PLEASE COMPLETE THE ATTACHED FORMS AND BRING THEM WITH YOU (ALONG WITH THIS COVER SHEET) TO OUR OFFICE. IF YOU ARE UNABLE TO COMPLETE THESE FORMS PRIOR TO YOUR FIRST VISIT, PLEASE ARRIVE 45-MIN EARLY (60 MIN FOR PERSONAL INJURY CASES) TO LEAVE ENOUGH TIME TO FILL OUT PAPERWORK.

Fort Worth Chiropractic Clinic, PLLC

dba My West Fort Worth Chiropractor ("FWCC")

2920 Oak Park Circle, Suite 101, Fort Worth, TX 76109

(817) 924-7243 | Support@MyWestFortWorthChiropractor.com

Patient Name: _____

Parent / Guardian: _____

Appointment Date/Time: _____

OFFICE USE ONLY: *By Initialing below, I certify that I have reviewed the attached medical forms (including without limit Pre-Day-1-Medical-Forms-CORE-FORMS, Modified-Oswestry-Neck-Index-and-FRI, and Informed Consent to Chiropractic Care) populated with specific data and identifying information. I also certify that any hand-written notations added by me were made on the date below.*

Name of Provider: Derek Page, DC Provider's Initials: _____ Date of Initials: _____/_____/_____

SECTION – PATIENT INFORMATION

Name of Patient: _____ Today's Date: ____/____/_____

Patient's Birthday: ____/____/_____ Patient's Gender: ___ M ___ F

(If Applicable) Name of Parent / Guardian / Healthcare Representative: _____

CONTACT INFORMATION

Address: _____

City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____

Email: _____

SECTION – CHIEF COMPLAINT

Name of Patient:: _____ Today's Date: ____/____/_____

What is your **CHIEF COMPLAINT**? _____

When did this begin? _____

How did this happen (i.e., car accident, slip or fall, bending and lifting)? _____

_____

_____Have you received treatment for this current episode? ___ YES ___ NO

If YES, what treatment have you had?_____

Have you ever experienced episodes of this in the past? ___ YES ___ NO

If YES, what treatment have you had? _____

_____Severity of pain 0 – 10 (0 is no pain at all and 10 is worst possible pain):

CURRENTLY _____/ 10 Described as: _____

at its **WORST** _____/ 10 Described as: _____

at its **BEST** _____/ 10 Described as: _____

Does the pain **RADIATE** (i.e., down the arm or leg)? ___ YES ___ NO

If YES, please describe: _____

Is your complaint: ___ Improving ___ Getting Worse ___ Staying the Same

What activities make the pain **WORSE** (i.e., sitting, standing, walking. Etc.)? _____

What activities make the pain **BETTER** (i.e., rest, stretching, ice. Etc.)? _____

How often do you experience this pain? ___ Daily ___ 1 – 2x/week ___ 3 or more x/week

Are your symptoms: ___ Constant ___ Half of the Day ___ More than Half ___ Less than Half ___ On and Off ___ Random

Time of day your symptoms are worse: ___ Morning ___ Afternoon ___ Evening ___ Not Applicable

What Activity of Daily Living (ADL) is MOST affected? **(CHOOSE ONLY 1)**

___ Lifting ___ Walking ___ Sitting ___ Driving ___ Standing ___ Sleeping ___ Computer Use

How long are you able to do this before pain starts (i.e. 10 minutes) _____

SECTION – REVIEW OF SYSTEMS

Name of Patient:: _____ Today's Date: ____/____/_____

Have you had a fever or infection within the last **30 days**? ___ YES ___ NO

If YES, please describe:_____

Past Medical History – Please mark any medical problem you currently have, or have had in the past:

Head, Eyes, Ears, Nose, Mouth or Throat

□ glasses or contact lenses □ cataracts □ glaucoma □ tinnitus □ difficulty hearing/deafness □ seasonal allergies
□ sinus trouble □ TMJ problems □ throat / mouth cancer
□ Other:_____

Respiratory

□ asthma □ COPD □ emphysema □ sleep apnea □ lung cancer □ tuberculosis
□ Other:_____

Cardiovascular

□ High Blood Pressure □ high cholesterol □ irregular heartbeat / arrhythmia □ heart attack □ blood clots
□ congenital heart defect □ coronary artery disease □ excessive / easy bruising □ heart murmur / valve disorder
□ palpitations □ congestive heart failure
□ Other:_____

Gastrointestinal

□ reflux / GERD □ irritable bowel / IBS □ Crohn's disease / Ulcerative colitis □ colon cancer □ stomach cancer
□ liver disease □ pancreatitis □ ulcer □ colon polyps □ diverticulitis □ leaky gut □ hiatal hernia □ GI bleed
□ Other:_____

Genitourinary

□ kidney stones □ incontinence □ urgency □ urinary tract infections □ painful urination □ sexual dysfunction
□ sexually transmitted disease □ bladder prolapse □ bladder problems
□ Other:_____

Endocrine

□ diabetes □ thyroid problems □ hypothyroidism □ hyperthyroidism □ parathyroid problems
□ testosterone deficiency □ Hashimoto's disease □ pre-diabetes
□ Other:_____

Skin

□ eczema □ skin cancer □ melanoma □ psoriasis □ acne

□ Other:_____

Neurological

□ stroke or TIA □ epilepsy or seizures □ multiple sclerosis □ Parkinson's □ cerebral palsy

