



Date of Accident: \_\_\_\_\_

Time of Accident: \_\_\_\_\_ AM/PM

Please describe the accident in your own words: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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

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:**

1. Road/Street Name: \_\_\_\_\_
2. Driving Conditions:  Dry  Wet  Icy  
 Other: \_\_\_\_\_
3. Which direction were you headed? \_\_\_\_\_
4. Speed you were traveling: \_\_\_\_\_

**VEHICLE INFORMATION:**

1. Make/Model of your vehicle: \_\_\_\_\_
2. Seatbelt:  Yes  No
3. Was vehicle equipped with airbags?  Yes  No  
- Did they inflate properly?  Yes  No
4. Did your seat have a headrest?  Yes  No  
- If yes, what was the position?  
 Low  Mid-position  High

**OTHER VEHICLE:**

1. Make/Model of other vehicle: \_\_\_\_\_
2. Which direction was the other vehicle heading?  
\_\_\_\_\_
3. Speed other vehicle traveling: \_\_\_\_\_

**IMPACT:**

1. Did your car impact another vehicle?  Yes  No
2. Did your car impact another structure?  Yes  No  
If yes to either, please explain: \_\_\_\_\_
3. Did any part of your body strike anything in the vehicle?  
If yes, please explain: \_\_\_\_\_
4. Was impact from:  Front  Rear  Left  Right
5. At the time of impact were you looking:  
 To the Left  To the Right  
 Down  Up  
 Straight Ahead
6. Were both hands on the steering wheel?  Yes  No  
If no, which hand was on the wheel?  Left  Right
7. Was your foot on the brake? If yes, which foot?  
 Yes  No  
 Left  Right
8. Were you:  
 Surprised by Impact  
 Braced for Impact
9. Please describe how you felt immediately after the accident:  
\_\_\_\_\_

**PREVIOUS TREATMENT IF APPLICABLE:**

1. Did you go to the hospital?  Yes  No
2. When did you go?  Immediately  Next Day  2 Days or more after accident
3. How did you get to the hospital?  Ambulance  Private Transportation
4. Were you unconscious immediately after the accident?  Yes  No If yes, how long: \_\_\_\_\_
5. Name of Hospital: \_\_\_\_\_
6. Diagnosis: \_\_\_\_\_
7. Treatment Received: \_\_\_\_\_
8. Radiology Received: \_\_\_\_\_

Front Desk Initials: \_\_\_\_\_

## MVA Insurance Information

PIP (your personal auto insurance)

Insurance Carrier: \_\_\_\_\_  
Address: \_\_\_\_\_  
Adjuster's Name: \_\_\_\_\_  
Adjuster's Phone Number: \_\_\_\_\_  
Email: \_\_\_\_\_  
Insured: \_\_\_\_\_  
Claim Number: \_\_\_\_\_

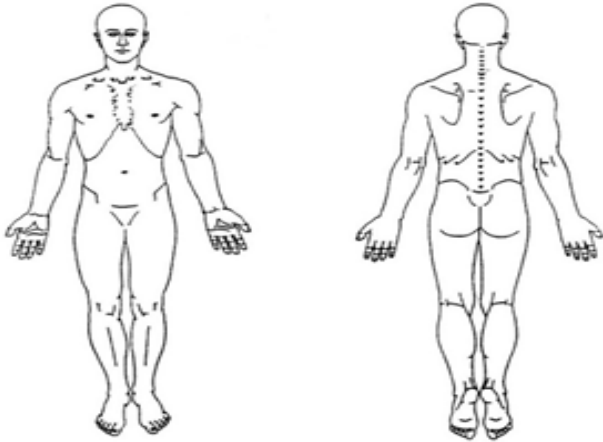
Liability (the auto insurance of the person who hit you)

Insurance Carrier: \_\_\_\_\_  
Address: \_\_\_\_\_  
Adjuster's Name: \_\_\_\_\_  
Adjuster's Phone Number: \_\_\_\_\_  
Email: \_\_\_\_\_  
Insured: \_\_\_\_\_  
Claim Number: \_\_\_\_\_

