Whole Health Chiropractic
3930 Naaman School Road
Suite B
Garland, TX 75043
972-530-2273 Fax 972-530-2608

SERVICES RENDERED AGREEMENT

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by Whole Health Chiropractic for services rendered and that this agreement is made solely for said doctor's protection and in consideration of Whole Health Chiropractic awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover.

I have been advised that if I do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance immediately due and payable by me.

Please acknowledge your agreement to this request by signing below and returning it to Whole Health Chiropractic.

________________________ ____________________________________

Date *Patient's Signature*

Whole Health Chiropractic Notice of Privacy Practices

We understand that treatment information about you and your health is personal. We are committed to protecting information about you. This notice briefly describes how treatment information about you may be used and disclosed.

We are required by law to:

- Make sure that treatment information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to treatment information about you; and
- Follow the terms of the notice that is currently in effect.

We may use treatment information about you to provide you with treatment or services. We also may disclose information about you to people outside the clinic who may be involved in your care, such as family members or others we use to provide services that are part of your care.

We may use and disclose treatment information about you so that the treatment and services you receive at the clinic may be billed to and payment may be collected from you, your insurance company, or a third party.

If you are involved in a lawsuit or a dispute, we may disclose treatment information about you in response to a court or administrative order. We may also disclose treatment information to a subpoena, discovery request, or other lawful process by someone else involved in the dispute as required by federal, state or local law.

You have the right to inspect and copy treatment information that may be used to make decisions about your care, usually, this includes treatment billing records. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of treatment information about you.

You have the right to request a restriction or limitation on the treatment information we use or disclose about you for treatments, payment, or health care operations. In your written request, you must tell us (1) what information you wanted limited; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example disclosure to your spouse.

You have the right to request that we communicate with you about your treatment matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

If you have any questions or concerns about your treatment in regard to our policies, would like to inspect a complete copy of this document, obtain copies of your treatment information, or restrict disclosure of your treatment information, please contact us at 972-530-2273.

____

Print Name

____

Patient Signature   Date

We reserve the right to change this notice without prior notification to you.

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for you services.

3. In the event of any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.

4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Texas.

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization for Assignment will be in continual effect until revoked by both parties.

____________________ __________________________________

Date Patient/Insured Signature

RECORDS RELEASE

To _______________________________, I hereby authorize you to release to ______________________________ any information including the diagnosis and records of treatment or examination rendered to me for all care during the period from _____________ to _________________.

____________________ __________________________________

Date Patient/Insured Signature

____________________ __________________________________

Date Staff Signature

RELEASE FROM CARE

I, _________________________ hereby understand that Dr. Teresa Jones is releasing me from care, for my accident dated ____________________, and that I have reached □ a pre-accident status or □ maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

__________________________________ ____________________ __________________________________

Patient Signature Date Staff Signature

PERSONAL INJURY PATIENTS

Whole Health Chiropractic would like to take this time to welcome you. We anticipate that your time with us will be a pleasant one. We understand the circumstances that have brought you here today, and we are willing to work with you and your insurance company. Listed below are just a few things to expect during your recovery from your accident.

1. We will need all of your insurance information. (i.e. claim number; adjuster's name; insurance company's name, address and phone number.)

2. We are here for you if you ever have any questions or concerns about your care or your account.

3. If you have an attorney involved we will also need his/her information as well as a Letter of Protection.

4. ***You must be aware that any and all medical expenses incurred by this office will be your responsibility if insurance does not pay or if payment is made directly to you.***

5. When settling your case with the insurance adjuster, please be aware that the settlement they are offering may include all of your medical expenses, and you are liable to pay for all medical expenses incurred with that settlement check.

6. Please contact our office in the event you are settling your case with your adjuster to verify that all expenses have been paid in full. This is in your best interest.

Again, thank you for choosing Whole Health Chiropractic for your medical needs.

By signing this document you are stating that you have read and understand your responsibility to Whole Health Chiropractic.

Signature of Patient____ Date:____________________

INSURANCE INFORMATION FOR PERSONAL INJURY PATIENTS

Patient Name ____

Date of Accident ______________ Claim # __________________

Insured's Name ____

Insured's Address ____

Insured's Birthdate ____________________ Insured: M / F

Insurance Company ____

Address ____

Phone Number ____________________

Adjuster ____________________

INSTRUCTIONS TO COUNSEL

I, ______________________________ clearly understand that all past, present and future bills incurred at Whole Health Chiropractic clinic, are my responsibility for payment.

I hereby ratify my agreement to pay all bills incurred during my health care at this clinic.

I also hereby irrevocably agree to have the doctor's entire bill paid from any proceeds of any nature by way of settlement, judgment, or otherwise I or you might receive. I do hereby irrevocable instruct you _______________________ to pay the doctor in full from any such proceeds of settlement, judgment, or enforcement of judgment actions. You are to pay the doctor prior to disbursing any proceeds to me.

I also understand that if the settlement does not cover the doctor's entire bill, I am still responsible for the remainder.

I do hereby waive any applicable statute of limitations of the collection of my account with this clinic.

I instruct you, _______________________________, not to attempt to negotiate my doctor's bill, who has provided all services billed for, and I agree to pay in full.

_____________________________________ _____________________
Signature Date

_____________________________________ _____________________
Witness Date