Personal Injury

BLAIR CHIROPRACTIC CLINIC
EST. 1949

WELCOME!

We are happy to serve you in this difficult time after an accident. If you EVER have any concerns or questions, please do not hesitate to ask!

Attached are several forms for you to fill out to the best of your ability. It can be tedious, but please take your time, we want the best outcome for you and the least irritations after we get started. If we can get this out of the way at the beginning then we can just concentrate on getting you well again!

- **New Patient Basic Information** - Please fill this out as completely as possible.
- **PI Back Office** - We retain a case manager to communicate on your behalf and our behalf with the insurance companies and attorneys.
- **Auto Accident Questionnaire** - Tell us about the accident.
- **Chief Complaint** - There are two copies of this form, please fill out one form for each major complaint. If you have more than two major problems please feel free to print more. Some problems may be obviously related, in which case feel free to put them both on the same sheet.
- **Health History** - Please fill out to the best of your ability, it gives us some idea of what has gone on before the accident.
- **Financial Policy & Agreement** - This lays out our financial policies.
- **HIPAA Privacy Notice & Consent** - Describes how private information about you may be used and disclosed and how you can get access to this information.
- **Assignment, UCC Lien and Authorization** - It lets the insurance companies and any attorneys know that we have an interest in funds from the settlement.
- **Letter of Protection** - Instructions to your lawyer, even if you don't have a lawyer, this is good to have on file in case one needs to be retained at a future date to protect your interests.
- **Personal Injury Insurance Waiver** - Directs us to bill any and all insurance companies necessary to cover your costs.
- **Informed Consent** - Legal requirement informing you of the risks inherent in receiving or not receiving care in our office.
- **Notice to Unrepresented Patients** - If you do not retain a lawyer, please be aware of these things.
- **Authorization to Use or Disclose (Release) Personal Health Information for Blair Chiropractic Clinic Research Studies**.

The best procedure is to print these out, fill them out, and bring them with you on your first visit. Please do not email them. Email is not considered secure enough to transmit private healthcare information. If you wish to get these forms into our hands before your visit you may drop them by (call first to make sure we are here) or fax them to (806) 702-4927.

If you have any other information from other doctors or healthcare services that you think may be pertinent to your case (including x-rays, ct scans, MRI reports, etc), please bring them to your first appointment as well.

Gordon David Elder, DC

Gordon D. Elder, DC, Director

Certified Advanced Blair Technique Instructor *Fellow of the International Chiropractic Pediatric Association*

1802 E 50th St, Ste 112, Lubbock TX, 79404 (806) 747-2735 office@BlairClinic.com

www.BlairClinic.com

New Patient Basic Information

Date: _____

Full Legal Name: _____ Gender: ◯Female ◯Male

What name do you prefer to be called? _____ Age: _____ Birthdate: _____

Occupation: _____ Employer: _____

Ethnicity: _____ Social Security#: _____-_____-_____ Marital Status: _____ # of Children _____

Name of Spouse/Partner or Parent/Guardian: _____

Street Address: _____ City: _____ St: ____ Zip: _____

Phone: Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Best time and way to contact? _____

May we text your cell phone? ◯Yes ◯No email: _____

Whom should we contact in case of emergency? _____Relationship: _____

Street Address: _____ City: _____ St: ____ Zip: _____

Phone: Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Is this visit due to a **recent** accident? ◯Yes ◯No. Type: ◯Auto ◯Work ◯Other: _____

How did you find out about the Blair Chiropractic Clinic? _____

Do you have health insurance? ◯Yes ◯No. Company(ies): _____

Full name of Policy Holder: _____ Birthdate: _____

Is this through the Policy Holder's work? ◯Yes ◯No. If yes: Employer: _____

Other than Medicare and Medicare supplements, we do not collect payment from health insurance companies. However, we can send electronic receipts so that they may possibly reimburse you under their guidelines. Would you like us to do this? ◯Yes ◯No.

Do you have a primary physician? ◯Yes ◯No. Name: _____

Street Address: _____ City: _____ St: ____ Zip: _____

Should you qualify and start care here, shall we send your physician a report? ◯Yes ◯No.

The above information is true and correct to the best of my ability:

Signature: _____ Date: _____

Office Only: ◯GC ◯Ac ◯MC ◯OA ◯GD ◯CN

PI Back Office

Administrative Office: P.O. Box 2822, Bremerton, WA 98311
Phone: 1-833-411-2121 extension 1
Fax: 1-833-411-3131
gina@pibackoffice.com

Gina Mills will be the representative who will be handling all our billing for your auto accident. She will call you at some point to introduce herself and then call periodically to update you on the status of your case and to answer any questions you may have. You can also feel free to contact here if you have any billing questions regarding your case with us.

Important Information for you to gather if you have not:

Company Name of Your Insurance _____
Policy# _____
Claim# _____
Name of Adjuster _____
Phone # _____

Please Note even if you are not at fault having a bodily injury claim open with your personal insurance will benefit you in your case.

Company Name of Other Drivers Insurance
Policy# _____
Claim# _____
Name of Adjuster _____
Phone # _____

Attorney Name and Number _____

Please Note even if you are not represented by an attorney, we can help you get your case settled with more money in your pocket and quicker. Please stay in contact with your case manager by contacting him directly.

Gina Mills
1-833-411-2121 extension 1
Fax: 833-411-3131
gina@pibackoffice.com

Please bring this with you at your next appointment

Auto Accident Questionnaire

Date: _____

Full Legal Name: _____

Date of Accident: _____ City or Town of Accident: _____State: _____

Time of Day of Accident _____ AM PM Location of Accident: _____

You were a: ◯Driver ◯Passenger ◯Pedestrian. Name of Driver (if not you):_____

The impact was on the: ◯Back ◯Front ◯Left side ◯Right side. Where you looking: ◯straight ahead ◯to the left ◯to the right?