□ peripheral neuropathy □ small fiber disease □ brain tumor

□ Other:_____

Musculoskeletal

□ scoliosis □ arthritis in spine □ degenerative disc disease □ arthritis in other joints □ TMJ □ rheumatoid arthritis □ gout □ osteoporosis □ osteopenia □ osteomyelitis □ sciatica □ pins/screws/plate – please explain:_____

_____

□ Other:_____

Mental Health

□ anxiety □ depression □ bipolar disorder □ ADD/ADHD □ schizophrenia

□ Other:_____

Are you currently in counseling? ___ YES ___ NO

Cancer – ANY type, please specify

□ Please specify:_____

□ Treatment:_____

Other Medical Conditions NOT Included Above

□ Please Specify:_____

Women Only: Are you currently pregnant? ___ YES ___ NO

If YES, how far along, or when is your due date?_____

SECTION – PAST, FAMILY AND SOCIAL HISTORY

Name of Patient: _____ Today's Date: ____/____/_____

Surgical History: (Please list ALL previous surgery and approximate date, or age, when it was performed)

_____

_____

_____

Hospitalization History: (Please list ALL non-surgical hospitalizations and date, or age, of hospitalizations)

_____

_____

_____

Medications: (Please list ALL prescription medications that you are currently taking)_____

_____

_____

_____

_____

Allergies to Medications: (Please list all medications that cause allergic reaction and associated symptoms)_____

_____

_____

Past Trauma/Accidents resulting in Injuries with approximate dates: (Examples – Car Accidents, Sports Injuries, etc.) _____

_____

_____

_____

Family Medical History: (Please indicate ANY major health condition)

Mother:_____

Father:_____

Siblings:_____

Smoking/Tobacco use: (Please indicate type and frequency)

Cigarettes:_____

Dip:_____

Cigar:_____

Other:_____

Alcohol use: (Please indicate type and frequency)

Type/Frequency:_____

Exercise Habits: (Please indicate type and frequency)

Type/Frequency:_____

SECTION – MODIFIED OSWESTRY / NECK INDEX / FUNCTIONAL RATING INDEX

Name of Patient: _____ Today's Date: ____/____/_____ **OFFICE USE ONLY – SCORE:** _____

Please mark which MOST CLOSELY DESCRIBES your condition right now

SECTION 1 – PERSONAL CARE	**SECTION 6 – SOCIAL LIFE / RECREATION / HOUSEHOLD**
□ No pain; no restrictions	□ Can do all activities without pain
□ Pain; no restrictions	□ Can do all activities; but causes pain
□ Pain; need to go slowly	□ Can do most activities; but causes pain
□ Pain; need some assistance	□ Can only do some activities due to pain
□ Pain; need 100% assistance	□ Can only do a few activities due to pain
□ Pain; unable to wash or dress due to pain	□ Cannot do any activities due to pain
SECTION 2 – SLEEPING	**SECTION 7 – HEADACHES**
□ Normal sleep; not disturbed by pain	□ I have no headaches at all
□ Slightly disturbed sleep; less than 1-hour sleepless	□ I have 1 or less headaches per week
□ Mildly disturbed sleep; 1-2 hours sleepless	□ I have 1-2 headaches per week
□ Moderately disturbed sleep; 2-3 hours sleepless	□ I have 3-4 headaches per week
□ Severely disturbed sleep; 3-5 hours sleepless	□ I have 4-5 headaches per week
□ Totally disturbed sleep; 5-7 hours sleepless	□ I have daily headaches
SECTION 3 – SITTING	**SECTION 8 – LIFTING**
□ No pain	□ I can lift as much as I need without pain
□ Pain; does not increase with time	□ I can lift as much as I need; but causes pain
□ Pain; prevents me from sitting more than 1-hour	□ I can only lift moderate weight due to pain
□ Pain, prevents me from sitting more than 30-minutes	□ I can only lift light weight due to pain
□ Pain, prevents me from sitting more than 10-minutes	□ I can only lift weight if it is conveniently positioned
□ Pain, prevents me from sitting at all	□ I cannot lift any weight due to pain
SECTION 4 – STANDING	**SECTION 9 – DRIVING / TRAVEL**
□ No pain	□ No pain
□ Pain; does not increase with time	□ Pain; does not increase with time
□ Pain; prevents me from standing more than 1-hour	□ Pain; prevents me from driving/travel more than 1-hour
□ Pain, prevents me from standing more than 30-minutes	□ Pain, prevents me from driving/travel more than 30-minutes
□ Pain, prevents me from standing more than 10-minutes	□ Pain, prevents me from driving/travel more than 10-minutes
□ Pain, prevents me from standing at all	□ Pain, prevents me from driving/travel at all
SECTION 5 – WALKING	**SECTION 10 – READING / COMPUTER USE**
□ No pain	□ No pain
□ Pain; does not increase with time	□ Pain; does not increase with time
□ Pain; prevents me from walking more than 1-hour	□ Pain; prevents me from reading/computer use more than 1-hour
□ Pain, prevents me from walking more than 30-minutes	□ Pain, prevents me from reading/computer use more than 30-min
□ Pain, prevents me from walking more than 10-minutes	□ Pain, prevents me from reading/computer use more than 10-min
□ Pain, prevents me from walking at all	□ Pain, prevents me from reading/computer use at all

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SECTION – INFORMED CONSENT TO CHIROPRACTIC CARE

Name of Patient: _____

DIRECTIONS: Please read this entire Informed Consent Document prior to signing it. It is important that you understand the information contained in this Document. Please ask questions before you sign if there is anything that is unclear. This Document applies to Care rendered by the Doctors and other Healthcare Staff at our Office.

