VILLAGE CHIROPRACTIC and medical massage Rx
INSURANCE COVERED

RECLAIM
PHYSICIANS MEDICAL GROUP

PATIENT INFO

Name: _____
(LAST) (MI) (FIRST)

Address: _____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

DOB: / / Soc. Sec # : - -

Driver's License #: _____ State: _____

Marital Status: S M W Spouse's Name: _____

Your Employer: _____ Occupation: _____

Employer Address: _____
(STREET) (CITY) (STATE) (ZIP)

How did you hear about the office: _____

Primary Care Physician: _____

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name: _____

Member #: _____ Group #: _____

Insurer's Name (If Different From Patient): _____ Relationship to Patient: _____

Insurer's DOB: / / Insurer's Soc. Sec #: - -

Insurer's Employer: _____

Person responsible for account: _____

I clearly understand and agree that all services rendered to 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 be immediately due and payable.

Patient/Guardian Signature **Date:**

_____ _____

Office use only

FAB5 FAB4 SELF MVA **Ded:**_____
DME: _____ **Inj: Yes / No / Ded**
Verified: _____

MVA INTAKE

Date of Accident: _____ **Time of Accident:**_____ **AM/PM**

Please describe the accident in you own words: _____
_____
_____

Were you the: ☐Driver ☐Front Passenger ☐L/R Rear Passenger ☐Pedestrian

How many people were in the accident vehicle? _____

Did the police come to the accident site? ☐Yes ☐No Were there any witnesses? ☐Yes ☐No

Was a police report filed? ☐Yes ☐No

Accident Site:

Road/Street Name: _____
Driving Conditions: ☐Dry ☐Wet ☐Icy
☐Other:_____
Which direction were you headed? _____
Speed you were traveling: _____

Vehicle Information:

Make/Model of your vehicle: _____
Seatbelt: ☐Yes ☐No
Was vehicle equipped with airbags? ☐Yes ☐No
Did they inflate properly? ☐Yes ☐No
Did your seat have a headrest? ☐Yes ☐No
If yes, what was the position?
☐Low ☐Midposition ☐High

Other Vehicle:

Make/Model of other vehicle: _____
Which direction was the other vehicle heading?
_____
Speed other vehicle traveling: _____

Impact:

Did your car impact another vehicle? ☐Yes ☐No
Did your car impact another structure? ☐Yes ☐No
If yes to either, please explain: _____
_____
Did any part of your body strike anything in the vehicle?
If yes, please explain: _____
_____
Was impact from: ☐Front ☐Rear ☐Left ☐Right
At the time of impact were you looking:
☐To the Left ☐To the Right
☐Down ☐Up
☐Straight Ahead

Were both hands on the steering wheel? ☐Yes ☐No
If no, which hand was on the wheel? ☐Left ☐Right
Was your foot on the brake? If yes, which foot?
☐Yes ☐No
☐Left ☐Right
Were you:
☐Surprised by Impact
☐Braced for Impact

Patient Condition & Treatment:

Were you unconscious immediately after the accident? ☐Yes ☐No If yes, for how long: _____
Please describe how you felt immediately after the accident: _____
_____
Did you go to the hospital? ☐Yes ☐No
When did you go? ☐Immediately ☐Next Day ☐2 Days or more after accident
How did you get to the hospital? ☐Ambulance ☐Private Transportation
Name of Hospital: _____ Name of Doctor: _____
Diagnosis:_____
_____
Treatment Received: _____
X-rays Taken: _____

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2430 FM 407 Suite B * Highland Village, TX 75077

