MILES OF CHIROPRACTIC CLINIC, LLC 3027 Marina Bay Drive #105 League City, Texas 77573 281-538-2062

Patient Information Sheet **Date**_____

Last Name_____ **First name**_____ **Mi**_____

Address_____ **Apt #** _____

City_____ **State**_____ **Zip**_____

Home Phone_____ **Cell Phone**_____ **Date of Birth**_____

Sex: ___**Male** ___**Female** **Social Security #** _____ **Dr. License #** _____

Patient's Employer_____

Address_____ **City**_____ **State**_____ **Zip**_____

Work Phone_____ **Ext**_____ **E-Mail**_____

Marital Status: ___**Single** ___**Married** ___ **Divorced** ___ **Widowed** **Whom may we thank for referring you?**

Responsible Party (if not patient) _____

Last name_____ **First name**_____ **Mi**_____

Address_____ **Apt#**_____

City_____ **State**_____ **Zip**_____

Home Phone_____ **Cell Phone**_____ **Date of Birth**_____

Sex: ___**Male** ___**Female** **Social Security #**_____ **Dr. License #** _____

Employer_____

Address_____ **City**_____ **State**_____ **Zip**_____

Work Phone_____ **Ext**_____ **E-Mail**_____

Relationship to Patient_____ **Date of Birth**_____

Emergency Contact_____ **Relationship**_____

Home Phone_____ **Cell Phone**_____

Primary Insurance_____ **Secondary Insurance**_____

Policy ID#_____ **Group#**_____ **Policy ID#**_____ **Group#**_____

Reason for visit?_____

When did symptoms first occur?_____ **Are symptoms getting progressively worse?** ___**Yes** ___**No**

Rate the severity of the problem from mild to severe **1 2 3 4 5 6 7 8 9 10 (circle one)**

How often do you have the problem?_____

Does it interfere with: ___ **Sleep** ___ **Work** ___ **Daily Life** ___ **Recreation**

Things that help the condition_____

Things that worsen the condition_____

Patients' Signature_____

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Name and address of other doctor(s) who have treated you for your condition_____

What treatment have you already received for your condition? ___Medications ___Surgery ___Physical Therapy ___Chiropractic Services ___None ___Other

Date of last: Physical Exam_____Spinal X-Ray_____BloodTest_____Spinal Exam_____

Chest X-Ray_____Urine Test_____Dental X-Ray_____MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Aids/Hiv	___Yes ___No	Chicken Pox	___Yes ___No	Liver Disease	___Yes ___No	Rheumatoid Arthritis	___Yes___
Alcoholism	___Yes ___No	Diabetes	___Yes ___No	Measles	___Yes ___No	Rheumatic Fever	___Yes ___
Allergy Shots	___Yes ___No	Emphysema	___Yes ___No	Migraine Headaches	___Yes ___No	Scarlet Fever	___Yes ___
Anemia	___Yes ___No	Epilepsy	___Yes ___No	Miscarriage	___Yes ___No	Stroke	___Yes ___
Anorexia	___Yes ___No	Fractures	___Yes ___No	Mononucleosis	___Yes ___No	Suicide Attempt	___Yes ___
Appendicitis	___Yes ___No	Glaucoma	___Yes ___No	Multiple Sclerosis	___Yes ___No	Thyroid Problems	___Yes ___
Arthritis	___Yes ___No	Goiter	___Yes ___No	Mumps	___Yes ___No	Tonsillitis	___Yes ___
Asthma	___Yes ___No	Gonorrhea	___Yes ___No	Osteoporosis	___Yes ___No	Tuberculosis	___Yes ___
Bleeding Disorders	___Yes ___No	Gout	___Yes ___No	Pacemaker	___Yes ___No	Tumors, Growths	___Yes ___
Breast Lump	___Yes ___No	Heart Disease	___Yes ___No	Parkinsons Disease	___Yes ___No	Typhoid Fever	___Yes ___
Bronchitis	___Yes ___No	Hepatitis	___Yes ___No	Pinched Nerve	___Yes ___No	Ulcers	___Yes ___
Bulimia	___Yes ___No	Hernia	___Yes ___No	Pneumonia	___Yes ___No	Vaginal Infections	___Yes ___
Cancer	___Yes ___No	Herniated Disk	___Yes ___No	Polio	___Yes ___No	Venereal Disease	___Yes ___
Cataracts	___Yes ___No	Herpes	___Yes ___No	Prostate Problem	___Yes ___No	Whooping Cough	___Yes___
Chemical		High Cholesterol	___Yes ___No	Prosthesis	___Yes ___No	Other_____	
Dependency	___Yes ___No	Kidney Disease	___Yes ___No	Psychiatric Care	___Yes ___No	_____	