At the time of impact, the vehicle you were in was: ◯stopped ◯turning ◯going straight forward ◯going backward ◯parked

◯Other: _____

Did your body strike anything in the car? ◯Yes ◯No. Describe in detail: _____

_____

You were: ◯surprised ◯braced for impact. Were you wearing a seatbelt? ◯Yes ◯No.

Were you wearing a hat? ◯Yes ◯No. Were you wearing glasses? ◯Yes ◯No. Were you wearing headphones? ◯Yes ◯No.

If you were wearing any of the above, did it/they come off? ◯Yes ◯No.

Type of vehicle you were in: _____

Type of other vehicle: _____

Did the vehicle you were in impact anything else besides the other vehicle? ◯Yes ◯No.

If "YES" what was it? _____

Describe in detail how the accident occurred: _____

_____

_____

Were you rendered unconscious as a result of the collision? ◯Yes ◯No. If so, for how long approximately? _____

Were you taken to the hospital after the accident? ◯Yes ◯No. By: ◯ambulance ◯private car.

Was it: ◯immediately ◯a while later? How much later? _____

Name of Hospital: _____

Have you had any diagnostic imaging done since the accident? ◯Yes ◯No.

If so what kind? ◯X-Ray ◯CT Scan ◯MRI ◯Ultrasound. Where was it done? _____

Have you lost any days of work as a result of the accident? ◯Yes ◯No. Number?: _____

Have you ever been in a previous auto accident? ◯Yes ◯No. Describe all instances, giving approximate dates of the accidents, as well as the injuries sustained, and names of attorneys who represented you.

Date of Accident: _____. Injuries sustained: _____
Attorney: _____. Were you a Medicare Patient at the time? ◯Yes ◯No.
Approximate date case was settled or resolved: _____.

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Attorney: _____. Were you a Medicare Patient at the time? ◯Yes ◯No.
Approximate date case was settled or resolved: _____.

Did a police officer write a police report on the accident? ◯Yes ◯No. *If yes, please provide a copy of the report to our office.*

Was a ticket or citation issued by a police officer as a result of the accident? ◯Yes ◯No. To whom? _____

Did the accident involve a hit-and-run driver? ◯Yes ◯No.

Was the car in which you were in registered? ◯Yes ◯No.

Who's vehicle were you in? ◯my own ◯my spouse's ◯a friend's ◯my parents' ◯other: _____

If it was not registered to you then please give the name of the registered owner: _____

And the address of registered owner: _____

Do you reside with a family member who owns their own vehicle or is insured under some other auto policy? Automobile insurance laws in applicable states require this info (check all that apply):
◯spouse ◯mother ◯father ◯guardian/foster parent ◯grandparent ◯sister/brother ◯child ◯none

Was there any property damage to either of the vehicles as a result of the accident?
◯both vehicles ◯other person's vehicle ◯vehicle I was in ◯neither vehicle was damaged.

Have you been contacted by an adjuster from the other party's insurance company regarding this claim? ◯Yes ◯No. Check all that apply:
◯ I have not signed any agreement, nor settled any portion of my claim.
◯ I have settled my personal injury claim with this company.
◯ I have settled the property damage claim.
◯ I have signed an agreement which will pay my medical expenses for a period of time (explain): _____

_____

Are you currently represented by an attorney? ◯Yes ◯No. If "NO" do you wish to retain an attorney? ◯Yes ◯No.

The above information is true and correct to the best of my ability.

Signature: _____ Date: _____

CHIEF COMPLAINT

Date: _____

Full Legal Name: _____

Please fill this out, ***one sheet for each problem or group of problems****. Answer as best you can. There are two sides.*

Problem: _____

- How and/or when did it start? _____

  _____

- Have you ever had it before? _____
- Have you ever been injured here before? _____
- Where is it exactly? _____
- Does it radiate to or affect other parts of your body? _____
- How often does it occur? *(circle one)* ***10% 20% 30% 40% 50% 60% 70% 80% 90% 100%*** of the time.
- When does it occur (AM/PM/Month/Year/activity, etc)? _____

  _____

- How long does it last? _____
- Describe how it feels: (*circle all that apply)* ***sharp dull aching throbbing crushing stabbing burning stiff numb tingling sore***

  other: _____
- Please rate the discomfort on a scale of 0-10, with THREE CIRCLES for best, worst and average, 10 being worst possible discomfort, 0 being none (7 is severe enough you are thinking about going to the hospital):

  0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10. What level is it at right now? _____
- What triggers it or makes it worse? (*circle all that apply)* ***sitting lifting bending standing walking lying reaching***

  other: _____
- What makes it feel better? _____
- How is it affecting you at home? _____

  At work? _____

  During outside activity? _____
- What have you done for this already? Doctors you have seen, treatments you have received, home remedies, etc: _____

