ABOUT THE PATIENT

AXIS Chiropractic Inc, 6370 LBJ FRWY, Dallas, TX 75240

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Gender ❑ M ❑ F

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

e-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes

Emergency Contact _____ ph # _____

Name of Medical Doctor(s)_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize AXIS Chiropractic Inc to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

10. Results: _____

NOTES: _____

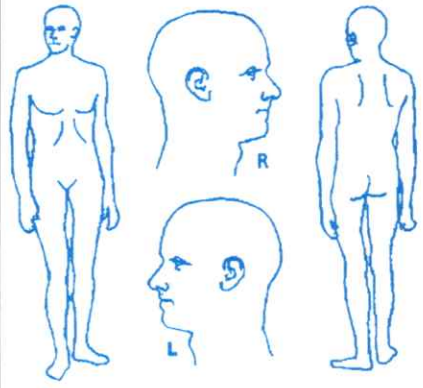
_____

_____

Are you pregnant?

❑ Yes ❑ No

Please mark all areas of concern.



Paying for your care is easy here!

Mark and initial which one is you:

❑ **No Insurance**:

- Easy! Our Care Plans and simple payment arrangements have helped over 1000 people and will work great for you too!

*Initial*_____

❑ **Health Insurance:**

- These days, insurance pays very little if anything for natural drugless care to get you healthy. So we make it easy!
- We will verify any benefits you may have and send your claims in to your insurance for you.
- If they pay anything after your deductible is met, we will accept payment directly from them.
- You are responsible for any deductible, co-insurance, co-pays and unpaid visits.
- Of course you can use your HSA, HRA and Flex dollars here!
- For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.

*Initial*_____

❑ **Auto Injury**

- Auto related injuries are covered 100% in Texas. Even if you were at fault or were a passenger. You can get the care you need and it costs you nothing. Great for you!
- All we need is your claim number, insurance, and attorney info.

*Initial*_____

❑ **Work Injury**

- Work injuries are covered 100% for up to x12 weeks of care.
- All we need is your claim number and Work Comp ins. info. *Initial*_____

❑ **Medicare**

- Regardless of your condition, Medicare pays for up to a maximum of 12 weeks of care. They have very strict rules and limitations.
- After this you will receive a significant Medicare discount. We simply need a copy of your Medicare card.
- Medicare supplements normally don't pay anything.

*Initial*_____

GENERAL HEALTH HISTORY

AXIS Chiropractic Inc, 6370 LBJ Freeway, ste 175, Dallas, TX 75240

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. List any medications you are taking:_____

_____

2. Please list all doctors you are currently seeing: _____

_____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes, Name_____

_____

_____

PAST HISTORY

4. List any past auto collisions:_____ Was any care received?_____
5. List any past work injuries: _____ Was any care received?_____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

COLLISION INFORMATION

AXIS Chiropractic Inc, 6370 LBJ Freeway, ste 175, Dallas, TX, 75240

Name: _____ Today's Date: _____

Where did the collision occur: Street: _____ City: _____ State: _____

Date when collision occurred: _____ AM or PM. Was the road: ❑ Dry ❑ Wet ❑ Snowy ❑ Icy

Where you the: ❑ Driver ❑ Front middle passenger ❑ Front right passenger ❑ Back left ❑ Back middle ❑ Back right

Describe what happened: _____

_____

_____

_____

_____

CRASH DETAILS

❑ Yes ❑ No If driving, were both hands on the wheel at impact?

❑ Yes ❑ No If passenger, did your hands brace yourself?

❑ Yes ❑ No Did you have your seat belt and shoulder strap on?

❑ Yes ❑ No Was your seat up at the time of impact?

❑ Yes ❑ No Where you wearing a bulky coat or slippery pants?

❑ Yes ❑ No Did the seat belt engage?

❑ Yes ❑ No Did the airbag engage?

❑ Yes ❑ No Did you hit the dash, steering wheel or window?

❑ Yes ❑ No Did you know you were going to be hit?

❑ Yes ❑ No Did you brace yourself with hands or feet?

❑ Yes ❑ No If driving, was your foot on the brake at impact?

❑ Yes ❑ No Was your head turned at impact?

❑ Yes ❑ No Were you leaning forward?

❑ Yes ❑ No Did your glasses fly-off at impact?

❑ Yes ❑ No Was your body turned at the moment of impact?

❑ Yes ❑ No Did you get hit into another car, tree, railing, etc?

❑ Yes ❑ No Any damage or marks on your vehicle, the vehicle that hit you, or another object that was hit?

