PATIENT INFORMATION

Patient Name: _____ Nickname_____ Accident Date _____

Address _____ City _____ Zip Code _____ SS # _____

DOB _____ Age_____ Gender M / F Marital Status S M W D

Cell Phone _____ Work Phone_____ E-mail _____

Employer _____ Job Description _____

Emergency Contact _____ Cell Phone _____ Relation_____

Family physician_____ Address_____ Phone #_____

Were you transported to a medical facility immediately following the accident? YES / NO

Have you received other medical treatment since the accident? YES / NO Date you first sought care after accident _____

Hospital_____

Medical Doctor _____

Chiropractor_____

Self Help (ice, aspirin, etc.) _____

Other_____

DESCRIBE THE ACCIDENT

1. **Actions of YOUR vehicle**: crossing an intersection / stopped at intersection / traveling at posted speed / turning
2. **How was YOUR vehicle hit**: head-on / right front / left front / right side / left side / right rear / left rear / rear-ended
3. **Place patient was seated in the vehicle**: driver / front passenger / back driver side / back passenger side
4. **Aware of approaching impact:** YES / NO 5. **Airbag deployed**: YES / NO
6. **Head position at impact**: straight / tilted forward / turned left / turned right
7. **Body position at impact**: straight / turned to left / turned to right
8. **Did you strike any portion of your body**: YES / NO Head / Knee / Arm / Hand / Shoulder / Other _____
9. **What objects did you strike**? Headrest / Steering Wheel / Dash / Windshield / Rearview Mirror / Center Console Side Window / Side Door / Other_____

Lawyer/ Law Firm_____ Phone #_____

Patient / Guardian Signature _____ Date _____

SYMPTOMS

Patient Name_____ Date of Incident _____ Today's Date_____

RIVERMEAD POST-CONCUSSION SYMPTOMS QUESTIONNAIRE

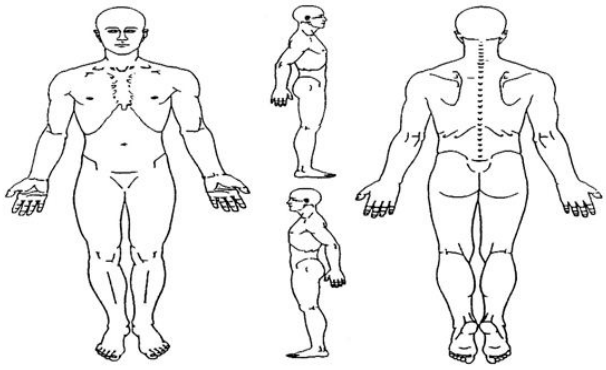
Compare to before collision	**(0 1 2 3 4)**
	none to severe
o Knocked out / unconscious	0 1 2 3 4
o Headaches	0 1 2 3 4
o Dizziness	0 1 2 3 4
o Nausea / vomiting	0 1 2 3 4
o Noise sensitivity	0 1 2 3 4
o Sleep disturbances	0 1 2 3 4
o Fatigue	0 1 2 3 4
o Irritable, easily angered	0 1 2 3 4
o Depressed or tearful	0 1 2 3 4
o Frustrated or impatient	0 1 2 3 4
o Forgetfulness / poor memory	0 1 2 3 4
o Poor concentration	0 1 2 3 4
o Taking longer to think	0 1 2 3 4
o Blurred vision	0 1 2 3 4
o Light sensitivity	0 1 2 3 4
o Double vision	0 1 2 3 4
o Restlessness	0 1 2 3 4
o Other	0 1 2 3 4