Personal Injury Protection - PIP
Liability Information

Patient Name: _____

Date of Injury: _____

PIP

Insurance Carrier: _____

Address: _____

Adjuster's Name: _____

Adjuster's Phone #: _____

Insured: _____

Claim #: _____

Liability

Insurance Carrier: _____

Address: _____

Adjuster's Name: _____

Adjuster's Phone #: _____

Insured: _____

Claim #: _____

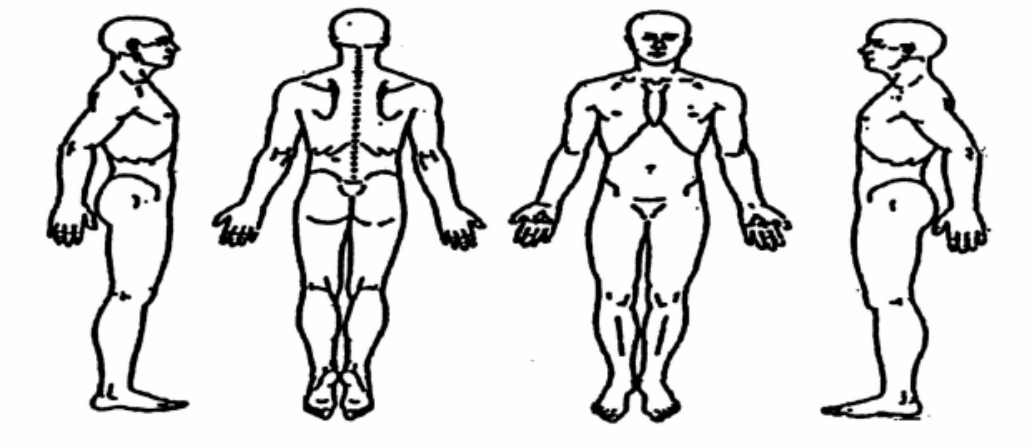
Do you have an Attorney? Yes / No

Name of Attorney: _____

Contact Name: _____

Phone #: _____

1. Indicate on the drawings below where you have pain/symptoms



2. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

3. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

4. Do you have numbness, tingling, or pain in your arms or legs? Yes/No

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other: _____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

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13. Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than ½ the days	Nearly every day
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**

14. What aggravates your problem?

_____

15. What alleviates your problem?

_____

16. Females only: When was your last Menstrual period? _____

17. What is your: Height_____ **Weight** _____ **Date of Birth** _____
Occupation_____

18. Have you had labs done recently (within last 6 months)? □ Yes □ No
If "Yes", when?_____

18a. Have you ever been told you had diabetes or a problem with blood sugar? Yes/No

19. For each of the conditions listed below, place a check in the "Past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "Present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	Kidney Disorders	□	□	**Gastric reflux**
□	□	Neck Pain	□	□	Bladder Infection	□	□	**Irritable Bowel**
□	□	Upper Back Pain	□	□	Painful Urination			**Syndrome/IBS**
□	□	Mid-Back Pain	□	□	Loss of Bladder Control	□	□	**Neuropathy**
□	□	Low Back Pain	□	□	Abnormal Weight Loss	□	□	**Weakness**
□	□	Shoulder Pain	□	□	***Abnormal Weight Gain***	□	□	**Fibromyalgia**
□	□	Elbow/Upper Arm	□	□	Loss of Appetite	□	□	**Gout**
□	□	Wrist Pain	□	□	**Abdominal Pain**	□	□	**Sleep apnea**
□	□	Hand Pain	□	□	**Ulcer**	□	□	**Snoring**
□	□	Hip Pain	□	□	Hepatitis	□	□	**Shortness of breath**
□	□	Upper Leg Pain	□	□	**Gall Bladder Disorder**	□	□	**Palpitations**
□	□	Knee Pain	□	□	Liver	□	□	**Heart arrhythmia**
□	□	Ankle/Foot Pain	□	□	***General Fatigue***	□	□	**Anxiety**
□	□	Jaw Pain	□	□	Muscular Incoordination	□	□	***Sexual dysfunction***
□	□	Joint Pain/Stiffness	□	□	Visual Disturbances	□	□	**Itching**
□	□	Arthritis	□	□	**Dizziness**	□	□	**Psoriasis**
□	□	Rheum. Arthritis	□	□	**Diabetes**	□	□	***Hyperthyroid***
□	□	Cancer	□	□	**Excessive Thirst**	□	□	***Hypothyroid***
□	□	Tumor	□	□	**Frequent Urination**			
□	□	Asthma	□	□	Smoking/Tobacco Use	**For Males Only**		
□	□	**Chronic Sinusitis**	□	□	Drug/Alcohol Dependence	□	□	**Prostate**
□	□	**Other Breathing**	□	□	Allergies	□	□	***Low – T***
		Abnormalities	□	□	**Depression**	□	□	***ED***
□	□	**Dermatitis**	□	□	Systemic Lupus			
□	□	**Rash**	□	□	Epilepsy	**For Females Only**		
□	□	Eczema	□	□	HIV/AIDS	□	□	*Birth Control Pills*
□	□	**High Blood Pressure**	□	□	**Anemia**	□	□	***Hot flashes***
□	□	**Heart Attack**	□	□	**Vitamin D Deficiency**	□	□	***Polycystic ovarian disease***
□	□	**Chest Pains**	□	□	**Metabolic syndrome**	□	□	***Infertility***
□	□	**Stroke**			**pre-diabetic**	□	□	***Painful periods***
□	□	**Angina**	□	□	**Bariatric surgery**	□	□	**Hormonal Replacement**
□	□	Kidney Stones	□	□	***Sleep Disturbances***	□	□	Pregnancy
					Mood changes			

