are always honored first. If you come late or early for a scheduled appointment, you may have to wait, and you will be promptly informed of what the waiting time will be.

Treatment or Therapy Preparation
A staff member will direct you to the appropriate treatment/therapy room. Comfortable clothing is always ideal. Patient gowns and shorts are available upon request. Please remove necklaces, large earrings, barrettes, belts, sandals, and loose-fitting boots. Empty your pockets and place valuable possessions on the self in the adjusting room. Please lie face down on the treatment table and breathe deeply before treatment to allow your body to relax. If lying face down in uncomfortable, please feel free to be seated.

Workshops
Health and wellness workshops are regularly scheduled. Attendance at these classes is highly recommended, especially if you are new to our clinic. Family and friends are always welcome, please look for announcements regarding these programs.

Financial Agreements
Financial agreements you make with our office are expected to be honored. If you find that you cannot fulfill the agreement you have made with us advise our office administrator, Crystal Morgan, at 325-695-9355 immediately so that new arrangements can be made. Insurance billing is complimentary service. Any insurance checks sent to your home should be brought to our office within three days. There is a $10 service charge for duplicate billing.

Missing or Changing Appointments
We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. Thus, if you need to chance the time of your appointment, plan to come another time the same day. If the same day is not

possible, be sure to make up the missed appointment within in one week. With the exception of an emergency, we charge $35 for missed or cancelled appointments with out a 24-hour notice.

Progress Evaluations and Re-evaluations
During your treatment series, progress evaluations and checkups usually occur on the 12th visit. The fee for these services should be paid according to the payment agreement made with our office.

Upsets
We are here to serve you. Please communicate with Dr. Morgan or Crystal Morgan, office administrator, about any upsetting matter. We see your comments as helping us to help you and others.

I have read the above and I understand and agree to these office policies.

X _____ _____
Patient Signature Date

_____ _____
Staff Signature Date

ASSIGNMENT, LIEN, AND AUTHORIZATION
FOR DIRECT PAYMENTS BY MY PAYERS TO ADVANCED CHIROPRACTIC & SPINAL REHAB

Purpose. The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to JAKE A. MORGAN D.C., the following rights, power and authority: The purpose of this Assignment & Lien is to assist the Office in obtaining Proceeds from various Payers for the payment of my Charges. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment & Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to Advanced Chiropractic & Spinal Rehab located at 5309 Buffalo Gap Rd Abilene, Texas 79606; "Assignment & Lien Document," "Assignment & Lien," and "Assignment" shall refer to this document. "Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, adjuster, claims handler, medical examiner, individual reviewer or review entity, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds, either now or in the future, or which may be involved directly or indirectly in determining the obligation to pay or disburse Proceeds, either now or in the future; "Proceeds" shall include without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, the proceeds relating to "health-care-insurance receivables" and "payment intangibles" as such are defined by the applicable Uniform Commercial Code, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare and Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, errors & omissions, and malpractice; "Charges" shall include without limit the full fees for the Office's goods and services (including without limit treatment, diagnostic services, medical equipment, supplies, supplements, narrative reports, photocopies, pre-authorization requests, no-shows, depositions, and testimony, whether rendered before or after the date of this Assignment & Lien), any Collection Costs incurred by the Office, delinquency penalties and interest to the maximum extent permitted under law or at the annual rate of eighteen percent (18%), whichever is greater, 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, fees or costs associated with requests for reconsideration, independent reviews, appeals, mediation, arbitration, 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.

Assignment and Lien Terms. I hereby assign to the Office to the extent permitted by law, but only to the extent of my Charges, all of my claims to, rights to, and interests in, Proceeds, whether resolved or unresolved, including without limit ownership rights, which I may have now or in the future relating directly or indirectly to my Charges, condition, or causes of my condition ("Claims to Proceeds"), including without limit any and all causes of action, receivables, payment intangibles, and remedies that I might have against or with respect to any Payer now or in the future, and the right to prosecute, seek, settle, or otherwise resolve such Claims to Proceeds either in my name or in the Office's name and as the Office otherwise sees fit. I agree that this assignment shall be effective as of the date and time the initial cause of my condition occurred. I further intend for this Assignment & Lien to create a security interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to the Office a primary, non-contingent security interest in all of my Claims to Proceeds to the extent permitted by law for the purpose of securing payment of my Charges, the attachment and perfection of which shall relate back to, and be effective as of, the date and time that the initial cause of my condition occurred. I further authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency relating to such security interests, and to make such filings in all relevant jurisdictions as the Office sees fit in its sole discretion. I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my agreement with the Office, such security interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Service Certified Mail. Consistent with these terms, 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 full extent of my Charges. To the extent that any law, including without limit a lien statute, purports to limit, reduce, or modify the distribution of Proceeds in any manner inconsistent with this Assignment & Lien including without limit through the reservation of a portion of the Proceeds exclusively to me, I hereby waive such limits, reductions, or modifications. Such waiver shall not adversely affect or prejudice any rights which the Office may have and elect to exercise under said law.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys who receive(s) Proceeds from one or more Payers, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding such Proceeds, 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 such Proceeds shall be primarily to pay my Charges. If I have a dispute regarding the Charges, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the Office. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney's fees and costs, or other expenses of obtaining Proceeds.

