BAKER CHIROPRACTIC CENTERS

PATIENT INFORMATION FORM

Date: ___ / ___ / ___

Name_____ □ Male □ Female Height: _____ Weight: _____

Date of Birth ____/____/____ SSN ____/____/____ E-Mail _____

Home Ph _____ Cell Ph _____ Work Ph _____

Are you under 18 yrs of age? _____ YES _____ NO If so, who are your legal parents/guardians?

Father: _____ DOB: _____ / _____ / _____ Phone: (___) _____

Mother: _____ DOB: _____ / _____ / _____ Phone: (___) _____

Guardian: _____DOB: _____ / _____ / _____ Phone: (___) _____

Who do you normally live with? Father & Mother Father Mother Legal Guardian None of These

MARITAL STATUS: Married Separated Widowed Single How many children? _____

CURRENT ADDRESS: Street: _____

City: _____ State: _____ Zip: _____

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

Street: _____ City/State & Zip: _____

Street: _____ City/State & Zip: _____

Occupation: _____ Employer: _____

Address: _____ Phone: (___) _____

Student at _____ ____ Full Time ____ Part Time

Name of Spouse _____ DOB: _____ / _____ / _____

Occupation: _____ Employer: _____

Address: _____ Phone: (___) _____

Student at _____ ____ Full Time ____ Part Time

Emergency Contact _____ Phone: (___) _____

Relationship _____ Address: _____

Is your condition or injury due to an ____ accident or ____ work-related cause? (please check one)

If the condition did not result from an automobile accident or is related to your work, how and where did the accident occur? _____

Approximately, when did your injury or condition occur? ____ / ____ / _____

How did you learn about us? _____

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Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Baker Chiropractic & Rehabilitation Centers, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me. I authorize any insurance companies, current and or former attorneys to release any and all information required for our office to process payments for services rendered. This includes, but is not limited to, First or Third-party insurance payments and claim information, Personal Injury Protection Payments and claim information, Medical Payment claim information and payments, private or publicly funded health insurance company's information and or payments made.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Baker Chiropractic & Rehabilitation Centers, and send to 15901 Central Commerce Dr., Ste. 503 Pflugerville, TX 78660.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Baker Chiropractic & Rehabilitation Centers, and to send any and all checks to 15901 Central Commerce Dr., Ste. 503 Pflugerville, TX 78660.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. 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.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM 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. 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 rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

Patient Name (Please Print) _____

Patient Signature _____ Date _____/_____/_____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (Please Print) _____

Parent/Guardian Signature _____

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purpose of this Consent Form, "Office" shall refer to Baker Chiropractic.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures; I should refer to the Office's privacy notice entitles, "Our Privacy Practices". I understand that I may review this privacy notice at any time prior to signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand the privacy risks of mail, telephone and email. I hereby authorize the Office to text or email me with communications regarding my scheduled treatments. I understand that I have the right to rescind this authorization at any time by notifying the Office in writing.

I understand that the Office may contact me via SMS text messaging regarding upcoming appointments. The Office will not use SMS text messaging regarding any personal information or billing records. I am aware that I can withdraw consent at any time by informing the Office in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing. I understand I may review the Office's HIPAA policy, which is located in a binder in the waiting room.

Patient Name (please print): _____

Signature: _____ Date: ____ / ____ / ____

Authorization for Release of Medical Records

Patient's Name _____

Address: _____ City: _____ Zip: _____

Social Security #: _____ - _____ - _____ DOB: _____ / _____ / _____

I, _____ request that you release my complete medical file including all records. (Intake forms, E.R., exams, diagnostic testing results, consultation, discharge, follow-up)

For the following dates: _____ to _____

From _____ to Baker Chiropractic.

Please forward information via: _____ Fax (512.532.6225) _____ Mail _____Orally

_____ _____

Patient's Signature or Authorizing Party Date

Patient Name_____ Date _____

Complete the following Questionnaire as it relates to your **current injury**.
Please circle all activities that cause pain/discomfort.

Bathing	Bending	Care of others	Care of pets
Climbing stairs	Concentrating	Cooking	Cleaning
Crouching/Squatting	Dressing	Driving	Eating
Exercising	Housework	Lifting	Personal Hygiene/Grooming
Reading	Sexual activity	Sitting	Standing
Walking	Work activities	Loss of sleep	

Job Description _____

Please mark your pain areas below with an X