_____

CIRCLE ALL ACCIDENT-RELATED COMPLAINTS

- LACERATIONS, CUTS OR BRUISING:
  - Cuts: _____
  - Bruising: _____
- JAW INJURY:
  - Jaw pain
- NECK INJURY:
  - Pain / Numb / Tingling / Spasm
  - Radiates into arm RIGHT / LEFT / BOTH
- SHOULDER INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
  - Radiates into arm / hand
- UPPER ARM INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
  - Radiates into arm / hand
- ELBOW INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
  - Radiates into arm / hand
- FOREARM INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
  - Radiates into hand
- WRIST INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
- HAND INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
- MID BACK INJURY:
  - Pain / Numb / Tingling / Spasm
- LOW BACK INJURY:
  - Pain / Numb / Tingling / Spasm
  - Radiates into leg: RIGHT / LEFT / BOTH
- HIP INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
  - Radiates into leg
- UPPER LEG INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
  - Radiates down leg
- KNEE INJURY:
  - Pain: RIGHT / LEFT / BOTH
- LOWER LEG INJURY: RIGHT / LEFT / BOTH
  - Pain / Numb / Tingling / Spasm
- FOOT INJURY:
  - Pain: RIGHT / LEFT / BOTH
- ANKLE INJURY:
  - Pain: RIGHT / LEFT / BOTH
- OTHER:_____

Shade in all areas of pain or altered sensations (numb/tingling)



Patient / Guardian Signature _____

Duties Performed Under Duress at Work and Home

Name_____ Injury Date _____ Today's Date_____

Please check all that apply to your WORK because of the accident

- o I go to work but work in pain
- o I limit my work activities
- o Bending at work hurts
- o Stooping at work hurts
- o Sitting at work hurts
- o Using the computer at work hurts
- o Pushing at work hurts
- o Kneeling at work hurts
- o I have lost status in my company
- o I have lost job security
- o I didn't get a promotion
- o I don't enjoy work as much as before
- o I doze off at work
- o I take unpaid time off work to go to Dr.
- o I daydream at work more than before
- o I feel tired at work
- o _____
- o I work in pain because I have bills to pay
- o I can't take time off because I would lose my job
- o I keep working so I don't lose status at company
- o My business would fail if I took time off
- o I believe in working even when I'm in pain
- o I feel obligated to work even though I'm in pain
- o My business would lose money if I took time off
- o My work is not as good as it was before accident
- o My boss reprimanded me for poor performance
- o I got a different job within the same company
- o I got a different job in another company
- o I make less money than before the accident
- o I cannot do the same work/job as before accident
- o I can't concentrate as well at work
- o I take paid time off to go to Dr.
- o I hide my poor work performance from my boss
- o _____

Please check all that apply to your HOME/DOMESTIC because of the accident

- o My house is not as clean now
- o My yard is not as neat now
- o My garden is not as productive now
- o I do yard work, but do it in pain
- o I cannot do my normal yard work
- o I do house work, but do it in pain
- o I cannot do my normal house work
- o Doing laundry hurts me
- o I cannot do laundry now
- o Washing dishes hurts me
- o I cannot vacuum now
- o Cooking hurts me
- o I cannot cook now
- o Washing the car hurts me
- o I cannot wash my car
- o Others living with me do my share of the work
- o I cannot take time off because I care for children
- o I have _____children ages_____
- o I had to hire a paid housekeeper
- o I asked someone for unpaid housekeeping help
- o I had to hire a paid gardener
- o I asked someone for unpaid yard work help
- o Mowing the lawn hurts me
- o I cannot mow the lawn
- o Taking out the trash hurts me
- o I cannot take out the trash
- o I do not enjoy gardening/yardwork like I used to
- o I do not enjoy my housework like I used to
- o Gardening hurts me
- o I cannot do my gardening at all since the accident
- o Others do my share of the gardening
- o _____

Patient / Guardian Signature _____

LOSS OF ENJOYMENT OF LIFE

Please check all that apply to your EXERCISE & SPORTS Activity because of the accident

- o I take walks & have pain while walking
- o I no longer take walks
- o I go to the gym & work out in pain
- o I no longer go to the gym to work out
- o I run but in pain
- o I no longer run
- o I have gained_____ pounds since the accident
- o I had to quit my sports team after the accident
- o I don't enjoy my sports anymore
- o I didn't enjoy sports for ____ weeks