The nature of the chiropractic adjustment.

The primary treatment used by Doctors of Chiropractic is Spinal Manipulative Therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment.

As part of the analysis, examination, and treatment ("Care"), you are consenting to the following procedures, including but not limited to: Vital Signs, Postural Analysis, Range of Motion Testing, Basic Neurological Testing, Orthopedic Testing, Palpation, Radiographic Studies (including without limit studies performed at the end of your course of Care if deemed necessary or appropriate), Spinal Manipulative Therapy, Massage Therapy, Ultrasound, Hot/Cold Therapy, EMS, Laser Therapy, Spinal Decompression, and others not specifically listed.

The risks inherent in Chiropractic Adjustments.

As with any healthcare procedure, there are certain complications which may arise during Chiropractic Manipulation and Therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including without limit stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. Our Doctors will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctors attention it is your responsibility to inform the Doctors.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by Chiropractic Manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR).

I, the below-signed (see "Person 2" below), hereby request and authorize the Care as set forth above to my minor son/daughter/ward. As of this date, I have the legal right to select and authorize healthcare services for the minor child / ward named below. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize Care should be revoked or modified in any way, I will immediately notify the Office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I, have read, or have had read to me, the above explanation of the Chiropractic Manipulative Therapy / Adjustment and related Care. I have discussed it with the Doctor(s) at the Office and have had my questions answered to my satisfaction. By signing this Informed Consent Document below, I state that I have weighed the risks involved in undergoing Care and have decided that it is in my best interest to undergo the Care as recommended or determined in the Doctors' discretion. Having been informed of the risks, I hereby give my consent to such Care.

Patient's Signature: **Patient Full Name –** ____/____/_____ **Date of Signature** ____/____/_____ **Date of Signature at Office**

Person 2's Signature: **Person Full Name –** ____/____/_____ **Date of Signature** ____/____/_____ **Date of Signature at Office**

OFFICE USE ONLY:

By signing below, I attest that I thoroughly discussed this Document and Care with the above-referenced individual(s) prior to the time this Document was signed by such individual(s) at the Office.

Provider's Signature: **Provider's Full Name –** ____/____/_____ **Date of Signature at the Office**

"New Patient Information Forms"

Patient's Full Name: _____ Today's Date: ____/____/_____

Social Security Number: _____ Birth Date: ____/____/_____ Age:_____ Gender: __ F __ M __ O

Marital Status: __Married __Separated __Widowed __Significant Other __Single

CURRENT ADDRESS

Street: _____

City: _____ State: _____ Zip: _____

Mobile Phone: _____ Home Phone: _____ Email: _____

How did you hear about us / who referred you to us? _____

If Advertisement (TV, Radio, Etc.), Any Promo Code or Name? _____

If Internet Search, What Query Did You Use? _____

==========

If you are under 18 years of age, who are your legal parents or guardian?

__ Father Date of Birth: ____/____/_____ (m) _____ (h) _____

__ Mother Date of Birth: ____/____/_____ (m) _____ (h) _____

__ Legal Guardian / Foster Parent Date of Birth: ____/____/_____ (m) _____ (h) _____

ANY OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street: _____

City: _____ State: _____ Zip: _____

Your Profession: _____ **Your Employer:** _____

Your Work Address: _____ **Your Work Phone:** _____

Student at _____ ☐ **FULL-TIME** ☐ **PART-TIME**

Name of Spouse: _____ Spouse's Date of Birth: ____/____/_____

Spouse's Profession: _____ Spouse's Employer: _____

Spouse's Work Address: _____ Spouse's Work Phone: _____

Spouse is a Student at _____ ☐ FULL-TIME ☐ PART-TIME

Who should we contact in the event of an emergency? _____

Mobile Phone: _____ **Home Phone:** _____ **Email:** _____

Full Address of Contact Person: _____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/_____

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/_____

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/_____

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/_____

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/_____

Name of Your Primary Care Clinician: _____ Name of PCC's Practice: _____

City / Town Where Primary Care Clinician's Practice is Located: _____

SECTION – HIPAA CONSENT FORM

ADDITIONAL DEFINITIONS. In addition to the definitions of phrases provided elsewhere, the following phrases shall have the following meaning. "Terms of Healthcare Services" means any Section, part, counterpart, or Document expressly denoted as such, or which is identified by, or denoted with, the Form ID referenced above. "Terms of Healthcare Services" includes without limit the Section entitled or relating to "Review of Terms of Healthcare Services". "HIPAA Consent Form" shall refer to the terms of this Section relating to the use and disclosure of Personal Health Information ("PHI"). The phrase, "Applicable Healthcare Providers," shall refer to all of the following named and defined entities (separated by semi-colon as applicable): Fort Worth Chiropractic Clinic, PLLC dba My West Fort Worth Chiropractor (www.MyWestFortWorthChiropractor.com) (herein, "FWCC"), together with any Applicable Healthcare Provider which has Executed the Section of these Terms of Healthcare Services entitled or relating to, "Additional Signors to These Terms of Healthcare Services." The phrases, "Office" and "Applicable Office," whether appearing in the singular or plural, shall have the same meaning as set forth in the Section entitled or relating to, "General Provisions." The phrases, "treatment," "payment" and "other healthcare operations," shall have the same meaning as set forth in 45 CFR §164.501 et seq. as such regulations are modified or reclassified from time to time and as qualified herein.

