United Chiropractic™

Dr. Hollis Helms
P.O. Box 700867
San Antonio, TX 78270-0867
(210) 490-3555

"The Most Trusted Name in Chiropractic"

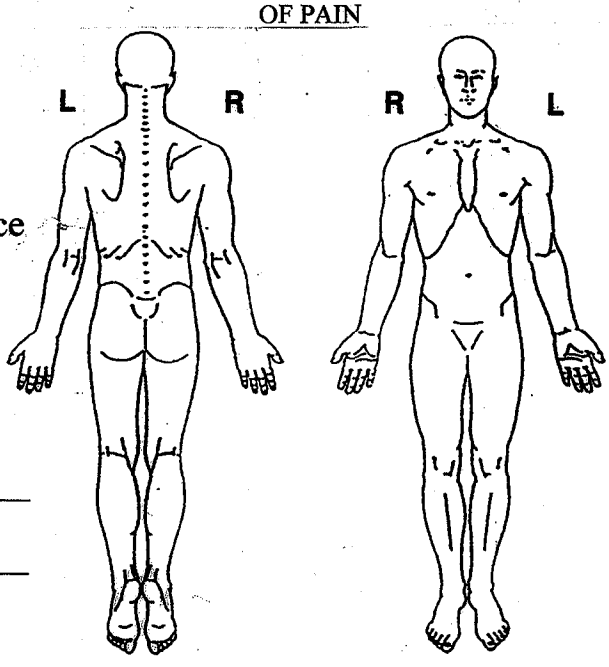
Name_____
Street Address _____
City_____ State_____ Zip_____
Hm Phone _____Wk Phone _____Cell #_____
Employer/Occupation _____
Date of Birth _____Social Security number_____
Martial Status: Married __Widowed __Separated __Divorced __Single__
Spouse Name _____ Employer _____
Children _____ Ages _____
Name of Nearest Relative _____
E-Mail Address _____

Patient's Statement of Problem_____
_____
_____
What condition is related to__Employment __Auto Accident __Other
Date Condition began_____
Have you ever had same or similar symptoms? __Yes __No
Lost work time? __Yes __No If yes, date you returned to work_____
Were you referred by another physician? __Yes __No
Have you seen another doctor for this condition? __Yes __No
Describe_____
Are you pregnant? __Yes __No
What medications are you currently taking?
_____
Referred By_____
Insurance Information:
__Major Medical __Medicare __No Insurance
__Auto Accident __Workers Compensation

I understand and agree to authorize United Chiropractic employees to administer examinations, procedures, and treatments as they deem necessary.

Patients Signature_____ Date_____
Guardian or Spouse
Authorizing Care_____Date_____

PLEASE MARK ALL AREAS OF PAIN



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NAME:_____

DATE:_____

I, _____, in signing this form, state to the best of my knowledge, there is no pregnancy, confirmed or suspected at this time.

_____
Patients Signature

_____
Witness Signature

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STATEMENT OF PAYMENT POLICY

HEALTH INSURANCE / GROUP INSURANCE

We will file your insurance claims for you and wait for your insurance company's payment. You will only be responsible for any unpaid deductible and co-payments (percentage not covered by your policy).

Most insurance companies cover chiropractic care including x-rays, examinations, and treatments. After a thorough consultation and spinal examination, the doctor will inform you of the necessary diagnostic procedures for your case.

After your insurance has been verified, you will only be required to pay the uninsured portion. Please present a copy of your insurance card to the front desk person.

Please note, most insurance policies do not cover supplements or supports (i.e. braces, collars, ice packs or hot packs) and payment for these items is expected at time of issuance.

If we can answer any questions concerning your insurance coverage, please do not hesitate to ask.

I have read the payment policy of United Chiropractic and fully understand the need for me to cooperate with supplying all necessary information regarding my claim for benefits.