EXERCISE	WORK ACTIVITY	HABITS	
___None	___Sitting	___Smoking	Packs a day_____
___Moderate	___Standing	___Alcohol	Drinks/Week_____
___Daily	___Light Labor	___Coffee/Caffeine	Cups/Day_____
___Heavy	___Heavy Labor	___High Stress Level	Reason_____

ARE YOU PREGNANT? ___Yes ___No Due Date:_____

Injuries/Surgeries you have had:	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	/ ALLERGIES	/ VITAMINS/HERBS/MINERALS
	/	/
	/	/
	/	/
	/	/
	/	/
	/	/

Consent for Purposes of Treatment, Payment, and Healthcare options

I acknowledge that Miles of Chiropractic "Notice of Privacy Practices" has been provided to me. The notice of privacy practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, and in the performance of healthcare operations of Miles of Chiropractic Clinic. Miles of Chiropractic reserves the right to change privacy practices that are described in this notice. I may obtain a revised copy by calling the office and requesting a revised copy t sent in the mail or asking for one at the time of my next appointment.

This authorization shall remain effective unless revoked in writing by the undersigned.

Signature_____Date_____

Miles of Chiropractic Clinic, LLC

3027 Marina Bay Drive, Suite #105 League City, Texas 77573 281-538-2062

Informed Consent for Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints in a very specific way. You may feel a "click" or "pop", such as when a knuckle is "cracked", and you may feel movement of the joint. This is normal but does not always occur with every adjustment. Various ancillary procedures, such as hot or cold packs, electric stimulation, ultrasound or dry hydrotherapy may also be used in your care.

Possible risks: As with any healthcare procedure, complications are possible following a chiropractic manipulation. Complications could include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon sever injury to arteries of the neck. These complications are extremely rare occurrences. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare". It is safer to get adjusted than it was to get in your car and drive to our clinic!

Other treatment options which could be considered may include the following: Over-the-counter analgesics include risk of stomach irritation, liver and kidney, and other side effects in a significant number of cases. Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics risks include a multitude of undesirable side effects and patient dependence in a significant number of cases. 100,000 Americans die from adverse drug reactions every year. Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable diseases in a significant number of cases. In-hospital errors result in 195,000 deaths per year. Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, post operative complications like infection and wound dehiscense, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes further reduce skeletal mobility, and induce chronic pain cycles. It is quite possible that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had many unusual risks explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. By signing this document, I have freely decided to undergo the recommended treatment, and hereby give my full consent for treatment.

Disclosure of Fees

Examinations:	99201 Brief History and Exam	$55.00	99204 Expanded History & Exam	$150.00
Therapy:	97035 Ultrasound (not incl. iontophoresis)	$35.00	97110 Therapeutic Exercises	$50.00
	97010 Ice/Heat Therapy	$25.00	97140 Manual Therapy	$50.00
	97014 Muscle Electrostimulation 15 min. or less	$35.00	98940 Manipulation (1-2 areas)	$50.00
	97035 Ultrasound (not including iontophoresis)	$35.00	98941 Manipulation (3-5 areas)	$75.00
	99201 Sp/Maint. Check	$40.00	98941 Maintenance	$40.00
			98941 Maintenance W/Modalities	$60.00

Fees for non-listed services will be disclosed at the time of service upon request. Prices are subject to change without re-notification.