HIPAA CONSENT TERMS. You understand that some of Your personal information, including without limit personal health information (herein, "Personal Health Information"), may be used and/or disclosed by the Applicable Office to carry out various services including without limit treatment, payment, and other healthcare operations, and that for a more complete description of services, uses, and disclosures, including without limit the method and nature of communications with You and other third-parties, You should refer to the Incorporated Documents set forth and incorporated herein by reference including without limit HIPAA Privacy Policy, General Privacy Policy, and Electronic Communications Consent. You understand that You may review such Incorporated Documents at any time. Consistent with HIPAA rules, You hereby acknowledge actual receipt of all such Incorporated Documents, including without limit the HIPAA Privacy Policy.

Regarding HIPAA Rules, You acknowledge that the Applicable Office (like many personal injury Payers) in many applicable circumstances either does not, or may not, currently conduct the financial and administrative electronic transactions identified by the U.S. Department of Health and Human Services for which standards have been adopted by the Secretary. While such Office may voluntarily elect to follow certain specific standards set forth under such law, under no circumstances shall such voluntary election be construed to be an adoption of all standards under such law or a final determination of jurisdiction or oversight authority by any applicable agency to the subject matter herein.

You understand that over time the privacy policies and legal notices of the Applicable Office may need to change in accordance with law and that if You wish to obtain a copy of the General Privacy Policy, HIPAA Privacy Policy, or Electronic Communications Consent as revised, You should visit the Designated Location(s) of the Office's Primary Website(s) or send a written request to the attention of "Privacy Director" at the Office.

You understand that You may request restrictions on how Your information is used or disclosed to carry out treatment, payment, or healthcare operations, and that You can also revoke these HIPAA Consent Terms, but only to the extent that the Applicable Office has not taken action in reliance thereon and also provided that You do so in writing.

You understand that for Your protection, any requests to amend Your Personal Health Information or to access Your medical records must be made in writing.

By Signing and Dating below, I certify that I have viewed, read, and understand, and/or that I have had ample opportunity to view, read, and understand, the Terms of Healthcare Services, populated with specific data and identifying information, together with Incorporated Terms, and including without limit the Section entitled or relating to "Review of Terms of Healthcare Services"; am acknowledging receipt of a copy thereof; am Agreeing to, Signing, Dating, and otherwise Executing and Affirming such Terms on behalf of Myself and also on behalf of any Dependent Patient(s) as set forth herein; and am attesting that all information provided or represented by me, and included herein, including without limit specific data and identifying information, is true and accurate to the best of my knowledge.

Patient's Signature: _____ / / ← *Enter Date of Signature if Different Than Below*

Patient Full Name – **(Date of Signature)**

Person 2's Signature: _____ / / ← *Enter Date of Signature if Different Than Below*

Person Full Name – **(Date of Signature)**

Instructions: Person 2 must either be a parent, guardian, or healthcare representative such as in a case where the patient is a minor or incapacitated. In the event that the Patient is a minor or incapacitated, Person 2 should complete the Section entitled, "Consent for Treatment of Minor or Incapacitated Patient."

SECTION – AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO OUR OFFICE

Patient hereby authorizes and directs any Healthcare entity where the Patient has been diagnosed or treated to release medical information relating to the Patient referenced herein to Applicable Healthcare Providers / Accounts Servicing Center. **AS PERMITTED BY HIPAA PRIVACY RULES, I SPECIFICALLY AUTHORIZE AND DIRECT SUCH HEALTHCARE ENTITIES TO PROMPTLY TRANSMIT SUCH RECORDS BY ELECTRONIC MEANS AS REQUESTED BY THE OFFICE, INCLUDING WITHOUT LIMIT FAX, EMAIL, GMAIL, AND UPLOADING VIA ONLINE PORTALS.**

Patient's Name: **Parent / Guardian Name:**

Patient's Date of Birth: ___/___/_____ **Patient's Social Security Number (Last 4 Digits) (if available):** _____

In addition to the definitions of phrases provided elsewhere, the following phrases shall have the following meaning. "Accounts Servicing Center" shall mean the entity as set forth in the Section entitled or relating to, "General Provisions," unless otherwise provided by such Section. The phrase, "Applicable Healthcare Providers," shall refer to all of the following named and defined entities (separated by semi-colon as applicable): Fort Worth Chiropractic Clinic, PLLC dba My West Fort Worth Chiropractor (www.MyWestFortWorthChiropractor.com) (herein, "FWCC"), together with any Applicable Healthcare Provider which has Executed the Section of these Terms of Healthcare Services entitled or relating to, "Additional Signors to These Terms of Healthcare Services."