Patient's Signature _____ **Date** _____

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PARTIAL ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LEIN AND TREATMENT AGREEMENT

Consideration. In order to facilitate the ability of the office to collect its charges from various payers and thereby to enhance the patient-provider relationship, I, the undersigned, as consideration for the office's services, agree to the following and direct all payers as follows:

Partial Assignment of the Cause of Action, Assignment of Proceeds and Contractual Lien. I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to the office, as well as any and all causes of action that I might have now or in the future against any payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the office's name, and the right to settle or otherwise resolve such causes of action as the office sees fit. I further assign my right to receive any proceeds from any payer to the office and further grant a contractual lien to the office with respect to my charges. I understand that these assignments of rights and contractual lien may effectuate, automatically or otherwise, a secured interest under the applicable Uniform Commercial Code. I intend for this agreement to effectuate such a lien and hereby authorize the office to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such a lien. Except as provided herein, nothing in this agreement shall be construed as an election or waiver by the office to a secured interest under any other statutory lien law. Consistent with these rights, I hereby direct any and all payers, to pay the proceeds directly and immediately to, and exclusively in the name of, the office in the amount of my charges.

Other Terms. I understand that I remain personally responsible for my charges. Consistent with law or contract, I agree to pay the full amount of my charges to the office upon its demand. Unless mutually agreed to in writing, the receipt and processing of partial payments by the office shall not constitute a waiver of the office's right to receive payment in full upon demand and shall not constitute an accord and satisfaction of my charges, irrespective of any restrictions indicated on any payments. I understand that at anytime, I can request a copy of my total charges. I hereby waive any statute of limitations which may apply to the collection of my charges.

In the event that I retain one or more attorneys to assist me in collecting any proceeds, I direct each attorney to issue an irrevocable letter of protection to the office regarding my charges. I further direct (and the office hereby requests) each attorney to provide immediate notice to the office regarding any proceeds received by the attorney, to promptly pay the office in full out of such proceeds, and to provide a full accounting of such proceeds to the office.

I authorize and direct the office to submit my charges to any and all payers including, without limit, my health benefit plan. I understand, however, that in the event that my charges are submitted to more than one payer, I hereby authorize and direct the office to apply any proceeds received from one payer to any reductions, write-offs, or discounts, issued by another.

I authorize the office to endorse or sign my name on any and all checks listing me as payee which are received by the office for payment of charges incurred by me, my spouse or my dependents. I further authorize the office to apply any credit balances on my charges 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.

This agreement shall not be modified or revoked without the mutual written consent of the office and myself. I hereby revoke the terms of any previously signed documents to the extent those terms conflict with the terms of this agreement.

This agreement shall be governed under the laws of the state where the office is located and performable in the county where the office is located. I hereby consent to personal jurisdiction and venue of any court in the said county and waive all objections based on improper jurisdiction, venue, or forum non-convenience.

I agree that each and every provision of this agreement is reasonably necessary for the protection of the rights and interests of the office and me. 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.

Definitions. For the purpose of this agreement, the following terms shall have the following meaning: "office" shall refer to Thousand Oaks United Chiropractic located at 2235 Thousand Oaks, Suite 111. "Payer" shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at fault party, tortsfeasor, individual, and any other entity, which may elect or be obligated to payer disburse proceeds to me, either now or in the future, for any reason; "proceeds" shall include, without limit the proceeds from any settlement, judgment or verdict, the proceeds from any promise to payer reimburse, and the proceeds relating to the following benefits, plans or coverage's; individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; "charges" shall include, without limit, the full fees for the office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, depositions, and testimony) any collection costs incurred by the office, 18% interest on outstanding charges, and any other charges incurred by me at the office; "collection costs" shall include, without limit, any pre-and post judgment court costs, filing fees, service of process charges, attorney fees, and any other costs of collection incurred by the office in any effort or action to collect my charges either from me or my payer.

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

Name of Custodial Parent or Legal Guardian, on behalf of the patient
(Please print) _____
Parent/Guardian Signature _____ Date _____