  _____

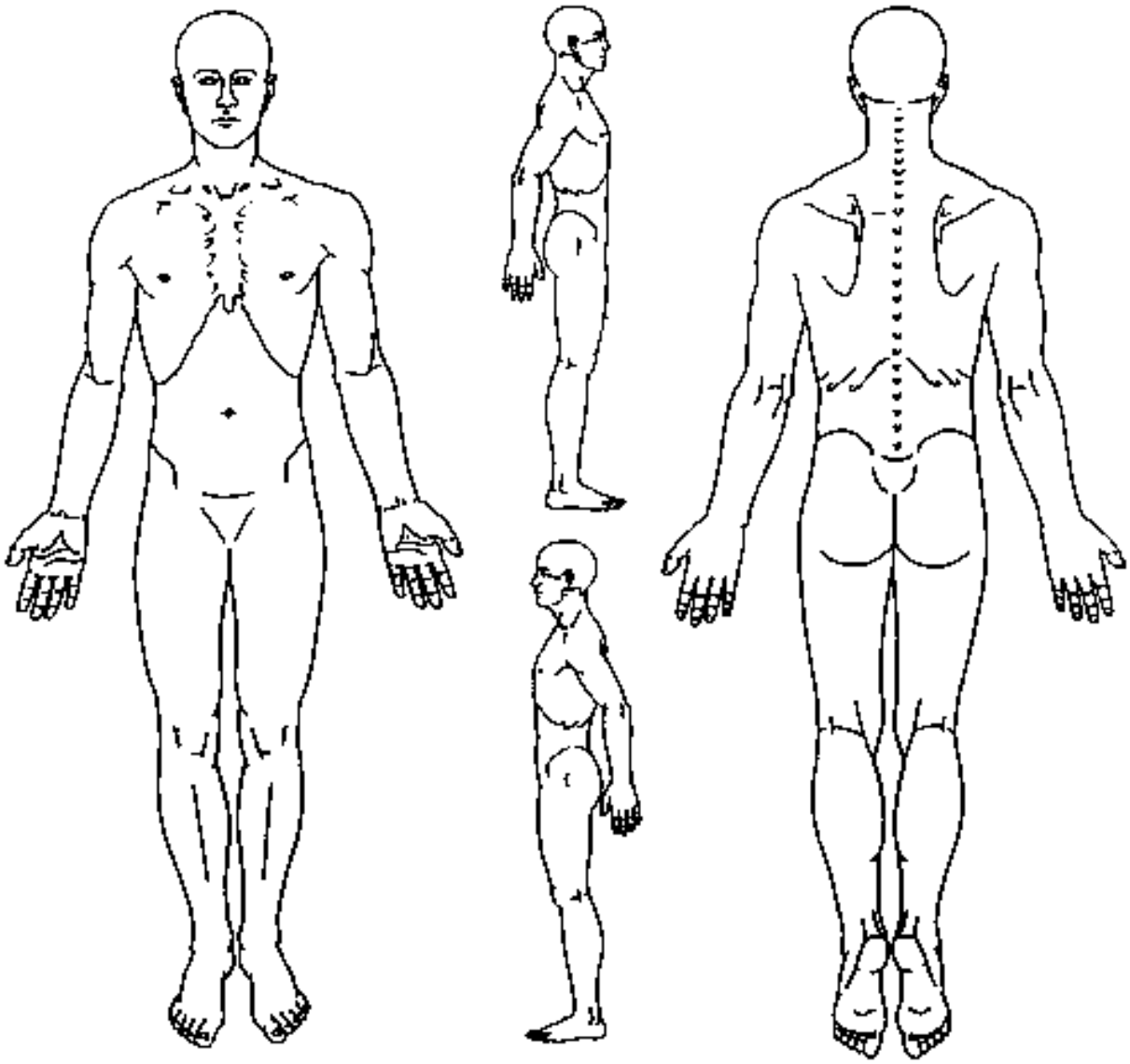
Signature: _____ Date: _____

Name: _____

Symptom described on previous page: _____

On the diagram below, please indicate where you are experiencing pain or other symptoms.

A = Ache B = Burning S = Stabbing N = Numbness T = Tingling C = Crushing Th = Throbbing St = Stiff O = Other



Signature: _____ Date: _____

CHIEF COMPLAINT

Date: _____

Full Legal Name: _____

Please fill this out, ***one sheet for each problem or group of problems****. Answer as best you can. There are two sides.*

Problem: _____

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- Have you ever been injured here before? _____
- Where is it exactly? _____
- Does it radiate to or affect other parts of your body? _____
- How often does it occur? *(circle one)* ***10% 20% 30% 40% 50% 60% 70% 80% 90% 100%*** of the time.
- When does it occur (AM/PM/Month/Year/activity, etc)? _____

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- What triggers it or makes it worse? (*circle all that apply)* ***sitting lifting bending standing walking lying reaching***

  other: _____
- What makes it feel better? _____
- How is it affecting you at home? _____

  At work? _____

  During outside activity? _____
- What have you done for this already? Doctors you have seen, treatments you have received, home remedies, etc: _____

  _____

Signature: _____ Date: _____

Name: _____

Symptom described on previous page: _____

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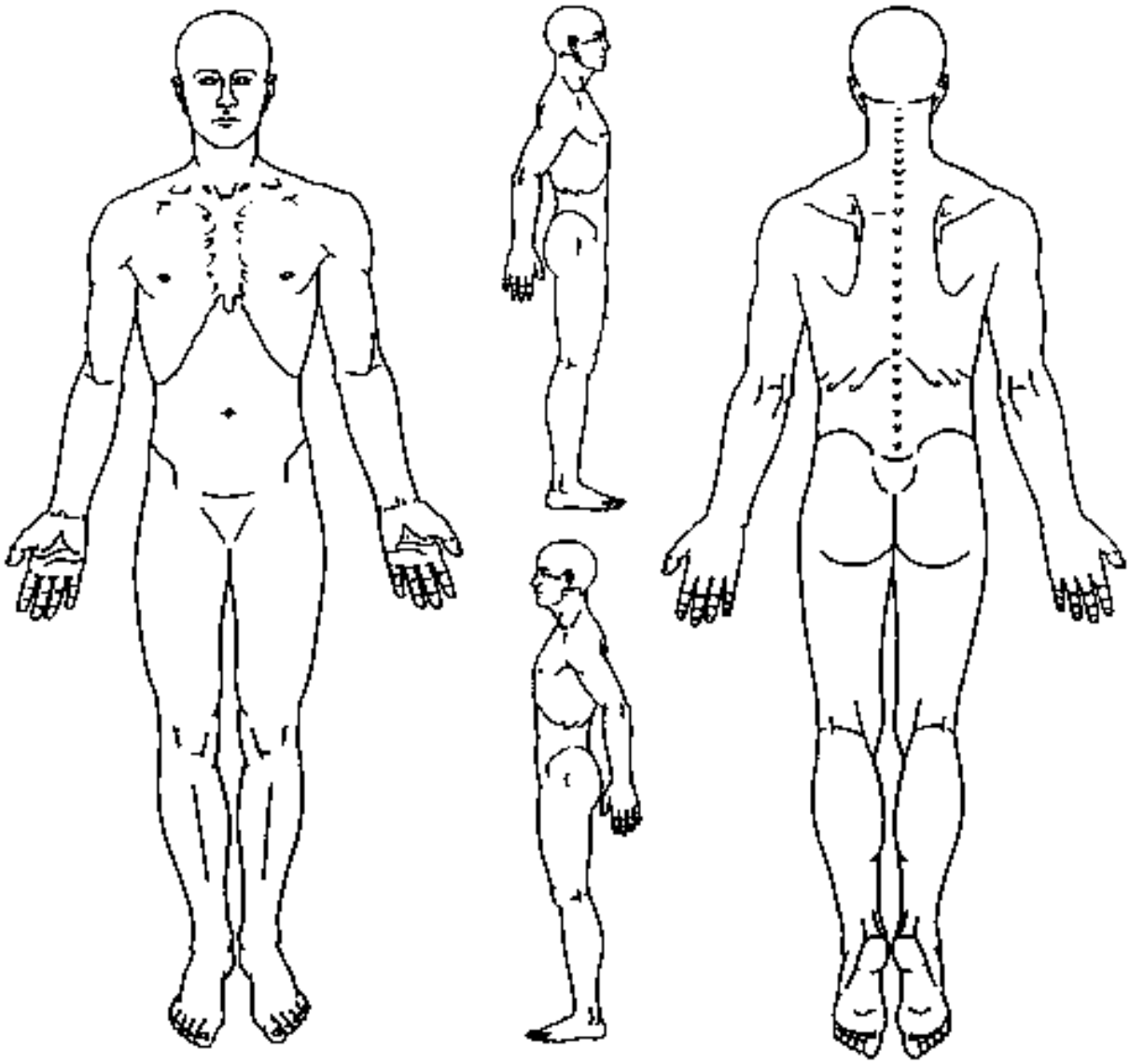
A = Ache B = Burning S = Stabbing N = Numbness T = Tingling C = Crushing Th = Throbbing St = Stiff O = Other