INFORMATION REQUESTED:

1. Complete Diagnostic and Treatment Records Generated by the Healthcare Entity
2. Complete Diagnostic and Treatment Records Received by the Healthcare Entity from Third-Party Healthcare Groups and Providers
3. Other: _____

I understand the information authorized and directed for release may contain highly-sensitive healthcare-related information about me including without limit conditions may be considered a communicable or venereal disease (including without limit, hepatitis, syphilis, gonorrhea, and human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDs)), alcohol and drug abuse records protected under the Code of Federal Regulations, information related to psychiatric conditions, as well as other highly-sensitive, healthcare-related information about me. Re-disclosure of this information by recipient is prohibited without specific authorization.

By Signing and Dating below, I certify that I have viewed, read, and understand, and/or that I have had ample opportunity to view, read, and understand, the Terms of Healthcare Services, populated with specific data and identifying information, together with Incorporated Terms, and including without limit the Section entitled or relating to "Review of Terms of Healthcare Services"; am acknowledging receipt of a copy thereof; am Agreeing to, Signing, Dating, and otherwise Executing and Affirming such Terms on behalf of Myself and also on behalf of any Dependent Patient(s) as set forth herein; and am attesting that all information provided or represented by me, and included herein, including without limit specific data and identifying information, is true and accurate to the best of my knowledge.

Patient's Signature: _____ / / ← *Enter Date of Signature if Different Than Below*

Patient Full Name – **(Date of Signature)**

Person 2's Signature: _____ / / ← *Enter Date of Signature if Different Than Below*

Person Full Name – **(Date of Signature)**

Instructions: Person 2 must either be a parent, guardian, or healthcare representative such as in a case where the patient is a minor or incapacitated. In the event that the Patient is a minor or incapacitated, Person 2 should complete the Section entitled, "Consent for Treatment of Minor or Incapacitated Patient."

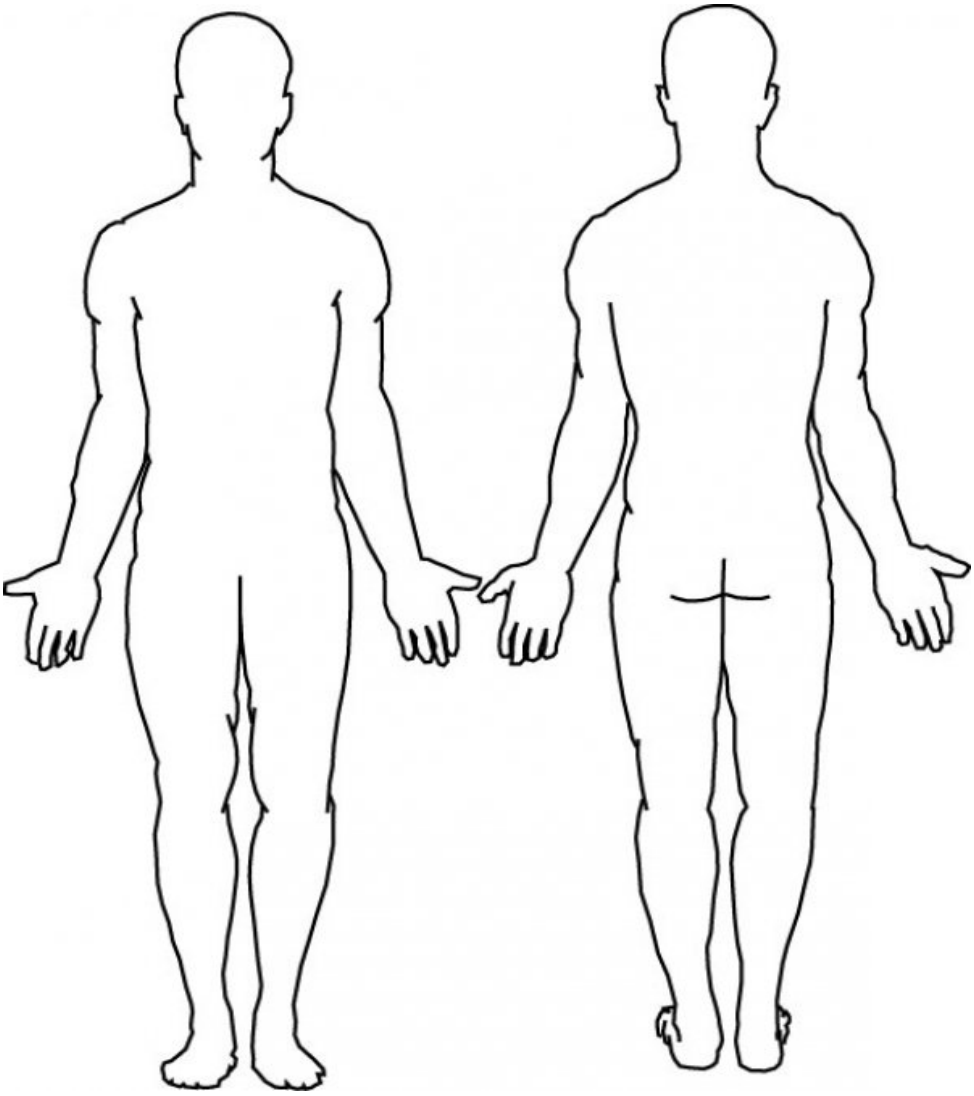
Fort Worth Chiropractic Clinic, PLLC

Pain Questionnaire

Name: _____ Date:_____

Use the letters below to indicate the type and location of your sensations you are feeling right now:

A: Aches	B: Burning	P: Pins & Needles
N: Numbness	S: Stabbing	O: Other



"Discounts Questionnaire"

1. Administrative Simplification – Open to NOT Filing Claims With Any Insurance Coverages Which May Be Available? Insurance doesn't necessarily pay for all of your care at our office. As an alternative to filing claims with insurance, we offer very affordable Discounted Payment Plans. In some instances, our Discounted Payment Plans may even cost less than what you have to pay out-of-pocket under insurance rules.	___ **Yes, I'm interested in discussing this option and possibly saving a lot of $$$.** Depending on what we discuss, I may opt to have you not file claims with insurance. ___ No, I definitely want for you to file claims with insurance. I want you to file claims with insurance even if it means that what is ultimately owed for care could be greater.
2. Prompt Pay – Open to Paying at the Time of Service or Maybe Even Pre-Paying? As a general rule, we expect payment at the time of service. Would you prefer to save a substantial amount on what is ultimately owed by paying at the time of service or maybe even pre-paying?	___ **Yes, I am interested in saving substantial $$$ by paying at the time of service … possibly even pre-paying.** ___ No, I would prefer to ask that you delay collecting from me at the time of service even though it means that I will lose the benefit of a substantial $$$ savings.
3. Quick Financial Hardship Question Okay, let's make an assumption together. It's just an assumption. Let's assume that at the end of your care, you were to have a material or substantial balance owing by you at our Office. IF that were to be the case (we're not saying it will be), what is the highest payment you feel you personally would be able to make per month given your present circumstances?	The highest monthly payment I feel I would personally be able to make, or would want to have to make out-of-pocket, assuming the balance at your office was, let's say, $500 or more, would be: __ $25 __ $50 __ $100 __ $200 __ $500 Comments: _____

Name: _____ Signature: _____ Date: ___/___/_____

SECTION – HEALTH INSURANCE ELECTION AND PAYER WAIVER

HEALTH INSURANCE ELECTION. In the event that law or contract may require Applicable Healthcare Providers to submit your Charges with your group or individual health benefit plan or health insurance, which Option would you prefer? Please check or select **one** of the Options in the checkbox or space provided ("Election Field"). You Agree that in the event that neither or both of the Election Fields associated with the Options are checked or elected by You, or You subsequently Elect a Cash Plan at Our Office, consistent with these Terms, Option 1 shall be deemed to be Your controlling choice.

___ **OPTION 1 – I DO NOT HAVE HEALTH INSURANCE / I DON'T WANT MY CHARGES SUBMITTED TO MY HEALTH COVERAGE. IF MY CARE RELATES TO INJURIES WHICH I SUSTAINED IN AN ACCIDENT, I WANT TO TREAT MY CARE AS A "PI CASE."**

I want the services we discuss, but either I don't have health insurance or I don't want my Charges submitted to my health coverage. You may keep any health coverage which I may have and that I provide to You on file, but only for the limited purposes set forth in, and as consistent with, the General Financial Policy. I understand that if my Charges or forms are not submitted to my health coverage in a timely manner, my Payer(s) may decline to pay on my Charges and I may not be able to appeal this decision. If I have health coverage, I understand that it is my responsibility at all times for Verifying coverage and benefits, including without limit Verifying in accident scenarios whether my coverage is (1) a "health benefit plan" as defined under Federal ERISA statutes and (2) potentially excluded in accident scenarios or otherwise primary / secondary to accident insurance coverages. I am electing not to Verify the nature of any health coverage which I may have at this time. I am further assuming the risk that the presence or availability of, or the act of filing claims with, my health coverage, if any, could entail special rights, including without limit rights relating to balance billing, access to greater benefits, and other special rights. I understand that in not Verifying any health coverage I may have at this time, and also requesting the non-filing of my Charges with such health coverage, I am effectively waiving such rights to the extent they may apply. If I have opted to accept one of the Office's Cash Payment Plans and I have health coverage, I understand that the Office makes no guarantees that such Cash Payment Plan will actually result in a savings to me during the course of My care at the Office. I further Attest that My decision to Accept any such Cash Payment Plan has been entirely voluntary. I understand that if I change my mind later and I request (or my representative or any other Payer requests) that my Charges be submitted to my health coverage or the Office elects in its sole discretion to submit my Charges to such Payer, (1) upon request, I will be required to complete this form (or a substantially similar form) again / provide the information requested, (2) I will be required to assist in the process of Verifying my health coverage and of securing payment or denial of benefits from such Payer upon request, (3) I will or may be required to pay for my Charges as set forth below, and (4) various additional Charges either will or may apply as set forth below and elsewhere in these Terms of Healthcare Services.