Disclosure Directives & Release of Information: I hereby direct each and every Payer to immediately release to the Office any Pertinent Information relating to (a) any coverage I may have and (b) any Proceeds Determination by the Payer relating to the Office's Charges. "Pertinent Information" shall include without limit the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information" shall also include without limit copies of all documents, records, and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny, or delay payment of any Proceeds relating to the Office's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or for me by the Office to all Payers, including without limit a copy of my Charges and a copy of this Assignment & Lien, unless otherwise agreed to in writing. You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

Rejections In Writing. I hereby authorize the physician/clinic named above to establish a PIP or UM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. If my carrier is unable to provide said rejections in a timely manner, I acknowledge that I am entitled to minimum levels of coverage, as per section 1952.152 of the Texas Insurance Code, and further instruct my carrier to pay up to available limits directly to physician/clinic named above, and to send any and all checks or financial instruments to 5309 Buffalo Gap Rd. Abilene, TX 79606. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of PIP or UM/UIM.

Miscellaneous. Except as provided in this paragraph, this Assignment & Lien 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 & Lien. I agree that each and every provision of this Assignment & Lien is reasonably necessary. However, should any provision of this Assignment & Lien 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 & Lien shall, nevertheless, remain in full force and effect. This Assignment & Lien 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 & Lien, 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 inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment & Lien. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

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

Patient Name (print): _____

Patient Signature: _____ Date: ____/____/_____

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

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

Advanced Chiropractic & Spinal Rehab

Disclosure & Consent

Chiropractic Adjustments and Care

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

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 the patient named below, for whom I am legally responsible) by Dr. Jake Morgan and/or other Doctors of Chiropractic, interns or those working at the clinic of Advanced Chiropractic & Spinal Rehab who now or in the future treat me while employed by, working or associated with, or serving as a backup for Dr. Jake Morgan. **Females**: To the best of my knowledge I am not pregnant and Advanced Chiropractic & Spinal Rehab has my permission to x-ray me for diagnostic interpretation.

I have had the opportunity to discuss with Dr. Morgan or his representative, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. 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 on the facts known, is my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, that above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan, I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

To be completed by the patient:

Print name X_____ Signature:_____

Date signed:_____

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or physically or legally incapacitated:

_____ _____

Print Name of Patient Print Name of Patient's Representative

As:_____ _____

Relationship or authority of patient's representative Signature of Patient's Representative

_____

Date Signed

To be completed by doctor or staff

_____ _____

Witness to patient's signature Translated by

_____

Date

Advanced Chiropractic & Spinal Rehab

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is you pleasure to help you.

Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your health information to:

• Treat you	• Collect payment	• Run our office	• Inform you about other services
• Discuss your case with family	• Do research	• Include you in care classes	• Thank you for referring other patients

We may use your health information for:

• Health and safety reasons	• Reporting to law officials	• Reporting victims of abuse	• Court hearing and fillings
• Reporting to worker's compensation			

You have the right to:

• Request a copy of your health record	• Request a list of whom we share your health information with	• Ask us to limit the information we share	• Advise our management if you believe your privacy rights have been violated
• Request confidential communications	• Amend your protected health information		

These privacy practices are effective:
For further information please contact Crystal Morgan-325-695-9355

Consultation & Exam

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests.

If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition.

We will always inform you of associated fees before we perform any procedure or service.

Report of findings

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination.
If we believe we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short and/or long-term goals.

As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy
- I understand the purpose of today's visit
- The doctor(s) may use my confidential health information in the manner previously described

X _____

Patient or Guardian Name Date

_____

Patient or Guardian Signature Date

ACKNOWLDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, acknowledge that I have received, reviewed, understand and agree to the Notice of privacy Practices of Advanced Chiropractic & Spinal Rehab, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ X_____

Date Signature

_____

Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgment of _____ receipt of our Notice of Policies Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ☐ Patient unavailable
- ☐ Patient physically unable
- ☐ Patient unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

- ☐ Personally
- ☐ Mail
- ☐ Phone follow up
- ☐ Other:_____

Date_____ Signature_____

Dr. Jake Morgan
Advanced Chiropractic & Spinal Rehab