Signature: _____ Date: _____

HEALTH HISTORY

Date: _____

Full Legal Name: _____

GENERAL HEALTH: please answer to the best of your ability.

Do any of the following apply to you as far as you know (please mark YES or NO for EACH condition):

Yes No Articular Hypermobility Disease
Yes No Severe demineralization of bone
Yes No Benign bone tumor in the spine
Yes No Bleeding disorder
Yes No Anticoagulant therapy?
Yes No Radiculopathy with progressive neurological signs
Yes No Radiating pain, numbness or weakness in upper extremities
Yes No Radiating pain, numbness or weakness in lower extremities

Yes No Rheumatoid Arthritis
Yes No Ankylosing Spondylitis
Yes No Fracture(s) _____
Yes No Dislocation(s) _____
Yes No Unstable Os Odontoideum
Yes No Malignancies that involve the vertebral column
Yes No Infection of bones or joints of the vertebral column
Yes No Myelopathy
Yes No Cauda Equina Syndrome
Yes No Vertebrobasilar Insufficiency Syndrome
Yes No Major artery aneurysm

List auto accidents or personal injuries with years: _____

_____

List other surgeries, hospitalizations, operations with years: _____

_____

List other previous major illnesses or injuries: _____

_____

Do you wear: __Heal Lifts __Sole Lifts __Inner Soles __Arch Supports __None

Have you ever (please mark YES or NO for EACH question and supply details for each YES):

Yes No Been knocked unconscious? _____
Yes No Used a cane, crutch or other support? _____
Yes No Been treated for a spine or nerve disorder? _____
Yes No Had a fractured bone? _____

Medications you are currently taking (prescription or non-prescription):

___ High Blood Pressure: _____
___ Pain: _____
___ ADD/ADHD: _____
___ Other: _____
___ Cholesterol: _____
___ Arthritis: _____
___ Insulin: _____

List any known allergies: _____

FAMILY HEALTH: please answer to the best of your ability (for your parents, siblings and children).

Health status of family members: _____

_____

Are there any immediate family members that suffer from:
__Stroke __Heart condition __Cancer/Tumor __Degenerative Disk Disease __Osteoporosis __Arthritis
__Any other potentially familial conditions: _____

SOCIAL HISTORY: tell us a little more about your lifestyle.

Education: __High School __Some College __College Grad __Post Grad
Daily Activities: __Sitting __Standing __Light Labor __Heavy Labor __Computer
Hobbies: _____

HEALTH HISTORY

Habits:	Heavy	Mod.	Light	None
Alcohol	____	____	____	____
Caffeine	____	____	____	____
Tobacco	____	____	____	____
Drugs	____	____	____	____

	Heavy	Mod.	Light	None
Exercise	____	____	____	____
Sleep	____	____	____	____
Appetite	____	____	____	____

REVIEW OF SYSTEMS:

Please check the appropriate box **(O)ccasional, (F)requent, (C)onstant** for any of the following symptoms which you now have or have had previously.

O F C GENERAL __None
_ _ _ Allergy
_ _ _ Chills
_ _ _ Convulsions
_ _ _ Dizziness
_ _ _ Fainting
_ _ _ Fatigue
_ _ _ Fever
_ _ _ Headache
_ _ _ Loss of sleep
_ _ _ Loss of weight
_ _ _ Nervousness / Depression
_ _ _ Neuralgia
_ _ _ Numbness
_ _ _ Sweats
_ _ _ Tremors

O F C MUSCLE AND JOINT __None
_ _ _ Arthritis
_ _ _ Bursitis
_ _ _ Foot trouble
_ _ _ Hernia
_ _ _ Low back pain
_ _ _ Lumbago
_ _ _ Neck pain / stiffness
_ _ _ Pain between shoulders
_ _ _ Pain / Numbness in shoulders
_ _ _ Pain / Numbness in arms
_ _ _ Pain / Numbness in elbows
_ _ _ Pain / Numbness in hands
_ _ _ Pain / Numbness in hips
_ _ _ Pain / Numbness in legs
_ _ _ Pain / Numbness in knees
_ _ _ Pain / Numbness in feet
_ _ _ Painful
_ _ _ Poor posture
_ _ _ Sciatica
_ _ _ Spinal curvature / scoliosis
_ _ _ Swollen joints