I have read the following disclosure and understand the cost of my car at Miles of Chiropractic Clinic, LLC. I understand that I am solely responsible for payment of all the expenses related to my care. I understand that if my balance is not paid in a timely and monthly fashion, I promise to pay any and all collections, court, and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the described fee schedule regardless of the outcome of my case. I understand that Miles of Chiropractic Clinic, LLC, charges 22% APR on accounts requiring billing or that are past due. There is a $30.00 fee on all returned checks.

_____ _____

Signature Date

Miles of Chiropractic Clinic, LLC

3027 Marina Bay Drive, Suite #105 League City, Texas 77573 281-538-2062 fax: 281-538-1046

FINANCIAL POLICY

MAJOR MEDICAL

We are happy to file your medical insurance for you. We require a copy of your driver's license and your insurance card. You will be provided a summary of your benefits at the time of report finding, however, as it is clearly stated by your insurance company, verification of coverage is not a guarantee of benefits and your insurance company my choose to not pay your bill. You are fully responsible for any services your insurance company does not pay, regardless of the reason your company provides for non-payment of the account. To insure your coverage, you should bring a copy of your policy plan booklet. If it is in your booklet, it is covered. Verbal verification does not guarantee coverage. Should you change insurance companies, change your benefit levels, or graduate to Medicare, you must let us know immediately to ensure proper billing of your account.

MEDICARE

Medicare does not cover your initial exam. Our contracts with Medicare state that it is illegal for us to reduce for those services. We apologize for any financial hardship this may cause. The good news is that Medicare will cover your manipulation at 80% once your yearly deductible has been met ($100.00). You may or may not have a secondary insurance policy. There are two types of additional policies: supplemental and secondary. You will be provided a summary of your benefits at the time of your report of findings, however, as it is clearly stated by your insurance company, verification of coverage is not a guarantee of benefits and your insurance company may choose to not pay your bill.

INJURY ASSOCIATED CASES

Miles of Chiropractic Clinic, LLC does not accept non-guaranteed third party assignments. You must have an alternate means of guaranteeing the account or you will have to pay cash for service. Such alternates may be major medical insurance or PIP auto insurance. Please note that the presence of an insurance claim number is not a guarantee of payment for your medical bills and does not relieve you of your financial obligation to Miles of Chiropractic Clinic, LLC. Our doctors will treat you as they deem medically necessary to best resolve your condition. By allowing treatment you agree to and accept the burden of responsibility for your medical bills.

PLEASE NOTE

You are required to provide us with a copy of the accident report and any relevant insurance information. We allow you four months interest free after the last date of service to settle your account with Miles of Chiropractic Clinic, LLC. Of course, payment in full is due immediately upon the attainment of any type of settlement. Interest will accrue after the fourth month at a rate of 22% per annum, compounded monthly. Payments will be applied first to interest charges and to principal last. We require that you instruct the third party insurance company to accept an assignment of benefits from Miles of Chiropractic Clinic, LLC, and either pay us directly or in a dual authorization (2 signatures required) manner. If a third party insurance company is involve, you may have one week from the involvement to provide us with an LOP or Letter of Protection before a doctor's lien is filed. You will be responsible for any expenses related to the filing of the lien. In addition, if an attorney is involved, you will be required to pay 100% of all the balances on the account without exception.

Due to the nature of accident claims, your insurance company (medical or PIP) will be notified of the possibility of third party involvement. This may delay or negate your coverage. If this occurs, you will be billed immediately and finance charges will commence regardless of the time frame.