Please check all that apply to your HOBBY Activities because of the accident

- o My hobby was affected by accident
- o Hobby: _____
- o I can't do my hobby anymore
- o I do my hobby but in pain
- o I have lost money from not doing my hobby
- o I didn't do my hobby for _____ weeks

Please check all that apply to your TRAVEL Activities because of the accident

- o Business / Pleasure travel was affected by crash
- o I hurt driving in my own car
- o I am in too much pain to drive
- o I hurt when a passenger in a car
- o I am in too much pain to sit in a car
- o I have anxiety when I'm in a car
- o I hurt when I'm on an airplane
- o I am in too much pain to travel by plane
- o I did not go on planned travel
- o I went, but did not enjoy travel as much
- o I went and the accident had no effect on travel
- o I missed time w/ family/friends b/c I can't travel

Please check all the DAILY LIVING activities that cause you pain because of the accident

- o Dressing
- o Putting on pants / shirt / shoes
- o Drying / Combing my hair
- o Bathing / Washing my hair
- o Brushing my teeth
- o Drying with a towel after bathing
- o Lying in bed
- o Sleeping
- o Riding in a car
- o Driving to/from work
- o Closing the trunk on my car
- o Opening doors
- o Sitting in church / movie theatre
- o Playing with my children
- o Caring for my children
- o Exercising
- o Stooping / Squatting / Kneeling
- o Leaning forward
- o Going out with my friends
- o Sitting at a restaurant
- o Shopping Eating
- o Standing to cook
- o Opening a jar
- o Lifting a pan when cooking
- o Sitting in my favorite chair
- o Using my home computer
- o Talking on the phone
- o Reading / Writing / Watching TV
- o Climbing stairs
- o Sexual activity
- o Turning my head left or right
- o Holding my head up all day
- o It's a chore to do usual things

Please check all that apply to your SCHOOL & EDUCATION Activities because of the accident

- o School was affected by the wreck
- o I am in the _____ year/grade
- o I was ☐ full time ☐ part time
- o Now ☐ full time ☐ part time
- o I had to take fewer classes
- o I missed _____ days of school
- o I dropped out of school
- o My grades are lower
- o I have pain carrying my books
- o I hurt sitting in class
- o Neck hurts when I look dn to read
- o I don't learn as quickly as before
- o I don't learn as well as before
- o It's difficult concentrating in class
- o It takes longer to do my studies

_____ _____ _____

Patient Name | Patient / Guardian Signature | Today's date

PAIN CONSULTATION

☐ I am having **FUNCTIONAL DIFFICULTIES** because of NECK PAIN since the collision.
Describe how NECK PAIN is affecting your normal daily activities _____
_____

☐ I am having **FUNCTIONAL DIFFICULTIES** because of UPPER BACK PAIN since the collision.
Describe how UPPER BACK PAIN is affecting your normal daily activities _____
_____

☐ I am having **FUNCTIONAL DIFFICULTIES** because of LOW BACK PAIN since the collision.
Describe how LOW BACK PAIN is affecting your normal daily activities _____
_____

☐ I am having **FUNCTIONAL DIFFICULTIES** because of SHOULDER / ARM PAIN since the collision.
Describe how SHOULDER / ARM PAIN is affecting your normal daily activities _____
_____

☐ I am having **FUNCTIONAL DIFFICULTIES** because of LEG / KNEE PAIN since the collision.
Describe how LEG / KNEE PAIN is affecting your normal daily activities _____
_____

EXACERBATING FACTORS (Check all below that make your NECK hurt worse)

- o Lying down
- o Sleeping
- o Sitting
- o Standing
- o Turning head
- o Bending
- o Twisting
- o Lifting
- o Bathing
- o Dressing
- o Grooming
- o Home chores
- o Computer
- o Work
- o Sports
- o Driving

ALLEVIATING FACTORS (Check all below that make your NECK feel better)

- o Sleep
- o Rest
- o Ice
- o Heat
- o Meditation
- o Massage
- o Over-the-counter medication
- o Prescription medication

EXACERBATING FACTORS (Check all below that make your UPPER BACK hurt worse)