O F C GASTRO-INTESTINAL __None
_ _ _ Belching or gas
_ _ _ Colitis
_ _ _ Colon trouble
_ _ _ Constipation
_ _ _ Diarrhea
_ _ _ Difficult digestion
_ _ _ Distension of abdomen
_ _ _ Excessive hunger
_ _ _ Gall bladder trouble
_ _ _ Hemorrhoids
_ _ _ Intestinal worms
_ _ _ Jaundice
_ _ _ Liver trouble
_ _ _ Nausea
_ _ _ Pain over stomach
_ _ _ Poor appetite
_ _ _ Vomiting
_ _ _ Vomiting blood

O F C EENT __None
_ _ _ Asthma
_ _ _ Colds
_ _ _ Crossed Eyes
_ _ _ Deafness
_ _ _ Dental Decay
_ _ _ Earache
_ _ _ Ear discharge
_ _ _ Ear noises
_ _ _ Enlarged glands
_ _ _ Enlarged thyroid
_ _ _ Eye pain
_ _ _ Failing vision
_ _ _ Farsightedness
_ _ _ Gum trouble
_ _ _ Hay fever
_ _ _ Tonsillitis
_ _ _ Hoarseness
_ _ _ Nasal Obstruction
_ _ _ Nearsightedness
_ _ _ Nosebleeds
_ _ _ Sinus infection
_ _ _ Sore throat

O F C CARDIOVASCULAR __None
_ _ _ Hardening of arteries
_ _ _ High blood pressure
_ _ _ Low blood pressure
_ _ _ Pain over heart
_ _ _ Poor circulation
_ _ _ Rapid heart beat
_ _ _ Slow heartbeat
_ _ _ Swelling of ankles

O F C RESPIRATORY __None
_ _ _ Chest pain
_ _ _ Chronic cough
_ _ _ Difficult breathing
_ _ _ Spitting up blood
_ _ _ Spitting up phlegm
_ _ _ Wheezing

O F C SKIN __None
_ _ _ Boils
_ _ _ Bruise easily
_ _ _ Dryness
_ _ _ Hives or allergy
_ _ _ Itching
_ _ _ Skin eruptions (rash)
_ _ _ Varicose veins

O F C GENITOURINARY __None
_ _ _ Bed-wetting
_ _ _ Blood in urine
_ _ _ Frequent urination
_ _ _ Inability to control urination
_ _ _ Kidney infection
_ _ _ Painful urination
_ _ _ Prostate trouble

O F C WOMEN ONLY __None
_ _ _ Congested breasts
_ _ _ Cramps or backache
_ _ _ Excessive menstrual flow
_ _ _ Hot flashes
_ _ _ Irregular cycle
_ _ _ Lumps in breast
_ _ _ Menopause symptoms
_ _ _ Painful menstruation
_ _ _ Vaginal discharge

ARE YOU PREGNANT? _____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize the Blair Chiropractic Clinic to provide me with chiropractic care, in accordance with State statutes.

Patient Signature: _____ Date: _____

I have reviewed this form. Doctor's Signature: _____ Date: _____

Financial Policy & Agreement

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Definitions. In this Agreement, "Office" and "Clinic" shall refer to Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic located at 1212 Avenue J, Ste 101, Lubbock, TX 79401. "Financial Policy" or "Agreement" shall refer to this document.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase, "(by [Name of Office])," shall serve as a properly authorized endorsement. 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.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office promptly upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. I agree that any delay by the Office in making demand for payment, any delay in paying the full amount of my Charges, and any partial payments received by the Office towards my Charges, shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full promptly upon demand, and shall not constitute an "accord and satisfaction" of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments. I also agree that my account with your Office shall be construed as in "default" on the earlier of the following dates: (a) a Payer fails to pay any or all of the Charges in-full and directly to the Office upon receipt of those Charges within thirty (30) days or the period established by the earliest prompt pay deadline applicable to the Payer (whichever occurs later), (b) I do not pay any or all of the Charges in-full within fourteen (14) days of request, or (c) the Office attempts to charge my credit card in compliance with a written Payment Arrangement, but the charge is declined or not approved.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). For example (without limiting this Agreement), I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I further understand that a Payer may Deny Payment stating that the individual provider who actually renders the treatment or procedure is out-of-network. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should, therefore, be denied or downcoded. I also understand that a Payer may require certain Charges to be pre-certified or pre-authorized. In the event that my condition arose from an accident, I further agree to the terms of the Office's Auto / Work Comp Advance Beneficiary Notices as applicable. I understand that there may be many other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I agree that if I have any questions about the Terms of Non-Coverage, I can request copies of the Office's verification (e.g., eligibility, pre-authorization) forms to gain further understanding. I agree that should the Office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or the Office may in my opinion not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office responsible or liable in any of the foregoing instances.

Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any and all Payers, not including in accident cases my health benefit plan or Medicare. Notwithstanding the foregoing, in the event that the Office determines in its sole discretion that it has any reasonable basis for either submitting or not submitting my Charges and/or other documentation to a Payer, I hereby authorize the Office to take such action without condition or restriction. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said Payers in writing, or (b) law expressly imposes on the Office to accept (collectively, "Mandatory Fee Reductions"). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply

the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are imposed on the Office by virtue of laws which regulate or restrict "balance billing," I hereby waive the application of such laws to the extent permitted by law. In the event that no Mandatory Fee Reductions are actually imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement 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 Agreement. I agree that each and every provision of this Agreement is reasonably necessary. 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. This Agreement 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 Agreement, 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 Agreement. I have reviewed the Office's "Assignment & Lien", Health Insurance Election, and, if applicable, Auto / Work Comp Advance Beneficiary Notices, and further agree to the terms and definitions set forth in these documents as applicable. Said documents are incorporated herein by reference. In the event that my condition is related to an accident, including without limit automobile accident, I understand that there will be an administrative fee necessary to cover the costs of verifying multiple Payers, filing and terminating liens, and submitting notices of same to Payers.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (please print): _____

Signature: _____ Date: _____

Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic
1802 E 50th Street Ste 112 Lubbock, TX 79404
(806) 747-2735

Notice of Privacy Practices
Your Rights & Our Responsibilities

EFFECTIVE: June 1, 2021

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical health condition and related health care services. **Please review it carefully.**

Your Rights

This section explains your rights and how we are required to acknowledge them.