Other:_____

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20. List all prescription medications you are currently taking:

_____
_____
_____

21. List all of the over-the-counter medications you are currently taking:

_____
_____
_____

22. List all Allergies (medications, food, seasonal, etc.) you may have:

_____
_____
_____

23. List all surgical procedures you have had:

_____
_____
_____

24. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

25. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

26. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

27. What activities do you do outside of work? _____

28. What concerns you the most about your problem; what does it prevent you from doing?

_____

29. Have you ever been hospitalized? □ Yes □ No

If Yes, why? _____

30. Indicate if you have any immediate family members with any of the following (Please indicate the relationship to you):

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer (see add. Forms) □ ALS
□ Other: _____

31. Have you had any past injuries or trauma, such as car accidents (ever?), falls, sports injuries, etc.?

□ Yes □ No If "Yes", please provide details:

_____
_____

32. Is there anything else you wish to let us know about you visit today? □ Yes □ No

If "Yes", please provide details:

_____
_____

Patient Signature_____ **Date:** _____

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Insurance Verification Disclosure/Agreement

As a courtesy, Village Chiropractic & Reclaim Physicians Medical will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Office Manager _____ Date _____

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Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the physician's hands or with the use of a machine. Frequently, adjustments create a "popping" or "clicking" sound/sensation in the areas being treated.

In this office, we use trained assistants who may assist the physician with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. On the occasion when your physician is unavailable, your care may be handled by another physician or trained assistant.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The chiropractic adjustment that is related to the vertebral artery stroke is called Extension-Rotation-Thrust Atlas Adjustment. We DO NOT use this type of adjustments on our patients. Other type of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractic would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disk Herniations: Disk herniations that create pressure on a spinal nerve or the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustment, traction, etc. This includes both in the neck and back. Yet, occasionally, chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely, surgery may cause a disk problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment (or treatment) may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or mid-back. They extend from your back to your front chest area. Rarely, a chiropractic adjustment will crack a rib bone and this is referred to as a fracture. This occurs only on patients who have weakened bones from conditions such as osteoporosis. Osteoporosis can be detected on your x-rays. We adjust all patients very

carefully, and especially with those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform your physician.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always provide you with the best care and if results are not acceptable, we will refer you to another health care provider who we feel may assist your condition.

If you have any questions on the above information, please ask your physician. Once you have a full understanding, please sign and date below.