What part of the vehicle was hit? _____

1. What make and model of vehicle were you in? _____ The other vehicle? _____
2. What kind of seat were you in? __ Bucket __ Bench __ Fabric __ Leather/Vinyl
3. Did the car have headrests? ❑ Yes ❑ No
4. Did you hit your head on the headrest? ❑ Yes ❑ No On the back window if in a small truck? ❑ Yes ❑ No
5. Was the headrest positioned: __ below __ level with __ above the center of your head
6. Did your head hurt after the collision? ❑ Yes ❑ No Did your TMJ/jaw hurt after the collision? ❑ Yes ❑ No
7. How soon after the collision did you notice any pain? _____
8. Did the crash affect: ❑ dizziness ❑ memory ❑ concentration ❑ headaches ❑ balance ❑ nightmares ❑ breathing ❑ fatigue ❑ irritability ❑ ability to read ❑ ability to listen ❑ appetite ❑ nausea ❑ vision
9. Is there anything else you want us to know? _____

_____

PROVIDERS SEEN

List **all** providers seen since injury occurred:

1. Clinic/Doctor/Hospital Name_____City_____
2. Clinic/Doctor/Hospital Name_____City_____
3. Clinic/Doctor/Hospital Name_____City_____
4. Clinic/Doctor/Hospital Name_____City_____
5. Clinic/Doctor/Hospital Name_____City_____

❑ Yes ❑ No Do you have pictures of your vehicle? Where is it being repaired?_____

❑ Yes ❑ No Do you have a copy of the police report?

Name of your Attorney if you have one:_____

Name of Your Car Insurance Co._____ Your Health Ins. Co. _____

Name of the Other Divers car Insurance if Applicable_____

AXIS Chiropractic, Inc ***6370 LBJ Frwy, ste 175 ***Dallas, TX 75240*** P: 469-646-7246 F: 469-646-7246

IRREVOCABLE PROVIDER/PATIENT ASSIGNMENT, LIEN, POWER OF ATTORNEY, DOCUMENT/RECORDS RELEASE, AND PAYMENT AGREEMENT

Claim #:_____ **Attention:** _____

THIS IRREVOCABLE, NON-RESCINDABLE, AGREEMENT and ASSIGNMENT OF LIEN INTEREST/BENEFITS is entered into this date by and between:___ _____hereinafter called "Patient", and **AXIS CHIROPRACTIC, INC., 6370 LBJ FRWY, STE 175, DALLAS, TX 75240**, hereinafter called "Provider".

WHEREAS, Patient desires to receive health care services from Provider and requests that Provider provide such services, but defer payment on the part of Patient for such services until Patient secures his/her insurance settlement proceeds. In consideration of Provider's willingness to agree to such terms Patient does hereby: (i) waive any obligation on the part of the Provider under Tex. Civ. Pract. & Rem. Code Ann., §146.002(b), and (ii) irrevocably assign the following rights and benefits to Provider as the legal consideration and inducement to cause Provider to forego its legal right to require payment upon provision of services and wait for the payment of such benefits from Patient or Patient's representative, it is hereby agreed:

SECTION 1. Patient hereby irrevocably acknowledges full financial responsibility for all services provided to patient by Provider as consideration for such Provider services. Patient irrevocably assigns to Provider any and all legal claims against the party or parties that gave rise to Patient's claims for damages for which Provider has been engaged to provide healthcare services, *including* Patient's legal entitlement to monetary proceeds due to be paid by or through any health insurance, liability, PIP or medical payment insurance coverage that is/are maintained by Patient or under which Patient derives some legal entitlement arising as a result of the injuries suffered from an automobile accident, for which Provider has rendered the above described health care services. Patient irrevocably grants, conveys and assigns to Provider a monetary interest and lien upon the proceeds of Patient's personal injury claim against the person(s) or party(ies) responsible for Patient's injuries in the exact amount necessary to pay the reasonable charges for the necessary treatment to alleviate Patient's injuries rendered by Provider. Patient's *lien interest* granted and conveyed to Provider shall extend to: (i) any and all benefits, claims and/or causes of action, payable by or from any automobile medical payment coverage maintained by Patient or any person under whose policy of insurance Patient may have a lawful right of recovery, (ii) any and all benefits, claims and/or causes of action, payable by or under any third party liability insurance coverage to which Patient may have a right of recovery due to the services rendered by Provider, and (iii) a "common law lien interest" in, and all contractual rights and claims to, any and all insurance proceeds to which Patient has or maintains a legal entitlement, to be paid by or from any insurance company, health care benefit plan, or any other party contractually liable for payment of all or any portion of the charges for health care services rendered by Provider to the Patient as a result of the injuries sustained by Patient. This irrevocable assignment of benefits, conveyance and assignment of lien interest and conveyance and assignment of contractual rights to and for those charges attributable to Provider's health care services shall extend to, but not be limited to, Provider's entitlement to any and all claims, causes of action and insurance proceeds remitted as a result of any insurance claim for damages by the Patient which has given rise to the above referenced health care services provider by Provider, as recognized under the holdings of Ford Motor Credit Co. v. Allstate, 2 S.W. 3d 810 (Mo.App.W.D. 1999) and Marvin's Midtown Chiropractic Clinic, LLC v. State Farm Mutual Automobile Insurance Company, 142 S.W. 3d 751 (Mo.App, W.D. 2004).

This irrevocable assignment of benefits and lien interest shall extend to the total amount of charges incurred by Patient for those services rendered by Provider. Patient agrees that full payment for all services rendered by Provider is due upon receipt of said services and Patient accepts full financial responsibility for payment for such services. Patient acknowledges that Patient is ultimately financially responsible for the payment of all services that Patient receives from Provider regardless whether any portion of those fees and charges due to be paid by Patient to Provider are paid through insurance proceeds to which Patient has asserted a claim. Patient acknowledges that Provider's acceptance of Patient's irrevocable assignment of benefits and lien interest is a convenience to Patient, and that Provider may revoke this assignment and lien interest at any time.

