DR. BRENT BRYANT
DR. G. G. GRANT

SHELL CHIROPRACTIC

3219 STERLINGTON RD.
MONROE, LA 71203

318-387-5388
FAX 318-325-9882

PATIENT CONFIDENTIAL INFORMATION

NAME: _____ **DOB:** _____ **MARITAL STATUS (M S W D)**

ADDRESS: _____ **CITY, ST. & ZIP:** _____

Email: _____ **SS#** _____ **MALE / FEMALE**

CELL #: _____ **FOR REMINDER TEXT (cell provider) VERIZON AT&T OR OTHER** _____

EMPLOYER _____ **OCCUPATION** _____

REFERRED BY (how did you hear about us) _____

SPOUSE'S NAME _____ **SPOUSE'S EMPLOYER** _____

PURPOSE OF THIS APPOINTMENT: _____

OTHER DOCTORS SEEN FOR THIS CONDITION: _____

PLEASE CHECK BY THE SYMPTOM YOU HAVE SUFFERED FROM

DIZZINESS___
BACKACHES___
HEART TROUBLE___
TUBERCULOSIS___
ARTHRITIS___
HEADACHES___
DIABETES___
ASTHMA___
NEURITIS___
DIGESTIVE DISORDER___
NERVOUSNESS___
SINUS TROUBLE___
ANEMIA___
CANCER___

PAYMENT IS EXPECTED AT THE TIME OF VISIT: Person responsible for this bill (provide name and phone #)_____ I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Shell Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered for me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will immediately be due and payable.

PATIENTS SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN SIGNATURE: _____

Assignment of Proceeds, **Contractual Lien, Release of Medical & Plan Documents and Authorization (Agreement)**

Shell Chiropractic, LLC 3219 Sterlington Road Monroe, La. 71203 318-387-5388

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers") which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("condition"), to pay directly to, and exclusively in the name of, **Shell Chiropractic LLC**, ("Office") such sums as may be owing to **Shell Chiropractic LLC**, for charges incurred by me, including but not limited to charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the office ("charges"). I further grant a contractual lien to **Shell Chiropractic LLC** with respect to my charges, applicable to all players however, I understand that nothing in this agreement shall be constructed as an election by **Shell Chiropractic LLC** to claim protection under any statutory lien law. For the purpose of this Agreement, "benefits" shall include, but shall not be limited to, proceeds from any settlement, judgement, or verdict, as well as any proceeds relating to the commercials health or group insurance, disability benefits, workers compensation benefits, medical payment benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured or underinsured motorist coverage, third party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay **Shell Chiropractic LLC**, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Shell Chiropractic LLC to extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name or in this office's name, and to settle or otherwise resolve such causes of action as the office see fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such a letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice to the office regarding any funds received by the attorney relating to my accident, to promptly pay such office, and to provide a full accounting of such funds to the office upon its request.

I hereby direct all payers to release to **Shell Chiropractic LLC** any information regarding any coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize **Shell Chiropractic LLC** to endorse/sign my name on any and all checks listing me as a payee which are presented to this office for payments of an account relating to me, my spouse, or any of my dependents. I further authorize **Shell Chiropractic LLC** to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents. Insurance policy and/or settlement information upon written request from such doctor or clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other rights I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of medical services I receive from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, Insurance reimbursement and any applicable remedies.

I understand that I remain personally responsible for the total amount due to **Shell Chiropractic LLC** for their services. This Agreement does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payments and will reimburse **Shell Chiropractic LLC** for all costs of such collection efforts, including but not limited to, all court costs and all attorney fees.

This agreement shall not be modified or revoked without the mutual written consent of **Shell Chiropractic LLC** and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interest of **Shell Chiropractic LLC** and myself. However, should any provision of this Agreement 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 Agreement shall, nevertheless remain in full force and effect.

Patient Name (please print)_____ **Patient Signature:** _____ **Date:**_____

Parent/Guardian (print)_____ **Parent/Guardian (signature):**_____

HIPPA INFORMATION AND CONSENT FORM

The health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for you care. Patient files may be stored in open file racks and not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other that staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means of convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, and delete or modify and of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to confirm to your request.

I acknowledge that I have received and have been informed of the above information.

Patient Name (print): _____

Patient Signature: _____ **Date:** _____

INFORMED CONSENT FORM

I (WE) hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on_____ by Shell Chiropractic and/or other licensed doctors of chiropractic who may be employed by or engaged in practice in this clinic.

I have had the opportunity to discuss with the doctor or other clinic professional the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science, and that my care may involve the making of judgments based upon the facts known to the doctor to be able to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no guarantee as to results has been made to nor replied upon by me, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care including, but not limited to, fractures, disc injuries, strokes, dislocations, and strains/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read or have had explained to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below agree and intend this content form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

_____ _____ _____

Patient's Name (PRINT) **Patient's Signature** **Date**

_____ _____

WITNESS **Relationship if not signed by patient**

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Request to Release Medical Records

Date: _____

Patient Name: _____

SSN#: _____

Date of Birth: _____

By signing my name below, I am requesting that copies of:

( ) All medical records be sent to _____

( ) Medical records be given to _____

( ) X-rays be released or emailed to me or _____

( ) All my records and/or X-rays be sent from _____

To Shell Chiropractic

Signature: _____

Parent/Legal Guardian: _____

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CONSENT TO TREATMENT OF A MINOR

I hereby authorize Dr. _____

and whomever he may designate as assistants

to administer chiropractic care as deemed necessary to my

_____ (indicate relationship of child)

_____ (name of child).

DATED: _____.

SIGNED: _____

WITNESSED: _____