Request a copy of your paper or electronic medical record

- Upon request, we will supply you with a ***Request to Inspect or Copy Patient Information*** form (also referred as a ***Patient Records Request*** form). The form contains the contact information of our compliance officer, and any related fees for copying your records. NOTE: Portions of an Electronic Health Record (if applicable) may be available via an on-line portal or other healthcare exchange. This will be noted in the request form.
- We will provide a copy or a summary of your health information, usually within 15 days of your request. We may charge a reasonable fee for cost of labor, postage, and supplies associated with your request (in compliance with state and federal laws regarding medical records request). We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program.

Receive a paper copy of this Notice of Privacy Practices

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

Request correction of your medical record

- Upon request, we will supply you with the ***Request to Amend Patient Record*** form.
- We may deny your request for an amendment if it is not in writing or does not include a reason to support the request; our response will be in writing within 60 days.

Request confidential or alternative communication

- Request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by email.
- Request alternative communications; you must make your request in writing to our privacy office, a ***Request for Alternative Communications*** form will be provided upon request.

Ask us to limit or restrict the information we share

- List individuals who are involved in your care and as a result PHI can be disclosed; a ***PHI Use and Disclosure Authorization*** form will be provided, upon request.
- Restrict payer access. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. You must make your request in writing to our privacy office; a ***Request to Restrict Disclosure to Health Plan*** form will be provided upon request.

Receive a list of those with whom we've shared your information

- You have the right to request an accounting of disclosures of your health information made by us. We are not required to list certain disclosures, including: disclosures made for treatment, payment, and health care operations purposes (TPO).
- You must submit your request in writing. A ***Request for Accounting of Disclosure*** form will be provided upon request. In turn you will receive a ***Response to Request for Disclosure*** form. The first accounting of disclosure request within a 12 month period will be at no cost. Additional request within that time period, will result in a charge based on the reasonable costs for providing accounting of disclosures.

Right to Receive Notice of a Breach

- We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of unsecured Protected Health Information as soon as possible, but in any event, no later than 30 days following the discovery of the breach.

File a complaint if you believe your privacy rights have been violated

- If you believe your privacy rights have been violated, you may file a complaint with our privacy officer also referred to as compliance officer; we will supply you with a ***Complaint*** form upon request (form contains the name of our privacy official and his/her contact information).
- All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, call-ing 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**
- We will not retaliate against you for filing a complaint.

Your Choices

This section addresses your choices regarding health information we may share.

You have the choice to tell us to:

- Share information with your family and friends about your condition.
- Disclose your health information when disaster relief organizations seek your health information to coordinate your care. Note: If you are unable to communicate your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest.

We will never share your information in these cases without permission:

- Marketing purposes. We are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. However, we may use and disclose health information to tell you about health-related benefits or services that may be of interest to you.
- Sale of your information. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization.

Our Uses and Disclosures

This section lists ways in which we may use your information and disclose it.

Healthcare Treatment

- Plan your care and treatment, including preauthorization and pre-certification.
- Communicate with other providers such as referring physicians.
- Billing and coordination of payment for services with health plan administrator.
- Quality and outcome assessments for improvement of care we render.
- Contracted third-party business associates for services, such as answering services, transcriptionists, record keeping, consultants, and legal counsel.
- Communicate to you via newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

Public Health and Safety Issues

- Product recalls
- Reporting suspected abuse, neglect or domestic violence ; reporting disease or other required data in compliance with state and federal laws.
- Communicating with healthcare exchanges and networks according to federal and state laws with regards to Right of Access and interoperability regulations.

Compliance with the law

- Department of Health and Human Services investigations for complying with federal privacy laws.
- Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions such as a court order, subpoena, warrant, summons, or similar process if authorized under state or federal law.
  If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative. To include communication with medical examiner and or funeral director (if applicable).

Other

- Text reminders
- Product offers
- Medical tips and suggestions

Our Responsibilities

- If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information.
  We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of unsecured Protected Health Information as soon as possible, but in any event, no later than 30 days following the discovery of the breach.
- To provide you with notice, such as this Notice of Privacy Practices and abide by the terms of our most current Notice of Privacy Practices.
- Notify you if we are unable to agree to a requested restriction.

Changes to the Terms of this Notice

- We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain. Should our information practices change; a revised Notice of Privacy Practices will be available upon request. We will not use or disclose your health information without your authorization, except as described in our most current Notice of Privacy Practices. If you have limited proficiency in English, you may request a Notice of Privacy Practices in Spanish

Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic

Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic's *Notice of Privacy Practices (NPP)*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

_____ _____

Patient Name (print) Patient's Date of Birth

_____ _____

Patient Signature Date

If signed by a personal representative or legal guardian:

Name of Personal Representative: _____ _____

(Print) Date

Signature of Personal Representative: _____

Relationship to Patient: _____Driver's License Number: _____State____

Signing the *NPP Acknowledgement* does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

OFFICE USE ONLY

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Attempt 1 Date _____ Staff_____

- ❑ Individual refused to sign.
- ❑ Communication barriers prohibited obtaining the acknowledgement.
- ❑ An emergency prevented us from obtaining acknowledgement.
- ❑ Other (Specify:)_____

Attempt 2 Date _____ Staff _____

- ❑ Individual refused to sign.
- ❑ Communication barriers prohibited obtaining the acknowledgement.
- ❑ An emergency prevented us from obtaining acknowledgement.
- ❑ Other (Specify:)_____

Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic

PHI Use and Disclosure Authorization

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. We have permission to (please check all that apply):

- ❑ Leave messages on home phone or with household members about appointments, and test results.
- ❑ Leave messages on work phone about appointments, and test results.
- ❑ Leave messages on cell phone about appointments, and test results.
- ❑ Email appointment reminders
- ❑ Confirm appointments by phone or text

This authorization is effective through (check one):

- ❑ ____ /____ /____
- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative.