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Secondary Number: _____

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Witnessed By _____ Date _____

Assignment of Benefits

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, grants and conveys for deferred payment to Reclaim Physicians Medical Group, a lien and assignment against the proceeds of the patient's insurance settlement 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 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 Reclaim Physicians Medical Group, and to 913 S. Main St., Unit 212, Grapevine, TX 76051.

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 Functional Medicine of Irving, and to send any and all checks to 913 S. Main St., Unit 212, Grapevine, TX 76051

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.

By my signature be it known that I have read and fully understand the above contract.

Patient Name (Printed) _____Date _____

Patient Signature _____

Parent/Guardian Signature _____

Office Manager_____Date _____

HIPAA Disclosure

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

All Patient Medical Records

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

Village Chiropractic

Personal Representative

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I hereby authorize the request and release of PHI held by Village Chiropractic to the above personal representative. By appointing the person named on this form as a personal representative, I understand that I am authorizing Village Chiropractic to give this person access to PHI, the right to talk to Village Chiropractic about medical care, and the right to make decisions that will bind me.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize Office Manager to use my protected information for the listed reasons.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Office Manager _____ Date _____

Medical Massage Policy Changes

Our facility is a medical massage clinic and has to be compliant with policies and guidelines of medical necessity. One stipulation is that treatment is directed by a Doctor. This will require our massage patients to see a chiropractor or the nurse practitioner at least once every 30 days to stay compliant. This applies to all patients regardless of being selfpay, insurance, MVA, etc. This can occur during your normally scheduled visits downstairs or at your convenience prior to a massage.

Massage Cancellation Policy

In order to better accommodate our growing number of patients in need of massage therapy, we encourage patients with an appointment who need to reschedule to give us as much advance notice as possible.

Less than a 24 hour notice is considered a no-show.

Beginning February 2017, we will be implementing a cancellation fee for no-show massage appointments. This is not something we do lightly and will only be used in extreme cases. We will always allow 3 grace cancellations or no-show appointments before we audit your account and make the decision to charge a $35 fee to the account. We do understand uncontrollable things in life do happen.

If we see that cancellations are a problem we reserve the right to ask for prepayment of massage or we may ask to put a credit card number on your account to charge a no-show fee if necessary.

Please remember to cancel or reschedule your massage appointment with at least 24 hours notice.

Thank you,
Village Chiropractic,

_____ _____

Patient Printed Name Patient Signature

_____

Date

FINANCIAL POLICY

Please initial next to each section indicating your acknowledgement:

_____All current balances, co-payments, co-insurance and deductibles are **due and payable PRIOR to services** being rendered and is required by your insurance to be paid at each visit. We accept cash, check, VISA, MasterCard, Discover, and American Express. We do not accept post-dated checks.

_____**REFERRALS:** If you have a managed care plan, an HMO, or similar plan that requires a referral, you will need a referral from your primary care physician to see our providers. If your insurance requires a referral that is generated through them, you must reach out to your primary care office for them to call your insurance. It is not our policy to generate a referral for ourselves. **If we have not received this referral prior to your arrival at our office, your appointment will either be rescheduled or you may be responsible for the entire bill. It is your responsibility to know if a referral is required and to obtain one.**

_____**INSURANCE BENEFITS:** Please be aware that when a patient requires a visit to a health care provider, there are diagnostic tests or procedures that may be suggested for appropriate care that may be done by one of our providers. These procedures may be done during the normal course of the exam by specialized personnel. Although necessary as part of routine evaluations, insurance companies often categorize these as procedures. The possible procedures which often are performed in this practice during your visit include, **but are not limited to**:

Trigger Point Injections	B-12 Injections
Autonomic Nervous System Tests	NCV/EMG tests
US guided Injections	Doppler Studies
EKG Evaluations	Joint Injections
PRP/Amnio therapies	Physical Rehabilitation/PT