- o Lying down
- o Sleeping
- o Sitting
- o Standing
- o Turning head
- o Bending
- o Twisting
- o Lifting
- o Bathing
- o Dressing
- o Grooming
- o Home chores
- o Computer
- o Work
- o Sports
- o Driving

ALLEVIATING FACTORS (Check all below that make your UPPER BACK feel better)

- o Sleep
- o Rest
- o Ice
- o Heat
- o Meditation
- o Massage
- o Over-the-counter medication
- o Prescription medication

_____ _____ _____ _____
Patient Name | Patient / Guardian Signature | Today's Date | Accident Date

PAIN CONSULTATION, continued

EXACERBATING FACTORS (Check all below that make your LOW BACK hurt worse)

- o Lying down
- o Sleeping
- o Sitting
- o Standing
- o Turning head
- o Bending
- o Twisting
- o Lifting
- o Bathing
- o Dressing
- o Grooming
- o Home chores
- o Computer
- o Work
- o Sports
- o Driving

ALLEVIATING FACTORS (Check all below that make your LOW BACK feel better)

- o Sleep
- o Rest
- o Ice
- o Heat
- o Meditation
- o Massage
- o Over-the-counter medication
- o Prescription medication

EXACERBATING FACTORS (Check all below that make your SHOULDER / ARM hurt worse)

- o Lying down
- o Sleeping
- o Sitting
- o Standing
- o Turning head
- o Bending
- o Twisting
- o Lifting
- o Bathing
- o Dressing
- o Grooming
- o Home chores
- o Computer
- o Work
- o Sports
- o Driving

ALLEVIATING FACTORS (Check all below that make your SHOULDER / ARM feel better)

- o Sleep
- o Rest
- o Ice
- o Heat
- o Meditation
- o Massage
- o Over-the-counter medication
- o Prescription medication

EXACERBATING FACTORS (Check all below that make your LEG / KNEE hurt worse)

- o Lying down
- o Sleeping
- o Sitting
- o Standing
- o Turning head
- o Bending
- o Twisting
- o Lifting
- o Bathing
- o Dressing
- o Grooming
- o Home chores
- o Computer
- o Work
- o Sports
- o Driving

ALLEVIATING FACTORS (Check all below that make your LEG / KNEE feel better)

- o Sleep
- o Rest
- o Ice
- o Heat
- o Meditation
- o Massage
- o Over-the-counter medication
- o Prescription medication

Name _____ Signature _____

HALL
CHIROPRACTIC

1171 Market Street, Suite 104, Fort Mill, SC 29708
HallChiropracticCenter.com
803.412.2240

WHIPLASH STUDIES

- In 1964, the Journal of Bone and Joint Surgery (American) published a study where the author followed 145 whiplash-injured patients for more than two years. The author reported that after a minimum of two years, **45%** of the injured patients continued to suffer from pain.

- In 1989, the journal Neuro-Orthopedics published a 12.5-year (mean duration) study on whiplash-injured patients. The authors reported that **62%** continued to suffer from significant pain symptoms attributed to the motor vehicle collision 12.5 years later.

- In 2000, the Journal of Clinical Epidemiology published a 7-year study on whiplash-injured patients. The authors reported that **39.6%** continued to suffer from neck-shoulder pain 7 years after injury. This 39.6% chronic pain rate was three times greater than the pain noted in the matched control populations.

- In 2005, the journal Injury published a 7.5 year prospective study on whiplash-injured patients. The authors reported that 21% of these patients continued to suffer from clinically relevant pain 7.5 years after injury. An additional **48%** continued to suffer from nuisance pain at the 7.5-year analysis.

- In 1990, the Journal of Bone and Joint Surgery (British) published a 10.8 year study on whiplash-injured patients. The authors reported that **40%** of these patients continued to suffer from clinically significant pain 10.8 years after injury. An additional 40% continued to suffer from nuisance pain at the 10.8-year analysis.