Signature of Patient_____ Date_____

Signature of Guardian (if patient is a minor)_____ Date_____

Signature of Legal Representative_____ Date_____

Miles of Chiropractic Clinic, LLC is a member of the CSC Credit Services, an Equifax subscriber

Miles of Chiropractic Clinic, LLC

3027 Marina Bay Drive, Suite #105 League City, Texas 77573 281-538-2062 fax: 281-5381046

Assignment & Instructions for Payment

Notifications of Doctor's Lien:

I fully understand that I am directly and fully responsible to said doctor or clinic for all medical bills submitted for services rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration for awaiting payment. I further understand that such payment is not contingent on any acceptance, settlement, judgment, or verdict by which I may eventually recover said fee. I understand that verification of insurance benefits is not a guarantee of coverage, as stated by any and all insurance companies. I am ultimately responsible for the full charge incurred for services here at Miles of Chiropractic Clinic, LLC.

I understand that should funds be paid to me directly that are intended to compensate for unpaid medical expenses at Miles of Chiropractic Clinic, LLC, I will immediately reimburse afore mentioned clinic their portion of the payment. I understand that the failure to do so will result in immediate finance charges being levied at a rate of no less than 22% APR (calculated retroactive to the first day of treatment), and the addition of any and all expenses related to the collection of said debt. I understand that Miles of Chiropractic Clinic, LLC is a member of CSC Credit Reporting Service, an Equifax subscriber and unpaid bills may be reported on my credit report.

I also agree to promptly notify said clinic of any changes in insurance plans or coverage, or changes in representation by attorneys, or claim status. I also understand that I am responsible for any uncollected debt in the event of denial of claims associated with billing disputes arising from changes in benefits, companies, levels of coverage, or processing of claims.

Insurance Companies Please Note:

If applicable, I hereby instruct and direct any and all insurance companies involved in this case to which I have claim for medical expenses, whether stated individually or not, to pay directly by check any and all payments for medical services rendered by Miles of Chiropractic Clinic, LLC to the referred clinic address, regardless of the nature of the payment or the association between the claimant and the policy holder. This is a direct assignment of my rights and benefits as a claimant on this policy for the professional or chiropractic expense/benefits allowable and otherwise payable to me.

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. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case, as set forth under the guidelines of HIPPA. A photocopy of this assignment shall be considered as effective and valid as the original.

By signing below, I acknowledge that I have read and understand the material contained within this document. Furthermore, I accept and agree to all contingencies contained within.

Claimant or policyholder signature_____**Date**_____

Guardian (if patient is a minor)_____

Witness or Notary_____

Miles of Chiropractic Clinic, LLC

3027 Marina Bay Drive, Suite # 105 League City, Texas 77573 281-5382062

HIPPA Notice of Privacy Practices

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use provided by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example: we would disclose your protected health information, as necessary, to a home health agency that provides care to you and/or to a physician to whom you have been referred to ensure that he/she/they have the necessary information to diagnose and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example: obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan for hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected healthcare information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting, or arranging for other business activities. For example: we may disclose your protected healthcare to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We use or disclose your protected health information in the following situations without your authorization: public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research of criminal activity, ,military and national security, workers' compensation, inmates: required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

You have the right to inspect and copy your protected health information. Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for

notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in the best interest to permit use and disclosure of your protected health information then your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively, i.e. electronically. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement. We will provide you with a copy of such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before April 14, 2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA compliance officer.

Signature below is only acknowledgement that you have received notification of our privacy practices:

_____ _____

Signature Date

MILES OF CHIROPRACTIC CLINIC, LLC

3027 Marina Bay Drive, Suite # 105 League City, Texas 77573 281-538-2062 Fax: 281-538-1046

Authorization to Release Health Information

Patient Name_____ **Date of Birth**_____

Home Phone_____ **Cell Phone**_____ **Social Security #**_____

Other names patient has used:_____

This information is being disclosed for the purpose of continuing health care. For health care covering the period(s) ___All or From:_____ To:_____. Complete health record to be disclosed or (check appropriate boxes):

___Operative notes ___History & physical exam ___X-rays/ultrasound ___Progress notes

___Lab tests ___Discharge summary ___Consultations

I understand that specific information to be released may include AIDS or HIV, alcohol and/or drug abuse, and mental health. I understand that if I request copies of records for myself or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

Unless otherwise indicated, this authorization will expire ninety (90) days from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be evoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above. I understand that there may be a fee for preparing and furnishing this information.

