

PATIENT INFORMATION

Please complete this form in ink. If you have any questions, or concerns, please do not hesitate to ask for assistance. We will be happy to help. Thank you for choosing our clinic for your chiropractic needs.

(Please print)

Name (First, Middle Initial, Last) _____

Address _____ City _____ State/Zip _____

Social Security # _____ - _____ - _____ Birth Date ____ / ____ / ____ Sex: _____

Status: Single Married Separated Divorced Widowed Student? FT PT

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____ E-mail Address _____

In case of emergency contact: (include phone number) _____

Referred By: YellowBook YellowBook.com Dex Book Dex Knows Byrnes Chiropractic Website
 Insurance Provider List A patient we can thank _____ Other _____

Is this condition due to an automobile accident: No Yes or work related accident: No Yes
*If "Yes", please request from the receptionist the **Accident Information** form.*

RESPONSIBLE PARTY

Name of person responsible for this account _____

Relationship to Patient _____ Phone Number _____

Address _____ City _____ State/Zip _____

INSURANCE INFORMATION (please present your insurance card)

If subscriber/insured is not the patient, please complete the following:

Subscriber Name _____ Relationship to Patient _____

Address _____

Birth Date ____ / ____ / ____ Social Security # ____ / ____ / ____ Phone Number _____

The patient/responsible party is hereby responsible for charges incurred during the course of treatment. Byrnes Chiropractic Clinic will, as a service to the patient, file claims with insurance carrier(s) listed. Any charges not covered by the carrier will be the responsibility of the patient/responsible party. I hereby authorize the doctor to release all information necessary to secure payment of benefits from the insurance carrier(s) listed.

I hereby give my permission and consent for treatment.

Patient/Legal Guardian Signature

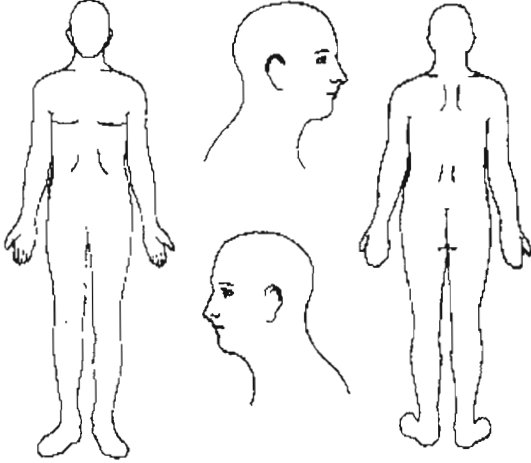
Date

Date of Visit: ___/___/___ Patient: _____ Age: _____

What brought you here today? _____

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES



PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10
NONE LITTLE MEDIUM SEVERE

Describe your past health history:

Prior Illness: _____

Past Hospitalizations: _____

Surgeries: _____

Medications: _____

Patient Signature: X _____

**PARTIAL ASSIGNMENT OF THE CAUSES OF ACTION, ASSIGNMENT OF PROCEEDS
CONTRACTUAL LIEN & AUTHORIZATION**

(*Assignment* or *Assignment / Lien* – Revised 05-15-06)

Purpose. The purpose of this Assignment is to improve the ability of the Office to collect my Charges directly from various Payers. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to **Byrnes Chiropractic Clinic**; "Payer" shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for any reason; "Proceeds" shall include, without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits, plans, or coverage: individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice, regardless of whether such Proceeds relate directly to my Charges or not; "Charges" shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony), any Collection Costs incurred by the Office, interest and delinquency penalties to the extent permitted by law, and any other charges incurred by me at the Office; "Collection Costs" shall include, without limit, any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Partial Assignment of the Causes of Action, Assignment of Proceeds, and Contractual Lien. I hereby assign to the Office, insofar as permitted by law, but only to the extent of my Charges, all of my rights, remedies, and benefits relating to any Payer, including without limit my right to receive Proceeds from any Payer now or in the future, and any and all causes of action that I might have against any Payer now or in the future, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further grant a contractual lien to the Office with respect to my Charges. I further intend for this Agreement to create a secured interest under the applicable Uniform Commercial Code and hereby direct the Office to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such lien. Consistent with these provisions, 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 extent of my Charges.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to 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. I agree that the purpose of any Proceeds received by the attorney is to pay my Charges.

Other Disclosure Authorization. I hereby direct all Payers to release to the Office any pertinent information regarding any coverage I may have including without limit the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize and direct the Office to release any information regarding my treatment or pertinent to my case(s), including without limit a copy of my Charges and a copy of this Assignment, to all Payers in order to facilitate collection of my Charges.

Miscellaneous Provisions. Except as provided in this paragraph, this Assignment 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. I agree that each and every provision of this Assignment is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Assignment 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 shall, nevertheless, remain in full force and effect. This Assignment 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, 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 non-conveniens as such term is defined by law. I further waive any statute of limitations which may apply in any action based upon this Assignment.

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

Patient Name (print): _____

Patient Signature: _____ Date: ____/____/____

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

Parent/Guardian Signature: _____ Date: ____/____/____

FINANCIAL POLICY AND AGREEMENT

("Agreement" – Rev. 05-03-05)

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

Incorporation of Assignment Terms and Definitions. In this Agreement, "Office" and "Clinic" shall refer to: Byrnes Chiropractic Clinic. I have reviewed the Office's Assignment form titled in short as "Assignment" or "Assignment / Lien." The terms and definitions contained in the Assignment are incorporated herein by reference.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at anytime, 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 upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that 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 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.

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"). Without limiting the foregoing, 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 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 further understand that a Payer may require certain Charges to be pre-certified or pre-authorized. I understand that there may be other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office ("Term 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 further agree that should the Office assist me in the verification process, I assume the risk that the Payer and/or the Office may fail to accurately understand or communicate to me the Terms of Non-Coverage. 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 liable in any of the foregoing instances.

Collection of Higher of Allowed Amounts When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize and direct the Office to submit my Charges, as well as a copy of an Assignment, to any and all Payers including, without limit, my health benefit plan. I understand that some or all of these Payers may utilize fee schedules to which the Office has agreed or as imposed by law ("allowed fees"). I further understand that the fees allowed or utilized by one Payer may exceed the fees allowed by another Payer. In the event that the fees allowed or utilized by one Payer exceed the fees allowed by another Payer, I hereby authorize and direct the Office insofar as permitted by law to collect its Charges up to, but not in excess of, the higher of the two amounts. In the event that a particular Payer does not utilize any fee schedule at all, I direct the Office to collect up to its full Charges.

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 checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. 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.

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 for the protection of the rights and interests of the Office and myself. 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, my treatment, or my Charges, 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 non-conveniens as such term is defined by law. I further waive any statute of limitations which may apply in any action based upon this Agreement, my treatment, or my Charges.

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

Patient Name (print): _____

Patient Signature: _____ Date: ____/____/____

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

Parent/Guardian Signature: _____ Date: ____/____/____

PATIENT CONSENT / ACKNOWLEDGMENT
RECEIPT OF NOTICE OF PRIVACY PRACTICES
FROM
BYRNES CHIROPRACTIC CLINIC
JILL C. BYRNES, D.C.

I have received a copy of this office's Notice of Privacy Practices and consent to usage and disclosure of protected health information by Jill C. Byrnes, D.C., her Staff and business associates for treatment, payment, health care operations and additional uses listed in the NPP. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices. You May Refuse To Sign This.

THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON APRIL 14, 2003.

Printed Patient Name _____ **Date** _____

Signature _____

IF APPLICABLE:

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____