United Chiropractic™

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

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

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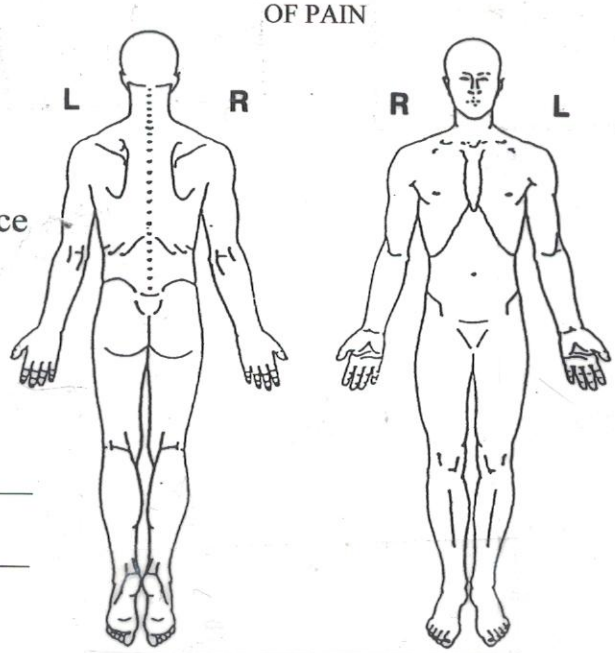
Name_____
Street Address _____
City_____ State_____ Zip_____
Hm Phone _____Wk Phone _____Cell #_____
Employer/Occupation _____
Date of Birth _____Social Security number_____
Martial Status: Married __Widowed __Separated __Divorced __Single__
Spouse Name _____ Employer _____
Children _____ Ages _____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



HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years.

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 our office services. HIPAA 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 your 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 than 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, e-mail, U.S. mail, or by any means 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 HIPAA.
4) You understand and agree to inspections of the office and review of documents which may include your 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, delete or modify any 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 within the office concerning your PHI. However, we are not obligated to alter internal policies to conform your request.

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

_____ Date: _____

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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** _____

ASSIGNMENT, UCC LIEN, AND AUTHORIZATION

FOR DIRECT PAYMENTS BY MY PAYERS TO Thousand Oaks United Chiropractic

PURPOSE AND CONSIDERATION; TERMS WHICH PAYERS MAY BE REQUIRING. The purpose of this Assignment & UCC Lien is to assist the Office and any duly-authorized A/R management agent of the Office in obtaining Proceeds from various Payers (including without limit my Attorney) for the payment of my Charges. In consideration for receiving / continuing health care at the Office based on terms which Payers may be requiring, as well as on terms set forth in various documents of the Office, I agree to the following and direct all Payers as follows:

DEFINITIONS. In this Assignment & UCC Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to Thousand Oaks United Chiropractic your formal corporate name followed by any fictitious / assumed names you may be using] located at 2235 Thousand Oaks Ste 111, San Antonio, TX 78232; "Assignment & UCC Lien Document," "Assignment & UCC Lien," "Assignment & Lien," and other like phrases shall refer to this document. "Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, adjuster, claims handler, medical examiner, individual reviewer or review entity, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds, either now or in the future, or which may be involved directly or indirectly in determining the obligation to pay or disburse Proceeds, either now or in the future; "Proceeds" shall include without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, the proceeds relating to "health-care-insurance receivables" and "payment intangibles" as such are defined by the applicable Uniform Commercial Code, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare and Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical expense or payments benefits ("Medpay"), personal injury protection ("PIP"), lost wages, lost services, property damage, errors & omissions, and malpractice; "Charges" shall include without limit the full fees for the Office's goods and services (including without limit treatment, diagnostic services, medical equipment, supplies, supplements, narrative reports, photocopies, pre-authorization requests, no-shows, depositions, and testimony), whether rendered before or after the date of this Assignment & UCC Lien, any Additional Costs incurred by the Office as defined herein, delinquency penalties and interest to the maximum extent permitted under law or at the annual rate of eighteen percent (18%), whichever is greater, and any other charges incurred by me at the Office; "Additional Costs" shall include without limit any costs incurred by the Office relating directly or indirectly to (i) the goods or services associated with my Charges, (ii) this Assignment & UCC Lien, (iii) the application or enforcement of any law relating to the issue of the Office's Charges, secured interests or its goods and services, (iv) any effort or action to collect my Charges either from me or from any Payer, or (v) any legal or medico-legal action, process, or claim of any nature against, or by, the Office or its employees for any reason relating to the foregoing items, (i)-(iv), of the previous clause ("Medico-Legal Process"). "Additional Costs shall further include without limit an hourly fee of $500.00 for our Office's administrative staff time, as well as an hourly fee of $500.00 for any lost-time at work by any treating or diagnosing health care provider employed by or contracted with our Office, relating to any of the foregoing items, as well as a fee of $500.00 for any failure on my part to provide to the Office, within five (5) days of the Office's request, any information required to be disclosed under this Agreement. "Medico-Legal Process" shall include without limit civil and administrative proceedings, mediation, arbitration, interpleader actions, cross-claims or counterclaims, requests for reconsideration, independent reviews, and internal appeals. Costs associated with such Medico-Legal Processes shall also include without limit any pre- and post-judgment costs, filing fees, service of process charges, and attorney's fees. In determining the Office's Charges, I hereby waive any defense or argument that such costs shall not apply or be awarded based on the claim that the Office's goods or services were somehow (i) not sufficiently necessary or effective, related to an accident, documented or otherwise warranted, or (ii) inappropriately directed, delivered, conducted or administered.

