FITZPATRICK CHIROPRACTIC CLINIC

New Patient Information

CONFIDENTIAL PATIENT INFORMATION   Date: ____/____/____

Full Legal Name: ______________________________

Date of Birth: ______________________ SS#: ______________________

Sex: Male or Female

Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Phone Number (home): ______________ Phone Number (cell): ______________

Email Address (optional): ______________________________

Marital Status (circle one): Single Married Widowed Divorced Legally Separated

Significant other's Name: ______________ Phone Number: ______________

Please initial next to the name above if we are allowed to speak with them about your information, appointment times, etc.

Emergency Contact Name: ______________ Phone Number: ______________

Primary Care Physician Name: ______________ Phone Number: ______________

WE NEED A COPY OF YOUR DRIVERS LICENSE

Medicare Patients: Please give the Front Desk your MEDICARE CARD and SECONDARY INSURANCE CARD.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

If a payment plan is necessary please speak with receptionist and we will gladly help you!

DURING YOUR APPOINTMENT WE KINDLY REQUEST THAT YOU REFRAIN FOR CELL PHONE USE

Patient Signature: ______________________________

FITZPATRICK CHIROPRACTIC CLINIC

Patient History

Name: Date: / /

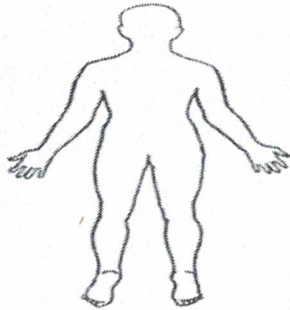
Reason for today's visit:

What DATE did this episode begin:

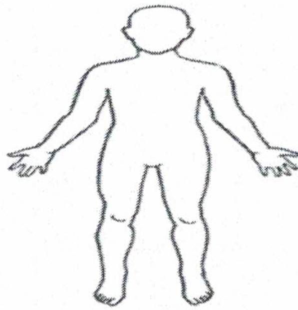
Have you had any X-Rays, MRI and/or CT Scans for this problem (please list ordering doctor and test):

What medication are you currently taking for this problem:

Please indicate your problem area(s) below. Feel free to explain the PAIN your experiencing (sharp/dull).



Back



Front

Surgeries/Date(s):

Hospitalizations/Date(s):

Below, if you answer YES, please describe how many/much for each question.

Exercise? Smoke?

Alcohol beverages? Sleep less than 8 hours?

Stressful demanding job? Stressful life outside of work?

WOMEN: Is there a chance you COULD be pregnant? Weeks?

Please list ANY condition, disease, health problems etc., you or parent/grandparent have/had:

FITZPATRICK CHIROPRACTIC CLINIC

LaGrange Chiropractic Clinic

250 East Colorado, LaGrange, Texas 78945

(979)968-3340 * (866) 827-3093 Fax

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 Michael D. Fitzpatrick, DC, 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

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 owed 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 La Grange Chiropractic Clinic and send to 250 E. Colorado St. /PO BOX 566, La Grange, TX 78945.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue separate draft to pay in full all services rendered, payable directly to La Grange Chiropractic Clinic and to send any and all checks to 250 E. Colorado St. /PO BOX 566, La Grange, TX 78945.

STATUTE OF LIMITAIONS: 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.

Signature of Patient and/or Responsible Parties: ______________________________ Date________________

FITZPATRICK CHIROPRACTIC CLINIC

La Grange Chiropractic Clinic, PA

250 East Colorado, La Grange, Texas, 78945 (979) 968-3340

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by **La Grange Chiropractic, PA** or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. ______Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affect

By my signature below I give my permission to use and disclose my health information.

______________________________ ______________

Patient or Legally Authorized Individual Signature   Date

______________________________ ______________

Print Patient's Full Name   Time

______________________________ ______________

Witness Signature   Date

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250 East Colorado Street, LaGrange, Texas 78945

(979) 968-3340 * (866) 827-3093 Fax

REQUEST FOR RECORDS

DATE________________

KNOW ALL MEN BY THESE PRESENTS: That I, ____

have request the release of ____

which are a part of the office records of ____

relating to my case. In consideration of the forgoing, I hereby release and forever discharge the

aforesaid ____ from any and all responsibility or liability

of any kind, nature, or character whatsoever from the beginning of the world to this day. This

transaction is consummated at my specific request.

PATIENT: ____

DOB: ________________________________

WITNESS: ____

Michael D. Fitzpatrick, D.C.