___ **OPTION 2 – I WANT MY CHARGES SUBMITTED TO MY HEALTH INSURANCE AND TO TREAT MY CARE AS A "HEALTH INSURANCE" CASE. I AM ELECTING ___ NOT TO VERIFY ___ TO VERIFY MY HEALTH COVERAGE AT THIS TIME. I AGREE TO PAY FOR MY CARE UPON REQUEST / AT THE TIME OF SERVICE. I UNDERSTAND THAT ANY WORK YOU PERFORM IN VERIFYING MY HEALTH COVERAGE, EITHER NOW OR IN THE FUTURE, COULD ENTAIL ADDITIONAL CHARGES OWING TO YOU. I UNDERSTAND AND AGREE THAT I MUST COMPLETE ALL CHOICES AND FIELDS ASSOCIATED WITH THIS OPTION EXCEPT AS INDICATED BELOW IN ORDER FOR YOU TO PROCESS MY ELECTION OF THIS OPTION.**

Name of Health Coverage: _____ Phone: _____

Policy #: _____ Group #: _____

Check One: __ I Have Supporting Documents or Information That My Coverage **IS** an ERISA Plan

__ I Have Supporting Documents or Information That My Coverage is **NOT** an ERISA Plan

__ I **Do Not Know** Whether My Coverage is an ERISA Plan or Not

Comments (Not Required): _____

I want the services we discuss, but I also want my Charges submitted to any health insurance I may have for an official decision on payment, conditioned upon the Terms of this Section and Terms of Healthcare Services. I understand that it is my responsibility at all times for Verifying coverage and benefits, including without limit verifying in accident cases whether my coverage is (1) a "health benefit plan" as defined under Federal ERISA statutes and (2) potentially excluded in accident scenarios or otherwise primary / secondary to accident insurance coverages. I understand that any work You elect to perform, or request an attorney or other entity to perform, in Verifying my health coverage in conjunction herewith, either now or in the future, could entail additional Administrative

Charges owing to You. These Charges may include without limit Charges owing to You for the time necessary for You (or for an attorney or other entity) as applicable to acquire, review, and assess written provisions contained within underlying plan documents, participation Agreements, and laws, relating to (i) coordination of benefits with accident Payers, (ii) the status of the coverage under, or applicability of, ERISA, Medicare/Medicaid or other applicable law, (iii) any rights of recoupment or recovery which such coverages may potentially claim, (iv) any other risks to the Office associated with the submission of Charges to health coverages in accident / complex scenarios, (v) balance billing terms, and (vi) other Charges related to work performed. If I elect not to assist in the process of Verifying my health coverage or of securing payment or denial of benefits upon request, I hereby authorize You in Your sole discretion to determine whether or not to actually submit my Charges to my health coverage. I understand that, in such circumstance, should you elect not to submit my Charges to my health coverage, I am hereby assuming the risk that my health coverage, if any, could entail special rights, including without limit rights relating to balance billing, access to greater benefits, and other special rights, and that I am effectively waiving such rights to the extent they may apply. You may ask to be paid now either in full for my past and present Charges (in the event You do not participate with my health coverage or I decline to assist in the insurance process) or for estimated co-pays, co-insurance, deductibles and other Non-Covered amounts associated with past and present Charges (in the event You DO participate with my health coverage, and I assist in the insurance process, and my Charges are actually submitted to my health coverage). I understand that in the event You DO participate with my health coverage, such participation does not necessarily entail an Agreement with the Payer to reduce my Charges and in such cases I will continue to be responsible for the full Charges. I understand that these are just estimates. In the event that any of my Payers delay or Deny Payment, I will be responsible for payment as described below and in Your General Financial Policy, but I understand that I will, or may, be able to appeal to my Payers coverage following their directions. Unless otherwise Agreed to in writing, I understand and Agree that upon submission of my claims to my health coverage, in the event that any discounts are actually applied by my health coverage, any right to receive a list of Charges from You for any purpose shall be limited to a list of Charges inclusive of said discounts actually applied.

PAYER WAIVER. Consistent with the General Financial Policy and this Waiver, I understand that I am personally and financially responsible for all Charges incurred at Applicable Healthcare Providers. Without limiting the General Financial Policy in anyway, I understand that there is a possibility or likelihood that payment of the Charges set forth in the "List of Services and Items Which You May Receive or Incur" (see attached) may, or could, be delayed or Denied by any of my Payers for any number of reasons, including without limit those reasons defined and set forth in the General Financial Policy and consistent with the Payer's policy. In the event of such delay or Denial, I understand that I continue to be personally and financially responsible for all Charges incurred at Applicable Healthcare Providers.

DEFINITIONS. The phrase, "Applicable Healthcare Providers," "Office," "Applicable Office," "Company," and "Adopting Company," whether appearing in the singular or plural, shall refer to all of the following named and defined entities (separated by semi-colon as applicable): Fort Worth Chiropractic Clinic, PLLC dba My West Fort Worth Chiropractor (herein, "FWCC") (URLs of Office's Primary Website(s) include without limit http://drderekpage.com/ and http://MyWestFortWorthChiropractor.com). "Terms of Healthcare Services" means any Section, part, counterpart, or Document expressly denoted as such, or which is identified by, or denoted with, the Form ID referenced above.

MISCELLANEOUS. This Health Insurance Election and Payer Waiver shall not be modified or revoked without the expressed written Consent of Accounts Servicing Center and Applicable Healthcare Providers. This election supersedes any prior Health Insurance Election and Payer Waiver.

By Signing and Dating below, I certify that I have viewed, read, and understand, and/or that I have had ample opportunity to view, read, and understand, the Terms of Healthcare Services, populated with specific data and identifying information, together with Incorporated Terms, and including without limit the Section entitled or relating to "Review of Terms of Healthcare Services"; am acknowledging receipt of a copy thereof; am Agreeing to, Signing, Dating, and otherwise Executing and Affirming such Terms on behalf of Myself and also on behalf of any Dependent Patient(s) as set forth herein; and am attesting that all information provided or represented by me, and included herein, including without limit specific data and identifying information, is true and accurate to the best of my knowledge.