- In 1996, the Journal of Bone and Joint Surgery (British) published a 15.5-year study on whiplash-injured patients. The authors reported that **43%** of these patients continued to suffer from clinically significant pain 15.5 years after injury. An additional **28%** continued to suffer from nuisance pain at the 15.5-year analysis.

- In 2002, the European Spine Journal published a 17-year study on whiplash-injured patients. The authors reported that **55%** of these patients continued to suffer from residual pain 17 years after injury. Of those with residual symptoms, **25%** suffered from neck pain every day, and **23%** had pain radiating into their arm daily.

- In 2006, the Journal of Bone and Joint Surgery (British) published a 30-year study on whiplash-injured patients. The authors reported that **15%** of these patients continued to suffer from clinically significant pain 30 years after injury; their pain was such that they still required ongoing treatment. An additional **40%** continued to suffer from nuisance pain at the 30-year analysis.

*** These studies show that symptoms from this type of injury last years or even decades. Since a cervical sprain/strain injury will only last 4-6 weeks, then other structures were obviously damaged. Fifty percent of all disability is due to ligament damage. X-Rays may be taken of your spine to assess / demonstrate Alteration of Motion Segment Integrity which, according to AMA guidelines is a permanent injury.

Patient Name: _____ Signature: _____ Date: _____

INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument / table upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- spinal manipulative therapy
- palpation
- vital signs
- range of motion testing
- orthopedic testing
- basic neurological testing
- muscle strength testing
- postural analysis
- exercise therapy
- massage therapy
- radiographic studies
- mechanical traction

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, 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 I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications 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 analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options as well and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read and understand the above explanation of the chiropractic adjustment and related treatment. 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 treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

PATIENT NAME: _____ DATE: _____

PATIENT / GUARDIAN SIGNATURE: _____

IRREVOCABLE ASSIGNMENT OF PROCEEDS AND CONVEYANCE OF LIEN INTEREST

Re: Medical Reports and Lien for Undersigned Patient.

I do hereby authorize Hall Chiropractic located at 1171 Market Street, Suite 104, Fort Mill, SC 29708, which is the health care facility at which I am receiving or have received health care services for the injuries I sustained in an accident upon which my case is pending to furnish my attorney and/or any and all insurance carrier(s) with a complete report of any medical records relating to my examination, diagnosis, treatment and prognosis for the need of future medical treatment, if any, including notes, x-rays, and other medical data, relating to the health care services I have been provided by Hall Chiropractic as a result of the accident or other contributing incident giving rise to my need for such health care services.

ASSIGNMENT, LIMITED POWER OF ATTORNEY AND CONVEYANCE OF LIEN INTEREST

I hereby execute and provide this **Irrevocable Lien Interest and Assignment of Proceeds** in favor of Hall Chiropractic. This **Irrevocable Lien Interest and Assignment of Proceeds** shall apply to all monetary proceeds from any third party liability insurance coverage Medical Payment insurance coverage to which I am entitled, or to which may become entitled at some time in the future, through my asserted claim(s) for personal injuries and/or losses against any person or persons, or their insurance representatives/coverage, arising as a result of injuries I have sustained as a result of the accident or incident referenced above. Through this assignment and conveyance of lien interest that I do grant and convey in favor of Hall Chiropractic, I do hereby direct that any and all insurance proceeds to which I am entitled, or to which I may become entitled, that are paid or intended to be paid to me as compensation for the injuries I sustained as a result of the accident or contributing incident giving rise to my need for such health care services, be remitted directly to Hall Chiropractic or its designee, in the amount and to the extent of any unpaid monetary balance that remains due and owing by me to Hall Chiropractic for such services. I do hereby grant and convey a limited power of attorney to the owner(s) of Hall Chiropractic for purpose of directing the disbursement of such insurance proceeds and for the purpose of receiving the remittance of any such insurance proceeds from any monetary settlement or award to which I may become entitled, including future proceeds to which I may become entitled, in an amount sufficient to satisfy the full, unpaid, balance of my account owed to Hall Chiropractic. I do direct that all such settlement proceeds to be paid as compensation for the cost of my medical services be remitted directly to and in the name of Hall Chiropractic.