I___ Do ___ Do Not authorize this information to be faxed. If yes, fax # : 281-538-1046.

Send records to: Miles of Chiropractic Clinic, LLC

c/o Jamie L. Miles, D.C.

3027 Marina Bay Drive, Suite # 105

League City, Texas 77573

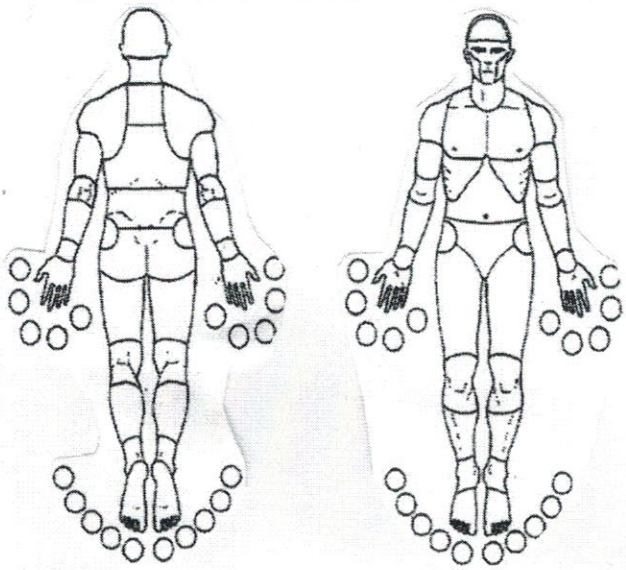
Signature of patient or legal representative_____

Relationship to patient_____ **Date**_____

CHIEF COMPLAINTS

Patient's Name:_____ **Date:**_____

Please indicate the current complaints you are experiencing by marking the image below and providing details using the sections below.



Office use only

Weight **Height**

BP **Pulse**

Resp:

Right/Left Handed

Neck **Back**

Lefs **Dash**

AREA(S) OF COMPLAINT

Location Left____ Right____ Both____ Center____

Severity No pain____ Pain____ Numbness____ Tingling____ / Mild____ Moderate____ Severe____

Pain Ratings 0 (zero)____ 1____ 2____ 3____ 4____ 5____ 6____ 7____ 8____ 9____ 10 (excruciating)____

Frequency Infrequent (25%)_____Occasional (25% to 50%)_____Frequent (50% to75%)_____ Constant (75% to 100%)_____

Onset: When and how did the condition begin:_____

Associated with: Dizziness____Nausea____Visual Problems____Ringing/Buzzing Ears____Bright Light____Sensitivity____ Loss of Balance____

What makes it better? Lying Down____Medication____ Nothing____Range of Motion____Sitting____Standing____Stretching____ Chiropractic Tx____Heat____Ice____Resting____

What makes it worse? Bending____Coughing____Movement_____Lifting____Prolonged Siting____Prolonged Standing____ Prolonged Lying____Transitioning____Reaching____

Symptoms are described as: Aching____Dull____Sharp____Stabbing____Throbbing____Electric____Fiery____Shooting____Deep____ Superficial____

Would you describe the pain as radiating/shooting? Yes____No____ If yes, where?_____

When does the pain seem to be at its worse? Morning____Afternoon____Evening____Night____After activities: Light____Moderate____Strenuous____

Side Effects: Decreased range of motion____Increased sensitivity____Numbness____Stiffness____Tightness____Tingling____

COMMENTS:_____

_____

Patient's signature_____