I hereby authorize Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic disclosure of my individually identifiable health information to the individuals listed below:

1. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future Appointments
- ❑ Receive phone messages and/or email regarding appointments or test results
- ❑ Other _____

2. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and Future Appointments
- ❑ Receive Phone Messages or email regarding appointments or test results
- ❑ Other _____

I understand that I may revoke this authorization to disclose information at any time by notifying Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic in writing (*Termination of Disclosure Form* provided upon request). If I choose to do so, I am aware that my revocation will not affect any actions taken by the clinic until the termination request is received in writing and processed.

Authorization to Disclose:

_____ _____

Patient Name (print) Patient's Date of Birth

_____ _____

Patient Signature Date

_____ _____

Signature of Personal Representative **Date**

Relationship to Patient: _____Driver's License Number: _____State____

Assignment, UCC Lien and Authorization

FOR DIRECT PAYMENTS BY MY PAYERS TO BLAIR CHIROPRACTIC CLINIC

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 Gordon D. Elder, DC, PA, DBA Blair Chiropractic Clinic located at 1212 Avenue J, Ste 101, Lubbock, TX 79401; "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 limitation an hourly fee of $100 for our Office's administrative staff time, as well as an hourly fee of $500 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. "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 limitation 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. (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.

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 limitation 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 another 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 limitation the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information" shall also include without limit copies of all documents, records, 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 limitation any determination by the Payer to pay, 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 limitation 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.

Patient Name (please print): _____

Signature: _____ Date: _____

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

_____

Parent/Guardian Signature: _____ Date: _____

Letter of Protection

Accident Date: _____

Patient Name: _____

Attorney Name: _____

I/We ("we") the undersigned patient and attorney, will protect the interests of Gordon D. Elder, DC, PA dba Blair Chiropractic Clinic ("the Office") out of the proceeds of any settlement, judgment, or verdict, as well as out of any no-fault proceeds, relating to the accident listed above.

By "interests," we mean any outstanding balance owed to the Office by me, the Patient, for any Charges incurred at the Office as defined by the Office's documents.

This letter of protection shall not be modified or revoked without the written consent of the Office. This letter of protection shall not be exclusive of any other security interests or rights, if any, which the Office may have.

Patient Signature: _____ Date: _____

Attorney Signature: _____ Date: _____

Personal Injury Insurance Waiver

For the purposes of this Notice & Consent Form, "Office" shall refer to Gordon D. Elder, DC, PA, dba the Blair Chiropractic Clinic.

I want to receive the below services as they have been explained before and/or during my initial visit. I want them for purposes of helping to correct my underlying conditions, to improve function, and to relieve the effects of my condition, as well as for purposes of evaluating treatment effectiveness as may be applicable. Instead of paying your Office at the time of service or based on credit plans commonly made available to patients at the Office, I'm electing instead to have you file claims with all applicable accident insurance payers ("Payer") along with a copy of this insurance waiver and any optional care plan I may elect. I want to receive the below services **EVEN THOUGH A PAYER MAY POTENTIALLY DEEM THEM TO BE** (1) not medically indicated or authorized, (2) not blended with sufficient "active care" at your particular Office or with sufficient home-based care, (3) based on a non-varying or non-unique treatment plan, (4) not sufficiently causally-related to my accident, (5) somehow non-conducive to my health (again, as potentially deemed by the Payer), (6) potentially subject to reduction based on, e.g., hardship and/or prompt pay discounts which may be extended by the Office on a conditional basis to qualifying patients as set forth on the Office's online financial policies, or (7) otherwise not reimbursable as deemed by the Payer based on a policy established or adopted by the Payer. My doctor has fully apprised me of the relative need and use at a certain stage for active forms of care as well as certain home-based forms of care. In the event my doctor has prescribed x-rays, my doctor has also fully apprised me of the potential risks associated with x-rays. I have read and understood and agree with the terms of the Office's Financial Policies. The terms of the Financial Policies are incorporated herein by reference. Consistent with the Financial Policies and this Waiver, I understand that I am personally and financially responsible for all Charges at the Office. Without limiting the Financial Policies in any way, I understand that there is a likelihood that the Charges listed below may be Denied by my Payer for any number of reasons including without limitation those defined and set forth above and in the Financial Policies. In the event a Payer seeks to file any type of Medico-Legal Process against the Office relating to these claims, I understand that I may be deemed to be, potentially, an indispensable party to such process. I understand that as part of my Optional Care Plan, I may be receiving some or all of the following services from the Office which may be Denied by my Payer. Any services I elect not to receive have been denoted below:

Name of Item	Description	List Charge	Elected to Not Receive (x)
Initial Imaging	X-Rays, CT Scans, and/or MRI's at the commencement of care.	$111.11 - 333.33 ea	_____
Initial C&E	Initial consultation and exam.	$250.00	_____
Adjustments	Adjustments to one or more joints of the body.	$106.00 - 150.00 ea	_____
Checkups	Checkups to assess progress.	$83.33 ea	_____
Re-Evaluations	Periodic evaluations to further document progress.	$111.11 - 166.67 ea	_____
Missed Appointments	Missed appointment fee	$25.00 ea	_____

I've read and understood and agree to the terms of this waiver.

Patient Name (please print): _____

Signature: _____ Date: _____

Notice to Unrepresented Patients

Please Be Advised:

If You Are Unrepresented by Legal Counsel, Be on the Look-Out for Low Settlement Offers

PLEASE BE ADVISED that as you attempt to negotiate the settlement of your case with the other party's insurance company (or your uninsured motorist coverage), the adjuster may make an offer that seems unfairly low and that may not even cover the amount of your medical / chiropractic bills. For this reason, we recommend that you consider retaining legal counsel to protect your rights.