Front Desk Initials: \_\_\_\_\_

Patient Name: \_\_\_\_\_

1. What are your current complaints: (Please Circle)



2. Describe your symptoms:

- Sharp
- Dull
- Diffused
- Achy
- Burning
- Shooting
- Stiffness
- Prickling
- Itchy
- Numbness
- Tingling
- Throbbing
- Stabbing
- Sharp with Motion
- Shooting with Motion
- Stabbing with Motion
- Electric with Motion

3. How long has the pain been going on? \_\_\_\_\_

**Office Use Only**

HR: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_  
Oxg: \_\_\_\_\_ TEMP: \_\_\_\_\_

**Treatment**

- TX1 – Acute/Symptomatic
- TX2 – Rehab/Repair
- TX3 – Stability/Strength
- TX4 – Restorative/Extended

**NOTES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Frequency: \_\_\_\_\_ X 8 Weeks

Provider Signature: \_\_\_\_\_

Current Dx: \_\_\_\_\_ Onset Date: \_\_\_\_\_

4. How often do you experience symptoms:

- Constant 76-100%
- Frequently 51-75%
- Occasionally 26-50%
- Intermittently 0-25%

5. Are your symptoms getting:

- Worse
- Same
- Better

6. The past **week** my pain has been a (0-10): \_\_\_\_\_

7. How did your problem begin?  
\_\_\_\_\_

8. Has your pain interfered with any of the following normal activities of daily living? (aggravating factors)

- Standing
- Activity
- Laying
- Travel
- Prolonged Standing
- Exercise
- Movement
- Running
- Twisting
- Computer
- Walking
- Sitting
- Lifting
- Work
- Driving
- Stooping/Bending
- Golfing
- Reaching Overhead
- Stress
- Weather Changes
- Working Out
- OTHER: \_\_\_\_\_

9. What alleviates your symptoms: \_\_\_\_\_

10. Review of Systems – Mark all that apply

- Fatigue
- Weight Gain
- Seasonal Allergies
- Muscle Weakness
- Upper Back Pain
- Low Back Pain
- Tingling
- Weight Loss
- Muscle Aches
- Headache
- Neck Pain
- Mid Back Pain
- Numbness
- Abnormal Posture

Front Desk Initials: \_\_\_\_\_

**11. How much has the problem interfered with your work?**

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

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

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

**13. Who else have you seen for your problem?**

- Chiropractor     Neurologist     Primary Care Physician  
 ER physician     Orthopedist     Other: \_\_\_\_\_  
 Massage Therapist     Physical Therapist     No one

**14. Do you consider this problem to be severe?**

- Yes     Yes, at times     No

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

	Not at all	Several Days	More than 1/2 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

**16. Females only: When was your last Menstrual period?** \_\_\_\_\_

**17. What is your:** Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Occupation \_\_\_\_\_

**20. Have you had labs done recently (within last 6 months)?**     Yes     No  
If "Yes", when? \_\_\_\_\_

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

**22. 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.**

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

Other: \_\_\_\_\_

Front Desk Initials: \_\_\_\_\_

23. List all prescription medications you are currently taking:

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

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

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26. List all surgical procedures you have had:

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27. How would you rate your overall Health?

- Excellent     Very Good     Good     Fair     Poor

28. What type of exercise do you do?

- Strenuous     Moderate     Light     None

29. What activities do you do at work?

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Sit:           | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand:         | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone:  | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

30. What activities do you do outside of work? \_\_\_\_\_

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

32. Have you ever been hospitalized?                       Yes     No

If Yes, why? \_\_\_\_\_

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

- |   |  |                                |
|---|--|--------------------------------|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Cancer (see add. Forms) | <input type="checkbox"/> ALS   |
| <input type="checkbox"/> Other: _____         |  |                                |

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

- Yes     No    If "Yes", please provide details:  
\_\_\_\_\_  
\_\_\_\_\_

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

If "Yes", please provide details: \_\_\_\_\_  
\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Front Desk Initials: \_\_\_\_\_

## **Informed Consent**

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

**Stroke:** Stroke is the most serious problem associated with manual therapy and/or chiropractic care. 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 types 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 Herniation:** Disk herniation 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 disc 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. 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 those with 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 in manual therapy and/or chiropractic care, 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 massage therapy 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.