Depending on your insurance policy provisions, these procedures and others may fall under a separate benefit other than your office co-pay, such as a deductible or coinsurance. In most cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Therefore, any estimate for services will be considered an estimate only and any payment will be considered a partial-payment only until such time that the insurance company processes your claim. Your insurance is a contract between you and your insurance carrier; payment for services is ultimately your responsibility. It is extremely important for you to know your coverage. Many of the diagnostic and therapeutic procedures performed in our office (such as those listed above and others) are considered additional costs by your insurance company. Your health care providers are not aware of what additional costs may be incurred and will not review that with you. As health care providers, our physicians may recommend a diagnostic or therapeutic procedure available only to specialist physicians in order to provide you with the best possible treatment. If you have concerns regarding the cost of any procedure, you may ask your doctor if you can discuss the cost with our business staff BEFORE the procedure is performed to decide if you would like to have it done.

_____**WAIVER OF CONFIDENTIALITY:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment and the type of treatment received at our office may become a matter of public record or disclosed to third parties.

_____ **DIVORCE:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible to us for those subsequent charges.

_____ **TRANSFERRING OF RECORDS:** You will need to request in writing, and pay a reasonable copying fee (currently $25) PRIOR to sending copies of your records to another doctor or organization. You authorize us to include all relevant information, including your payment history and hereby indemnify and hold us harmless for any claims or damages resulting from our providing records pursuant to your request. If you request records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

_____ **PERSONAL INJURY:** If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. Payment of the bill remains the patient's responsibility.

_____ **LIABILITY:** If you are being treated for a 3rd party liability claim and do not have an attorney, we will require that you allow us to bill your health insurance or file on your Personal Injury Protection. Upon settlement of your claim, YOU WILL BE RESPONSIBLE FOR ANY BALANCE OWED ON YOUR ACCOUNT REGARDLESS OF THE AMOUNT OF SETTLEMENT YOU RECEIVE FROM THE INSURANCE COMPANY. Please understand upon settlement of your claim, the 3rd party carrier will NOT PAY US DIRECTLY; however, you remain fully responsible for payment of your account. If you do not have health insurance or PIP, we must have a letter of protection on file from an attorney. Otherwise, you will be responsible for payment in full at the time services are rendered. We have the right, at our sole discretion, to refuse to accept a letter of protection for payment of your services.

_____ **FORMS FEE:** Please allow 5-7 business days to complete all forms that require a physician signature and medical review (i.e., Worker's Comp, FMLA, Short-term disability (STD), other extended leave of absence, etc.) The physician must take the time to fill out the forms and as such may charge for each record requested, a $30.00 Forms Fee. Each time a correction needs to be made to a form, another Forms Fee will be charged to the account. There is no exception to this rule. Additional medical records request will also have a $40.00 assigned fee.

_____ **NO SHOW/CANCELLATION COURTESY:** We are committed to making you an appointment at your earliest convenience; likewise, we require a call at least 24 hours in advance if you are unable to keep your appointment to allow for other patients to be seen. If you "no show" for an appointment or cancel with less than 24 hours' notice, you will be charged a $25.00 fee. Multiple missed appointments may result in our request for you to find another provider.

_____ **RETURNED CHECK FEE:** There is a $35.00 fee for checks returned for any reason and will be added to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

_____ **PATIENT BALANCE POLICY:** After filing with the insurance company, we will promptly mail you a patient statement. Payment in full is due upon receipt of this statement and is a courtesy from our office. If you have any questions or dispute the balance, it is your responsibility to contact our billing office within 30 days. Accounts past 30 days will be considered past due and may be referred to outside resources for further management. If you are unable to pay the balance due in full, you must contact our billing office to discuss a payment schedule or arrangements. Any late fees incurred on past due balances will be included in any mutually agreed upon arrangements.

_____ **BANKRUPTCY:** If we attempt to collect a debt and you have filed for bankruptcy, and we are listed as a creditor, please advise us of this and we will cease collection activity immediately.

Patient Name: _____Date: _____

Parent/Guardian Name: _____

Patient Signature: _____ (Parent/Guardian if minor)