ASSIGNMENT AND UCC LIEN TERMS; AUTOMATIC RE-EXECUTION AND RE-AFFIRMATION. (i) Assignment Terms: I hereby assign to the Office to the extent permitted by law, but only to the extent of my Charges, all of my claims to, rights to, and interests in, Proceeds, whether resolved or unresolved, including without limit ownership rights, which I may have now or in the future relating directly or indirectly to my Charges, condition, or causes of my condition ("Claims to Proceeds"), including without limit any and all causes of action, receivables, payment intangibles, and remedies that I might have against or with respect to any Payer now or in the future, and the right to prosecute, seek, settle, or otherwise resolve such Claims to Proceeds either in my name or in the Office's name and as the Office otherwise sees fit. I agree that this assignment shall be effective as of the date and time the initial cause of my condition occurred. (ii) UCC Lien Terms: I further intend for this Assignment & UCC Lien to create a security interest under the applicable Uniform Commercial Code; accordingly, I hereby grant to the Office a primary, non-contingent security interest in all of my Claims to Proceeds to the extent permitted by law for the purpose of securing payment of my Charges ("UCC Lien"), the attachment and perfection of which shall relate back to, and be effective as of, the date and time that the initial cause of my condition occurred; I further authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency relating to such security interests, and to make such filings in all relevant jurisdictions as the Office sees fit in its sole discretion; I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my agreement with the Office, such security interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Service Certified Mail. (iii) Other Assignment and UCC Lien Terms: Consistent with the foregoing terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the full extent of my Charges. To the extent that any law, including without limit a lien statute, purports to limit, reduce, or modify the distribution of Proceeds in any manner inconsistent with this Assignment & UCC Lien including without limit through the reservation of a portion of the Proceeds exclusively to me, I hereby waive such limits, reductions, or modifications. Such waiver shall not adversely affect or prejudice any rights which the Office may have and elect to exercise under said law. I agree that following the original execution of this Agreement, the Office shall be entitled at any time hereafter to request that I re-execute and re-affirm an identical version of this Agreement, such as in cases where additional causes of action may have arisen. In the event that the Office presents an identical version of this Agreement, along with a request for payment of the Office's Charges or for any additional information required to be disclosed under this Agreement, and I fail to promptly provide such payment or information within five (5) days of such request, this Agreement shall be deemed to be automatically re-executed and re-affirmed by me effective as of the date of the request. I hereby waive any defense, reasonable or unreasonable, and regardless of any action by the Office which I claim to be inconsistent with the terms herein that such actions on my part shall not constitute a re-execution and re-affirmation of this Agreement.