As consideration for my execution of this **Irrevocable Lien Interest and Assignment of Proceeds** I represent that said doctor and/or treating facility has provided me professional services upon my request, that I am aware of the nature and expense of all such services so provided and that as consideration for his forbearance of his legal right to require payment by me at the time such services were rendered, said doctor and treating facility relied upon my express declaration and intention to execute and instruct that this **Irrevocable Lien Interest and Assignment of Proceeds** apply to all insurance proceeds to which I am or may become entitled and direct that the amount of such proceeds required to satisfy my outstanding balance with said doctor and/or treating facility be remitted directly to the doctor and/or treating facility at such time as I receive an insurance settlement or other monetary settlement/award.

In the event my insurance settlement proceeds are paid directly to my attorney, I hereby instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt my settlement award(s).

I fully understand and stipulate that I am ultimately and directly responsible to the doctor and/or treating facility for payment of all medical bills incurred by me for those services rendered to me, or on my behalf or request, and that this agreement is made solely for the benefit of the doctor and treating facility, as additional protection and in consideration of the treating facility's agreement to forgo its legal right to require immediate collection of payment for those chiropractic services rendered to me or on my behalf. It is my understanding that the Doctor will off-set any monies received through insurance or otherwise against the remaining debt owed by me.

I hereby direct that my attorney furnish to Hall Chiropractic any and all settlement papers, settlement disbursement breakdowns or other documentation relating to any insurance settlement, monetary award or judgment that I have received or have become entitled, as a result of the above described accident or incident for which Hall Chiropractic has provided to me the above referenced health care services.

SIGNED:_____ DATE:_____

Printed Name of Patient:_____

For or On Behalf of the Minor Child: _____, I do hereby assume full financial responsibility for the expense and payment of all services provided to me and to my minor child, if any. I acknowledge that I am independently liable for the cost of all medical/chiropractic services so provided regardless of the existence of insurance coverage or payments.

SIGNED:_____ DATE:_____

Acknowledgements

To set clear expectations, improve communication and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_____ Initials

I instruct Dr. Hall to deliver the care that, in his professional judgement, can best help me in the restoration of my health. I understand that the care offered in this practice is based on the best available evidence and designed to reduce or correct body posture and motion thus reducing many symptoms. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity. I certify that no guarantee or assurance has been made to the results that may be obtained.

_____ Initials

I authorize Dr. David Hall and whomever he may designate as his assistant to perform diagnostic tests and to administer treatment deemed necessary to treat my problem (illness). I understand that diagnostic X-rays may be advisable in my case so that a complete analysis can be made of my problem. I authorize Dr. Hall to perform such x-ray exams necessary to diagnose my present condition. I realize that X-ray may be hazardous to an unborn child and I certify to the best of my knowledge that I am NOT pregnant.

_____ Initials

I grant Hall Chiropractic permission to send and / or receive my complete patient file, including information relating to any medical history, mental or physical condition and any treatment received by me for the purpose of consultation, collaboration or transfer of care to another health care provider.

_____ Initials

I grant Hall Chiropractic permission to contact me via phone, email or text to confirm or reschedule an appointment and to be sent occasional correspondents to me as an extension of my care in this office. I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ Initials

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier or attorney and myself. Furthermore, I understand that this office may help prepare necessary reports and forms, as a courtesy, to assist me in making collection from the responsible Insurance Company and that any monies authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

_____ Initials

I authorize Hall Chiropractic to release my medical / health information necessary to process my insurance and / or personal injury claim(s) and also certify that all insurance information I give to Hall Chiropractic is correct and complete.

_____ Initials

I authorize any and all insurance companies and / or attorney to pay directly to Hall Chiropractic, 1171 Market Street, Suite 104, Fort Mill SC 29708. The expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given limited power of attorney to endorse / sign my name to any and all drafts of payment of my bill.

Patient / Guardian Signature _____ **Today's Date** _____