PATIENT INFORMATION PERSONAL INJURY

PATIENT'S NAME: _____ CIRCLE: MALE / FEMALE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____-_____-_____ **CELL: _____-_____-_____**

SS#: _____-_____-_____ **D.O.B. _____/_____/_____**

E MAIL ADDRESS:_____

EMERG. CONTACT: _____ EMERGENCY #: _____-_____-_____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

EMPLOYER'S #: _____-_____-_____ **EMPLOYER'S FAX: _____-_____-_____**

DATE OF INJURY/ ACCIDENT: _____/_____/_____

BODY PARTS INJURED:_____

ACCIDENT INFORMATION:

LAW FIRM/ CASE WORKER:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

LAWYER PH.: _____-_____-_____ EXT: _____ FAX: _____-_____-_____

INSURANCE CO.: _____ CLAIM #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INSURNACE PH.: _____-_____-_____ **FAX: _____-_____-_____**

ADJUSTER'S NAME: _____

PHONE: _____-_____-_____ **EXT: _____**

Do you have vertigo (dizziness)?
☐Yes ☐No
Do you pass out easily (faint or loss of consciousness)?
☐Yes ☐No
Do you have double vision or have you lost sight in one eye?
☐Yes ☐No
Do you have any slurred speech or difficulty with speech?
☐Yes ☐No
Do you have or have you ever had difficulty in arranging words properly?
☐Yes ☐No
Do you have any difficulty walking, with coordination or falling to one side?
☐Yes ☐No
Do you have nausea or vomiting?
☐Yes ☐No
Do you have numbness on one side of your face or body?
☐Yes ☐No
Do you have any visual disturbances or rapid eye movement?
☐Yes ☐No
Do you have a headache or head pain that is unlike any you have had before?
☐Yes ☐No
Do you have headaches for hours or days?
☐Yes ☐No
Do you have a history of stroke in your family?
☐Yes ☐No
Do you have chest pain?
☐Yes ☐No
Do you have any change in bowel or bladder habits?
☐Yes ☐No
Do you have a sore that does not heal?
☐Yes ☐No

Do you have any unusual bleeding or discharge?
☐Yes ☐No
Do you have any thickening in your breasts or elsewhere?
☐Yes ☐No
Do you have indigestion or difficulty swallowing?
☐Yes ☐No
Do you have a change in any wart or mole?
☐Yes ☐No
Do you have a nagging cough or hoarseness?
☐Yes ☐No
Do you have night sweats?
☐Yes ☐No
Do you have pain in neck, jaw or face?
☐Yes ☐No
Do you have a drooping eyelid or change in your pupils?
☐Yes ☐No
Do you have any ringing in your ears?
☐Yes ☐No
Do you take birth control pills?
☐Yes ☐No
Have you ever had cancer?
☐Yes ☐No
Does your pain ever wake you from a sound sleep?
☐Yes ☐No
Are you losing weight now without trying?
☐Yes ☐No
Are you coughing up blood or noticing it in your stools or urine?
☐Yes ☐No
Have you had any loss of bladder or bowel control?
☐Yes ☐No
Have you lost consciousness or had double vision recently?
☐Yes ☐No
Are you seeing any other doctor now for any reason?
☐Yes ☐No

Are you taking any medication or over-the-counter drugs?
Please indicate type (aspirin, etc.) _____
What prescription medication are you taking if any?
[ ] High blood pressure medication
[ ] Blood thinners
[ ] Other _____
What was the date of onset of your last menses? _____

Social History

SMOKER _____ Yes or _____ No, If Yes, how many packs _____
ALCOHOL _____ Yes or _____ No, If Yes, how much _____

Family History

Did you mother or father have any of the following:
Put an **M** for mother, **F** for father and **B** for both.

( ) High Blood Pressure
( ) Ulcer or Stomach Problems
( ) Heart Attack
( ) Stroke
( ) Emphysema
( ) Arthritis-Rheumatism
( ) Seizure-Convulsions
( ) Mental Illness
( ) HIV Positive
( ) Thyroid Disease
( ) Asthma
( ) Circulation Problems
( ) Diabetes
( ) Cancer
( ) Kidney Disease

HEALTH COMPLAINTS

Are you here because you were injured in a motor vehicle accident, while working or because of another traumatic incident? □Yes □No

What is your primary complaint?

_____

_____

How long have you been experiencing this complaint? _____

Describe the quality of you primary complaint.
□Sharp □Dull/achy □Numb □Tightness □Tingling □Burning □Cold □Weakness

How often do you experience this complaint? □Constantly □Intermittent

Have you missed work because of your primary complaint? □Yes □No

Treatment thus far for your primary complaint:

_____

Have you ever had this complaint before? □Yes □No
If yes, what treatment was used?

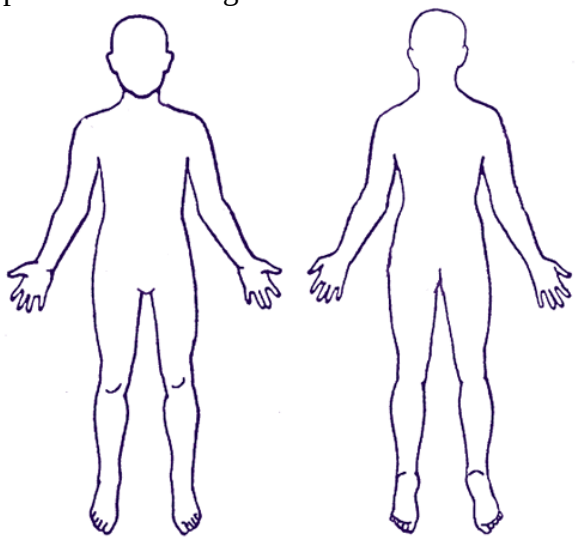
_____

Please list any other health complaints:

_____

_____

Please mark areas of all your complaints on the diagrams below:



FRONT BACK

Victory Injury & Rehab, LLC

4632 Camp Bowie Blvd
Ft Worth, TX 76107
PH # (817) 735-3839 FAX # (817) 735-3837

IRREVOCABLE AUTHORIZATION AND ASSIGNMENT OF BENEFITS AND LIEN

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, assigns to the physician or facility named above 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 adjuster, for purposes of processing my claim for benefits and payment of 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, court costs, or other legally compensable amounts by any insurance company, in accordance with **article 21.55** of the Texas Insurance Code or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree 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, you are hereby tended demand to pay in full the bill for services rendered by the physician/facility named above within 21/45 days (electronic/paper) following your receipt of such bill for services to the extent such bills are payable under the terms of demand specifically conforms with **Article 21.55** of the Texas Insurance Code, providing for attorney fees, **18% penalty**, court costs, and interest from judgment, upon violation.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to cut a separate draft to pay in full for all services rendered, payable directly to the physician/facility named above.

STATUE OF LIMITATIONS: I waive my rights to claim and Statute of Limitations regarding claims for services rendered, or to be rendered, by the physician/facility named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instruments representing payment from any insurance company representing payment for treatment and health care rendered by 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 office upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if do not keep appointments as recommended to me by my caring doctor at this chiropractic clinic, he/she has the 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, any insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.
A photo copy of this instrument shall serve as original.

Signature of Patient and/or responsible parties:

_____ Date_____/_____/_____

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To Whom It May Concern,

I, _____, give authorization and power of attorney for my Third Party Insurance, _____, to pay any and all medical bills related to my injury on ___/___/____ directly to Victory Injury& Rehab, LLC. dba Five Star Personal Injury, Victory Injury & Rehab, LLC. dba Natural Health Chiropractic Sport and Spine or Brian Saul, D.C. at the time of the settlement disbursement. This check for medical bills is to need only sole endorsement by Victory Injury& Rehab, LLC. and any other monies I may receive not related to their medical bills will not be included in this authorization and should be endorsed only with my name. They are also authorized to negotiate for their medical bills on my behalf as this will stand as a power of attorney for that one purpose only.

The patient hereby irrevocably acknowledges full financial responsibility for all services provided to patient by Provider as consideration for such Provider services. Patient irrevocably assigns to Provider any and all benefits payable by or from any insurance or health care plan(s) coverage maintained by Patient as consideration for the total fee for those charges incurred by Patient as a result of those services rendered by Provider. Patient also assigns to Provider: (i) any and all benefits payable by or from any automobile medical payment coverage maintained by Patient or any party under whose policy of insurance Patient may have a lawful right of recovery, (ii) any and all benefits payable by or under any third party liability insurance coverage to which Patient may have a right of recovery due to the injuries for which Patient has sought Provider's health care services, and (iii) a "common law lien interest" in, and all contractual rights and claims to, any and all future insurance proceeds Patient has against any insurance company, health care benefit plan, or any other party contractually liable to Patient for payment of all or any portion of the health care services rendered by Provider, and the resultant charges therefore, to the Patient as a result of the injuries sustained by Patient. This irrevocable assignment of benefits, conveyance of lien interest and contractual rights to and for those charges attributable to Provider's health care services shall extend to, but not be limited to, Provider's entitlement to any and all insurance proceeds remitted as a result of any insurance claim for damages by the Patient which has given rise to the above referenced health care services provider by Provider.

_____ _____/_____/_____
Injured Party's Signature Date

_____ _____/_____/_____
Brian Saul, D.C., DACBSP Date

_____ _____/_____/_____
Witness Date

Assignment And Instruction For Direct Payment to doctor for Private, Group, or Accident Health Insurance

I, _____, hereby instruct and direct

_____

Insurance Company to make check payable and mail directly to:

Five Star Personal Injury

4632 Camp Bowie Blvd

Fort Worth, TX 76107

If my current policy prohibits direct payment to the above, then I hereby instruct and direct you to make the check payable to me and mail it as follows:

_____

c/o Five Star Personal Injury

4632 Camp Bowie Blvd

Fort Worth, TX 76107

the benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Dated at _____, this _____day of _____ 20___.

_____ _____

Signature of policyholder Signature of Claimant, if other than Policyholder

HIPAA
Notice of Privacy Practices

Victory Injury & Rehab, LLC
4632 Camp Bowie Blvd.
Fort Worth, TX 76107

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of you health records.

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this notice of our legal duties and privacy practices with respect to that information.
(2) We are required to abide by the terms of this notice currently in effect.
(3) We reserve the right to change the terms of this notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this notice will be promptly displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We ma also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization.** Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that several people may be treated at the same time in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in our healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this

happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose our protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information,** as follows:

(1) You may request that we restrict the uses and disclosures of your health record information from treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
(3) You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.
(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and address to the Privacy Officer at our address. We will respond to your request in a timely fashion.
(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We w ill not charge you for the first accounting in any twelve-month period; however we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.
(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take on home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to

Lynn Saul
4632 Camp Bowie Blvd.
Fort Worth, TX 76107

PRIVACY PRACTICES PATIENT ACCEPTANCE FORM

I have received or reviewed the privacy practice notice (2 pages) for Victory Injury & Rehab, and understand the situation in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in the privacy practices statement.

_____
Patient Name (Printed)

_____ ____/_____/_____
Patient Signature Date