SPECIFIC DIRECTION TO ANY ATTORNEY I RETAIN, SUCH AS IN ACCIDENT CASES. In the event that I retain one or more attorneys relating to my Claims to Proceeds, I hereby direct (and the Office hereby requests) each attorney to review the terms of this Assignment & UCC Lien, including without limit the fact that I may become responsible for various costs arising hereunder. Accordingly, I respectfully request that each attorney not unilaterally assume to arbitrate potential disputes relating to this Assignment & UCC Lien. I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office and to any duly-authorized A/R management agent of 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 and to any duly-authorized A/R management agent of the Office. I agree that the purpose of such Proceeds shall be primarily to pay my Charges. If I have a dispute with the Office, attorney, or any other party for any reason, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the Office for any portion of the Charges. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney's fees and costs, or other expenses of obtaining Proceeds.

DISCLOSURE DIRECTIVES TO ALL PAYERS. I hereby direct each and every Payer to immediately release to the Office and to any duly-authorized A/R management agent of the Office any Pertinent Information relating to (a) any coverage I may have and (b) any Proceeds Determination by the Payer relating to the Office's Charges. "Pertinent Information" shall include without limit the amount of total coverage available and remaining, the amount of any outstanding claims which the Payer has received from any claimant relating to my condition, and the terms of any resolution or settlement of my Charges by the Payer. "Pertinent Information" shall also include without limit copies of all documents, records, settlement agreements, and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, settle, reduce, deny, or delay payment of any Proceeds relating to the Office's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or for me by the Office to all Payers, including without limit a copy of my Charges and a copy of this Assignment & UCC Lien, unless otherwise agreed to in writing.

DISCLAIMERS. I UNDERSTAND THAT THE OFFICE MAY RETAIN THE SERVICES OF AN A/R MANAGEMENT AGENT TO ASSIST THE OFFICE IN MANAGING ITS PERSONAL INJURY ACCOUNT RELATING TO MY CHARGES. I UNDERSTAND THAT THE OFFICE AND/OR A/R MANAGEMENT AGENT MAY HAVE NEED FROM TIME TO TIME TO CONTACT ME REGARDING MY CHARGES AND THE MANAGEMENT OF MY ACCOUNT WITH THE OFFICE. I UNDERSTAND AND AGREE THAT NOTHING IN THIS ASSIGNMENT & UCC LIEN, OR ANY INTERACTION I MAY HAVE EITHER WITH THE OFFICE AND/OR A/R MANAGEMENT AGENT, OR ANY INTERACTION BETWEEN SUCH ENTITIES AND ANY PAYER, SHALL CONSTITUTE LEGAL ADVICE OR ESTABLISH AN ATTORNEY-CLIENT RELATIONSHIP. I UNDERSTAND THAT ALL SUCH INTERACTIONS, TO THE EXTENT THEY OCCUR, SHALL BE FOR THE PURPOSES OF HELPING THE OFFICE AND/OR A/R MANAGEMENT AGENT TO MANAGE THE OFFICE'S PERSONAL INJURY ACCOUNT EXCLUSIVELY FOR THE BENEFIT OF THE OFFICE, AND SHALL NOT BE CONSTRUED AS BEING PROVIDED FOR THE BENEFIT OF HELPING ME TO SETTLE ANY CAUSES OF ACTION I MAY HAVE AGAINST ANY ENTITY OR INDIVIDUAL. I UNDERSTAND AND AGREE THAT IF I HAVE QUESTIONS OF A LEGAL NATURE, I WILL SPEAK WITH AN ATTORNEY AT LAW.

MISCELLANEOUS. Except as provided in this paragraph, this Assignment & UCC Lien shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment & UCC Lien. I agree that each and every provision of this Assignment & UCC Lien is reasonably necessary. However, should any provision of this Assignment & UCC Lien 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 Assignment & UCC Lien shall, nevertheless, remain in full force and effect. I agree to indemnify and hold the Office harmless for Charges, including without limit any Additional Costs as defined herein. In the event that I file for bankruptcy, I waive any objection to the Office proceeding after any Payer for receiving reimbursement of the Office's Charges. This Assignment & UCC Lien shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment & UCC Lien, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment & UCC Lien.

I have read, understood, and agree to the terms of this Assignment & UCC Lien.

Patient Name (print): _____

Patient Signature: _____ Date: ___/___/_____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print):_____

Parent/Guardian Signature: _____ Date: ___/___/_____

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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