

Dr. Derik Sanders, DC, LLC
300 Beardsley Ln. Bldg. E, Suite #104
Austin, TX 78746
ASSIGNMENT OF BENEFITS

I, _____ hereby assign to _____

All rights, privileges and remedies to payment for healthcare services provided by Dr. Derik Sanders for the accident which occurred on or about _____, CLAIM# _____

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 benefits payable by or from any insurance or health care plan(s) coverage maintained by Patient as consideration for the total fee for those charges incurred by Patient as a result of those services rendered by Provider. Patient also assigns to Provider: (i) any and all benefits payable by or from any automobile medical payment coverage maintained by Patient or any party under whose policy of insurance Patient may have a lawful right of recovery, (ii) any and all benefits payable by or under any third party liability insurance coverage to which Patient may have a right of recovery due to the injuries for which Patient has sought Provider's health care services, and (iii) a "common law lien interest" in, and all contractual rights and claims to, any and all future insurance proceeds Patient has against any insurance company, health care benefit plan, or any other party contractually liable to Patient for payment of all or any portion of the health care services rendered by Provider, and the resultant charges therefore, to the Patient as a result of the injuries sustained by Patient. This irrevocable assignment of benefits, conveyance of lien interest and 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 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 provided by Provider.

AUTOMOBILE INJURY QUESTIONNAIRE

Name: _____

Date: _____

Date of Accident: _____ Location: _____

Describe Accident: _____

Describe Your Injuries: _____

If You Were Hospitalized, Where?: _____

Doctors Seen for Your Injuries: _____

Dates Unable to Work Due to Injuries: _____

If You are Unable to Perform All of Your Usual Job, Please Explain: _____

Check Symptoms You Have Had (Related to Accident):

- Headache
- Neck Pain
- Neck Stiff
- Shoulder Pain
- Arm Pain
- Lightheaded
- Dizzy

- Ears Ring
- Fatigue
- Nervousness
- Irritability
- Depression
- Loss of Memory
- Numbness in Arms

- Sensitive to Light
- Shortness of Breath
- Mid Back Pain
- Chest Pain
- Lower Back Pain
- Leg Pain
- Leg Numbness

Any Other Symptoms Not Listed Above: _____

Were You: Driver / Passenger / Pedestrian

Wearing Seatbelt? yes / no

Struck From: Behind / Left / Right / Front

Did your car strike the other(s) involved? yes / no

Or did the other vehicle strike yours? yes / no

Was the car you were in owned by you? yes / no

Were traffic citations issued to you or the driver of your car? yes / no

Or to the driver of the other car? yes / no

Do you plan to file any of the following insurances?

- Auto Liability (of the car that struck you)
- Personal Injury Protection (PIP)
 - of the car you were in
 - of your car
 - of your parent's car
- Health Ins.

Do you have an attorney representing you in this case? yes / no

yes / no

Attorney's Name: _____

Atty. Phone: _____

ACTIVITIES OF DAILY LIVING

For each activity, please circle the description that most closely describes how your pain or symptoms affect your life.

Activity	0	1	2	3	4
Mental Concentration	No difficulty	Slight difficulty	Moderate difficulty	A lot of difficulty	Cannot concentrate
Sleep	Perfect	Mildly disturbed	Moderately disturbed	Greatly disturbed	Totally disrupted
Sitting	Can sit as long as I like	Can only sit 1 hour	Can only sit 30 minutes	Can only sit 10 minutes	Unable to sit due to pain
Standing	No pain after several hours	Pain after several hours	Can only stand 1 hr	Can only stand ½ hr	Pain with any standing
Travel / Driving	No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
Walking	No pain any distance	Pain after 1 mile	Pain after ½ mile	Pain after ¼ mile	Pain with all walking
Washing / Dressing	No restrictions and no pain	Mild pain, but no restrictions	Need to go slowly due to moderate pain	Need assistance due to pain or limitations	Require 100% assistance
Bending / Moving	No movement restrictions or pain	Mild pain, but no restrictions	Difficult to bend or change position	Bending or moving causes lingering pain	Unable to move more than a little
Lifting	No pain with heavy weight	Pain with heavy weight	Pain with moderate weight	Pain with lifting light weight	Pain with any lifting or bending
Work	No limitations and can do extra work	Can do usual work with difficulty	Can do 50% of usual work	Can do 25% of usual work	Cannot work
Social Life	Normal	Normal, but increases my pain	Energetic activities are limited	Stay home most of the time due to pain	Pain restricts me to my home
Recreation / Sports	Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

Name _____

Date _____

Add Numbers to Get Total Score _____

Acknowledgement for Use and Disclosure of Protected Health Information and Consents to Chiropractic Evaluation, Treatment and Financial Policies

Notice of Privacy Practices I have read and understand the Notice of Privacy Practices for Dr. Derik Sanders; *"Your Information. Your Rights. Our Responsibilities."* which describes how my Protected Health Information may be used or disclosed. I understand that I may request a copy of the Notice from Dr. Derik Sanders at any time.

Informed Consent and Authorization for Chiropractic Evaluation and Treatment I understand that although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, there are possible risks and complications associated with these procedures. I have read and understood the description of common risks associated with these procedures. I hereby authorize Dr. Derik Sanders to perform the history, diagnostic and examination procedures they deem necessary related to conditions presented in this office.

I understand that the doctor has the right to refuse or accept me as a patient at any time before treatment begins. Should they accept me for treatment, I give my consent to the performance of conservative, noninvasive treatment to the joints and soft tissues. I understand that chiropractic procedures may consist of adjustments involving movement of the joints and soft tissues. Adjunctive physical therapy, exercises and nutritional therapy may also be used in my treatment. I understand that there may be additional risks associated with any of these forms of treatment. Should I have any adverse reactions to treatment, I will notify my doctor as soon as possible. I intend this consent to apply to all present and future chiropractic care received in this office.

Non-Covered Services Policy I understand that some of the services or supplies I receive from Dr. Derik Sanders may not be approved for reimbursement by insurance companies. If such is the case, I will be informed in advance of these items. Should I then choose to utilize these supplies or services, they will not be billed to my insurance company and will be my sole financial responsibility.

Informed Consent of Appointment Scheduling Policies If I discover that I am not able to make a scheduled appointment, I will notify Dr. Derik Sanders at the earliest possible opportunity. I understand that if I miss an appointment or fail to provide twenty-four hours notice prior to canceling or rescheduling an appointment, I will be responsible for paying for that appointment in full.

Authorization for Direct Payment to Dr. Derik Sanders Should I have an outstanding balance on my account with Dr. Derik Sanders, I authorize direct payment of my medical benefits to Dr. Derik Sanders for the health care services rendered to me. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that I am personally responsible for these services should they not be covered by insurance.

Signature

I have reviewed and agree with this consent form. I also give my permission to this office to use and disclose my health information in accordance with the described Protected Health Information Policies described.

Name of Patient (print)

Signature of Patient (Or Patient Parent/Representative)

Date

Office Representative

Date