Patient's Signature: _____ / / ← *Enter Date of Signature if Different Than Below*

Patient Full Name – **(Date of Signature)**

Person 2's Signature: _____ / / ← *Enter Date of Signature if Different Than Below*

Person Full Name – **(Date of Signature)**

Instructions: Person 2 must either be a parent, guardian, or healthcare representative such as in a case where the patient is a minor or incapacitated. In the event that the Patient is a minor or incapacitated, Person 2 should complete the Section entitled, "Consent for Treatment of Minor or Incapacitated Patient."

SECTION – GENERAL FINANCIAL POLICY

DEFINITIONS. The phrase, "Applicable Healthcare Providers," "Office," "Applicable Office," "Company," and "Adopting Company," whether appearing in the singular or plural, shall refer to all of the following named and defined entities (separated by semi-colon as applicable): Fort Worth Chiropractic Clinic, PLLC dba My West Fort Worth Chiropractor (herein, "FWCC") (URLs of Office's Primary Website(s) include without limit http://drderekpage.com/ and http://MyWestFortWorthChiropractor.com). "Terms of Healthcare Services" means any Section, part, counterpart, or Document expressly denoted as such, or which is identified by, or denoted with, the Form ID referenced above. "General Financial Policy" shall refer to the terms of this Section.

PERSONAL RESPONSIBILITY FOR MY CHARGES. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from Accounts Servicing Center. Except where provided otherwise by law or by contract, I Agree to pay the full amount of my Charges to Accounts Servicing Center promptly upon its demand. I understand that Accounts Servicing Center's Assignment does not constitute an Agreement by Accounts Servicing Center to await payment of my Charges. I Agree that any delay by Accounts Servicing Center in making demand for payment, any delay in paying the full amount of my Charges, and any partial payments made towards my Charges, shall not constitute Acceptance of any installment payment plan, shall not constitute a waiver of Accounts Servicing Center's right to receive payment-in-full promptly upon demand, and shall not constitute an "accord and satisfaction" of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments.

PERSONAL RESPONSIBILITY FOR VERIFYING THE LIMITATIONS IN MY COVERAGE; FINANCIAL RESPONSIBILITY FOR NON-COVERED CHARGES. I understand that in any given situation, a Payer may initially refuse to make payment to Applicable Healthcare Providers / Accounts Servicing Center, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from Applicable Healthcare Providers / Accounts Servicing Center after making payment, and do so either in whole or in part with respect to any given Charge incurred at Applicable Healthcare Providers / Accounts Servicing Center (collectively, "Deny Payment"). For example (without limiting this Agreement), I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I further understand that a Payer may Deny Payment stating that the individual provider who actually renders the treatment or procedure is out-of-network. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I also understand that a Payer may require certain Charges to be pre-certified or pre-authorized. In the event that my condition arose from an accident, I further Agree to the terms the Section entitled or relating to, "Advance Beneficiary Notice – Combination Wcomp / Private Injury Cases." I understand that there may be many other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to Applicable Healthcare Providers (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I Agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at Applicable Healthcare Providers. I Agree that if I have any questions about the Terms of Non-Coverage, I can request copies of the Healthcare Accounts Servicing Center's verification (e.g., eligibility, pre-authorization) forms to gain further understanding. I Agree that should Applicable Healthcare Providers / Accounts Servicing Center assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or Applicable Healthcare Providers / Accounts Servicing Center may in my opinion not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by Accounts Servicing Center in its sole discretion, I Agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold Applicable Healthcare Providers / Accounts Servicing Center responsible or liable in any of the foregoing instances.

MISCELLANEOUS ADMINISTRATIVE CHARGES. Miscellaneous Administrative Charges include without limit: (i) a fee of $50 for any scheduled appointment missed by Patient without any prior notice ("No-Show Fee"); (ii) a fee of $50 for any scheduled appointment which is cancelled or changed by the Patient within 24 hours of the scheduled appointment ("Late Cancellation Fee"); and (iii) a fee of $50 for each instance that a check is not honored or returned or draft of any Available Payment Method is declined, not approved, or reversed ("Payment-Not-Honored Fee").

By Signing and Dating below, I certify that I have viewed, read, and understand, and/or that I have had ample opportunity to view, read, and understand, the Terms of Healthcare Services, populated with specific data and identifying information, together with Incorporated Terms, and

including without limit the Section entitled or relating to "Review of Terms of Healthcare Services"; am acknowledging receipt of a copy thereof; am Agreeing to, Signing, Dating, and otherwise Executing and Affirming such Terms on behalf of Myself and also on behalf of any Dependent Patient(s) as set forth herein; and am attesting that all information provided or represented by me, and included herein, including without limit specific data and identifying information, is true and accurate to the best of my knowledge.

Patient's Signature: _____ / / ← *Enter Date of Signature if Different Than Below*

Patient Full Name – **(Date of Signature)**

Person 2's Signature: _____ / / ← *Enter Date of Signature if Different Than Below*

Person Full Name – **(Date of Signature)**

Instructions: Person 2 must either be a parent, guardian, or healthcare representative such as in a case where the patient is a minor or incapacitated. In the event that the Patient is a minor or incapacitated, Person 2 should complete the Section entitled, "Consent for Treatment of Minor or Incapacitated Patient."