**Patient Name (Printed)** \_\_\_\_\_ Date \_\_\_\_\_

**Patient Signature** \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

**Front Desk Initials:** \_\_\_\_\_

## 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 VRx Medical, 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 VRx Medical at 2430 Justin Rd, Suite B, Highland Village, Tx 75077.

**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.

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_

**Front Desk Initials:** \_\_\_\_\_



# HIPAA Disclosure

## Standard Authorization of Use and Disclosure of Protected Health Information

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:

- VRx Medical, PLLC
- Village Chiropractic & Medical Massage Rx
- Medical Massage Rx
- Medical Massage Rx II

### Personal Representatives and Emergency Contacts:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I hereby authorize the request and release of PHI held by VRx Medical to the above personal representative. By appointing the person named on this form as a personal representative, I understand that I am authorizing VRx Medical to give this person(s) access to PHI, the right to talk to VRx Medical 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 Village Chiropractic & Medical Massage Rx to use my protected information for the listed reasons.

**Patient Name (Printed)** \_\_\_\_\_ Date \_\_\_\_\_

**Patient Signature** \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Front Desk Initials: \_\_\_\_\_

## FINANCIAL POLICY

Please initial next to each section indicating your acknowledgement:

\_\_\_\_\_ **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 responsibility 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. **Depending on your insurance policy provisions, these procedures 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 and processes the claim. Therefore, any estimate for services will be considered an estimate only and any payment will be considered a partial-payment 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 provider to discuss the cost BEFORE the procedure is performed.

\_\_\_\_\_ **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.

\_\_\_\_\_ **MOTOR VEHICLE ACCIDENT:** Our offices only accept personal injury protection claims. As a courtesy to our patients, if you have a personal injury protection claim open and allow VRx Medical to be directly reimbursed we will accept liability insurance for any balance over what your personal injury pays to VRx Medical. VRx Medical does not accept LOP or LIAB only cases. If you have any further questions in regards to motor vehicle accidents please feel free to reach out to our MVA specialist.

\_\_\_\_\_ **TRANSFERRING OF RECORDS:** You will need to request in writing, and pay a copying fee of \$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.

\_\_\_\_\_ **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

Front Desk Initials: \_\_\_\_\_

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. Additional medical records request will also have a \$40.00 assigned fee.

**MESSAGE NO SHOW/CANCELLATION COURTESY:** In order to better accommodate our growing number of patients, we are encouraging each patient to give as much notice as possible when you need to cancel or reschedule an appointment. Less than 24-hour's notice is considered a no-show. We allow **2 grace cancellations per year (no-shows)** before we begin charging you this fee, as we understand life happens. As of January 1, 2021 we will charge patients a \$25 fee on their 3<sup>rd</sup> no-show and every no-show after. If it becomes difficult for you to make your scheduled appointments and you reach 5 no shows we will help you by only allowing same day appointments to be scheduled.

**PATIENT BALANCE POLICY:** After your insurance company processes your claims, we will promptly mail you a patient statement if deemed necessary. Payment in full is due upon receipt of this statement. If you have any questions or would like to 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 with an additional 30% fee added to the balance due. If you are unable to pay the balance due in full, you must contact our RCM department to discuss arrangements. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees we incur plus court costs and other charges.

**SUPPLY & DURABLE MEDICAL EQUIPMENT RETURN:** Supplies may be returned within 30 days of purchase date. If you return a supply we will credit your account the amount you paid for future use within our offices. DME (Durable Medical Equipment) is billed to insurance and cannot be returned after the date it is issued. Please discuss any concerns with receiving durable medical equipment (DME) before signing off and leaving our offices.

Patient Name (Printed) \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

## **Consent to Treat a Minor**

I \_\_\_\_\_ (Parent/Guardian) hereby authorize VRx Medical, PLLC and whomever they designate to administer manual therapy treatment, soft tissue therapy, examination and evaluation as deemed necessary to my child (Child's Name) \_\_\_\_\_.

Additional Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Front Desk Initials: \_\_\_\_\_