SECTION 2. Patient hereby grants and conveys to Provider a limited power of attorney to accept any payment provided in Patient's name by any insurer as consideration for the services provided by Provider to Patient and Patient does grant and convey Provider with a limited power of attorney to sign patient's name to any such insurance check, bank draft or other form of negotiable instrument remitted by any person or insurer as consideration or compensation for the injuries sustained by Patient and/or the health care services rendered to Patient by Provider.

SECTION 3. Patient hereby irrevocably directs all insurers, health care plans, legal counsel, and other persons or parties responsible for the payment, co-payment or other obligation for Patient's health care costs arising from injuries sustained by Patient for which the above referenced services have been provided by Provider, to remit and/or make all monetary payments remitted as consideration, in whole or in part, for those health care services rendered by Provider for and on behalf of Patient, directly to Provider. Patient further directs that any lawyer or representative employed by Patient to represent Patient in any action for which the above referenced services have been rendered by Provider, insurer or third party, shall be, and is hereby, irrevocably instructed and required to withhold from any monetary distribution to Patient, Patient's lawyer and/or any other person or party asserting any monetary interest against any proceeds to which Patient may awarded, the full amount of Patient's outstanding and unpaid account due and owing to Provider out of any private party settlement proceeds, insurance settlement proceeds of whatever nature (liability, PIP, etc.), and/or any court verdict and remit payment of the dollar amount of Patient's unpaid and outstanding account with Provider, directly to Provider immediately upon receipt of same. This directive made by the Patient to the Patient's lawyer is to be deemed irrevocable and non-rescindable and shall extend to and include any PIP or medical payment benefits recovered by or on the Patient's behalf of the Patient or Patient's lawyer.

AXIS Chiropractic, Inc. ***6370 LBJ, Ste 175 ***Dallas, TX 75240*** P: 469-646-7246 F: 469-646-7246

Claim#:_____ Attention: _____

SECTION 4. Patient willfully and voluntarily makes and appoints Provider, through its duly appointed representative, residing in the City of Dallas Dallas County, Texas, as Patient's lawful Attorney-in-Fact for purposes of receiving and directing disbursement of the above described payments or settlement proceeds to be paid to Patient, or on Patient's behalf, as compensation for those for the health care services rendered by Provider, and the resultant payment obligations owed by Patient to Provider as a result of same. Patient hereby delegates and conveys to Provider those rights and powers of substitution on Patient's behalf, to ask, demand, sue for, collect, endorse, sign, and receive such monetary proceeds, in Patient's name, to PIP insurance, other health benefits, and third party claims relating to services rendered to Patient by Provider. Although Provider is granted such special powers contained herein, Provider is not obligated or compelled to exercise such powers but may do so at Provider's discretion. Patient agrees to cooperate with Provider to request and receive from any insurer, employer, or other third party payor any and all information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claims arising from services rendered to Patient by Provider.

SECTION 5. To the extent that Patient has lawful authority, Patient waives any applicable statute of limitations that may at any time interfere with Provider's right to collect for services rendered to Patient as well as any other statutory obligation on the part of Provider to bill for or seek collection from any other source of insurance proceeds. Patient agrees that in the event Patient or Patient's authorized representative, including legal counsel, receives any check, draft, or other payment subject to this Agreement, Patient and Patient's authorized representative shall be deemed to serve in a fiduciary capacity to Provider, for the benefit of Provider, with full obligation to immediately deliver said check(s), draft(s), or payment(s) to Provider. Provider agrees to apply the proceeds from said check(s), draft(s), or payment(s) to Patient's debt for services rendered.

SECTION 6. Patient hereby irrevocable consents to, and authorizes, his lawyer/legal counsel to release to Provider, upon request by Provider, any and all records or documentation pertaining to Provider's insurance claims, legal claims, pending causes of action, or otherwise pertaining to the expense or charge for any service rendered by Provider for Patient's benefit.

SECTION 7. Patient irrevocably agrees and consents to Provider's submission of a copy of this Agreement and any other claim for payment of insurance proceeds to any and all insurance carrier(s) against whom Patient is, or may, assert or maintain any claim for damages and reimbursement for the cost for those services provided by Provider, including, but not limited to, any insurance coverage for Medical Payments, Personal Injury Protection or third party liability insurance payments. A copy of this document shall be as binding as the document bearing original signatures.

SECTION 8. In the event that any Section or provision of this Agreement is determined to be legally void, invalid, or unenforceable, all other Sections and provisions of this Agreement shall remain in full force and effect. Patient may not revoke the assignments and agreements contained in this document without the express written consent of Provider.

IN WITNESS WHEREOF, this agreement has been entered into the day and year set forth below.

_____ _____

Date Patient

_____ _____

Date Parent/Guardian's Signature if Patient is a Minor

_____ **AXIS Chiropractic, Inc** _____

Witness Provider Date