For instance, the adjuster may persuasively attempt to convince you that for a number of reasons the offer will not go any higher and you may be given an ultimatum of "take it or leave it." This is just one of the many reasons why we recommend you consider retaining legal counsel to protect your interests. In the absence of representation, the adjuster's offer may simply be what the adjuster thinks he or she can get you to take versus what is fair and equitable.

In fact, in some cases, we have heard of adjusters telling unrepresented patients that the health care bills were unreasonably high and that not all of the treatment was necessary. **BEWARE OF THESE AND OTHER LIKE PRACTICES.** Rest assured that the treatment that was provided to you at our Office for your injuries was medically necessary and that the amount of our charges are well within the usual and customary range for this region of the country.

Whenever this office is notified that the full amount of our bills may not be covered by the settlement amount, on our own behalf, not representing any patient, our office demands to see a **PROPER WRITTEN REVIEW PERFORMED BY AN APPROPRIATE HEALTH CARE PROVIDER** who is trained and experienced in the care you received, who can understand what the care was about, and who can provide a more fair, less biased, opinion on the matter.

It should be clear to you based on your previous acknowledgment that it is your responsibility to pay your outstanding balance (or make sure that we are paid) at our Office, regardless of the amount of your settlement with the insurance company.

THE TIME TO HAVE A PROPER MEDICAL NECESSITY REVIEW PERFORMED IS BEFORE SETTLEMENT IS COMPLETED, AND NOT AFTER. AGAIN, CONSIDER RETAINING LEGAL COUNSEL TO PROTECT YOUR RIGHTS.

Thank you!

Patient Name (please print): _____

Signature: _____ Date: _____

This notice does not constitute legal advice and does not establish an attorney-client relationship. If you have questions of a legal nature, you should contact an attorney at law.

Informed Consent

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment: The treatment used to help people by Doctors of Chiropractic is the chiropractic adjustment, also called spinal manipulative therapy. The purpose of a chiropractic adjustment is to correct a subluxation or slight joint dislocation that is affecting nerves and thereby adversely affecting the health and function of the body. The adjustment may cause an audible "pop" or "click." The upper-cervical specific adjustment primarily used in this office does not involve any twisting and generally is not accompanied by any joint noise.

Analysis / Examination / Correction: As a part of the analysis, examination, and correction you are consenting to the following procedures as needed:

- chiropractic adjustment
- palpation
- range of motion testing
- orthopedic testing
- neurologic testing
- postural analysis
- radiographic studies (x-rays/CT scans)

The material risks inherent in chiropractic adjustments: As with any healthcare procedure, there are certain complications that may arise during chiropractic adjustments. Some patients will feel some stiffness and soreness due to changes in spinal alignment. Other possible complications include but are not limited to fractures, disc injuries, dislocation, muscle strain, cervical myelopathy, costovertebral strains, and separations. In addition, some types of manipulation of the neck have been associated with injuries of the arteries in the neck leading to or contributing to serious complications including stroke. Every reasonable effort to screen for contraindications to care will be made; if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which should be discovered during the history, examination or x-ray portion of your initial visits. Stroke has been the subject of tremendous disagreement, they are associated with rotational adjustments of the neck which are not performed in this office, and even then are exceedingly rare. Recent research suggests that strokes are no more likely after a rotational chiropractic adjustment than any other time. The other complications mentioned are also generally described as rare.

The availability and nature of other treatment options: Other treatment options for your condition may include:

- Self-administered over-the-counter pain medications and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers
- Physical Therapy
- Surgery

If you choose to use one of the above listed "other treatment" options, you should be aware that there are risks and benefits to each option and you should discuss these with your primary medical physician.

The risks and dangers attendant to not correcting the subluxation: Remaining subluxated may allow the formation of joint adhesions and the reduction of mobility which may set up a pain reaction further reducing mobility. Furthermore, any neurologic disruption caused by the subluxation will not be removed and the areas controlled by those nerves will be weakened, diseased, or otherwise dysfunctional. Over time this process may complicate future correction, making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE.

I have read the above explanation of the chiropractic adjustment and related procedures. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the correction recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name (please print): _____

Signature: _____ Date: _____

Doctor's Name: ▢ Dr. Elder ▢ Dr. Jensen ▢ Other: _____

Signature: _____ Date: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

Authorization to Use or Disclose (Release) Personal Health Information for Blair Chiropractic Clinic Research Studies

By signing below, I permit the Blair Chiropractic Clinic to use or disclose (release) my personal health information for research studies performed by the clinic or doctors. This signed notice gives the clinic permission to disclose my protected health information to researchers when:

a) their research has been approved by an institutional review board that has reviewed the research proposal and

b) established protocols are in place to ensure the privacy of my protected health information.

The information that may be used or disclosed for research purposes may include, but is not limited to, medical history, results of physical exams, lab or imaging results, information related to a particular condition or treatment.

I may withdraw this consent and authorization at any time. Even if I withdraw this authorization, the Blair Chiropractic Clinic may still use or disclose health information they have already obtained if necessary to maintain the integrity or the reliability of the current research.

To withdraw this authorization, I must do so in writing to the Blair Chiropractic Clinic.

This authorization does not have an expiration date.

____ Yes, I give the Blair Chiropractic Clinic permission to use my personal health information for research study purposes. I understand the type of information that may be used for research purposes, and this authorization may be withdrawn at any time. _____ (patient initials here)

____ No, I do NOT give the Blair Chiropractic Clinic permission to use my personal health information for research. _____ (patient initials here)

Patient Signature: _____ Date_____

Doctor Signature: _____ Date_____

Gordon D. Elder, DC, Director

Certified Advanced Blair Technique Instructor *Fellow of the International Chiropractic Pediatric Association*

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