White Rock
Chiropractic

ACCIDENT INFORMATION

Patient Name:_____

Please circle one:
Was this accident Auto Accident Work related Slip and Fall

Date of Accident: _____

Please describe how the accident Occurred:

_____

_____

_____

If Auto Accident, please describe the following:

Weather conditions: _____

Time of day, Dark or light out:_____

Where were you seated in the vehicle:_____

Did any part of your body strike anything in the vehicle? If, so What?

_____

_____

Did you visit the emergency room? If so Where?_____

Did you travel to the emergency room by ambulance?_____

Have you seen any other Doctor? If so who (name and number)_____

Did the airbags deploy?_____
Were you wearing a seatbelt? _____

Was there anyone else in the car with you?_____

Did the police respond to the scene? If so which Department?_____

Was your car drivable?_____

If you have an Attorney, please provide name and contact information:

_____

_____

At fault party Insurance info:

Name of at fault party:_____

Name of Insurance Company:_____

Contact name and telephone No. at Insurance Co.: _____

_____

Policy number and claim number:

Policy #_____

Claim # _____

If auto accident your insurance Info:

Insurance Carrier:_____

Policy No.: _____

Contact name and telephone No.:_____

Claim number:_____

White Rock Chiropractic

10677 E. Northwest Hwy Ste. 100
Dallas TX, 75238

HIPAA Awareness Form

I have read or had the opportunity to read the "Notice of Privacy Practices" as required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that I may have a copy or request to review the information contained within these regulations at any time.

Patient signature _____ Date _____

Consent to Treat

I hereby request and consent to the performance of chiropractic and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me by Dr. Parent or any other licensed doctors who now or in the future may provide treatment to me. I have had an opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice if medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to anticipate and explain all risks and complications, and I wish to rely on the doctor to excercise judgement in the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interest. I have read the above consent. I have also had an opportunity to ask questions about it's contents and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

Patient signature _____ Date _____

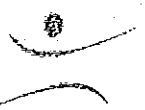
Consent to Treat a Minor

I hereby authorize Dr. Larry Parent, D.C. and whomever he may designate as assistants to administer chiropractic care as deemed necessary to my _____ (Relationship), _____ (Name of Child).

Dated this _____ day of _____, 20_____.

Signed: _____ (Parent or Guardian)

Witness: _____



White Rock Chiropractic

10677 E. Northwest Hwy Ste. 100
Dallas, TX 75238
Telephone (214) 328-2225
Fax (214) 328-2227

I,_____, give _____ permission to release my medical records to White Rock Chiropractic.

I hereby authorize the use and/or disclosure of the following *Protected Patient Health Information* that pertains to me (check all that apply):
___ Chart Notes ___ Reports ___ X-Rays ___ Labwork

As required by the Health Insurance Portability and Accountability Act of 1996, White Rock Chiropractic may neither use nor disclose your Protected Patient Health Information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the use/disclosure/use and disclosure of Protected Patient Health Information described herein. You may revoke hie authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

I understand that the Information for which use/disclosure/use and disclosure is hereby authorized mat be re-disclosed to additional parties and, once re-disclosed, is no longer protected for reasons beyond our controlour control. I understand that I have the right to:

1. Revoke the authorization by sending written notice to this ofice and that revocation will not affect this office's previous reliance on the uses or discloser pursuant to this authorization.
2. Knowledge of any remunertion involved due to any marketing activity as allowed by this authorization, and as a result of a result of this athorization.
3. Inspect a copy of Protected Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this athorization.
5. Receive a copy of this athorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment payment, enrollment in a health plan, or eligibility for benifits whether or not I provide authorazation to use or disclose Protected Patient Health Information.

I understand that White Rock Chiropractic may receive compensation for the use/disclosure/use and disclosure that I have athorized.

_____
Print your Name

_____
Sign your name

_____
Address

_____
DOB

_____
Address

_____
Social Security Number

_____
Telephone Number

_____
Date

White Rock Chiropractic
10677 E. Northwest Hwy. Ste 100 Dallas, TX 75238

Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Larry W. Parent, DC, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all 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 for 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, interest, court cost, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code 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 within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct my carrier to make all checks payable to White Rock Chiropractic, and send to 10677 E. Northwest Hwy., Ste. 100 Dallas TX 75238.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to White Rock Chiropractic, and to send any and all checks to to 10677 E. Northwest Hwy., Ste. 100 Dallas TX 75238.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

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

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

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

Signature of Patient and/or Responsible Parties:
I declare under penalty of perjury that the forgoing is true and correct. [CPRC: Sec. 132.001(a)]

_____ Date:_____
Print Name

_____ Date:_____
Signature

White Rock Chiropractic

10677 E. Northwest Hwy, Suite 100
Dallas, TX 75238

Fee Schedule

TREATMENT FEES:		
98940	CMT Spinal 1-2 Regions	$70.00
98941	CMT Spinal 3-4 Regions	$85.00
98942	CMT Spinal 5 Regions	$100.00
98943	CMT Extra Spinal 1+ Regions	$70.00
97535	Activities of Daily Living Instructions	$85.00
97112	Balance / Coordination/ Muscle Re-Education	$80.00
97032	Attended Phototonic Stimulation	$55.00
97039	Dry Hydrotherapy	$55.00
99211	Office Visit / Telehealth Visit	$65.00
99212-25	Re-Exam (Limited)	$250.00
99213-25	Re-Exam (Expanded)	$300.00
99214-25	Re-Exam (Detailed)	$350.00
99215-25	Re-Exam (Comprehensive)	$400.00
A4556	Electrodes	$20.00
A9273	Ice Pack	$20.00
97140-59	Manual Therapy 1+ Regions (15 min each)	$80.00
97124	Massage Therapy (15 min each)	$50.00
99202-25	New Patient Exam (Expanded)	$400.00
99203-25	New Patient Exam (Detailed)	$450.00
99204-25	New Patient Exam (Comprehensive)	$500.00
99205-25	New Patient Exam (Comprehensive / Complex)	$550.00
99080	Special Reports (Narrative)	$150.00
99080	Report Preparation	$20.00
97014	Electrical Muscle Stimulation	$55.00
97010	Application of Ice / Heat Packs	$30.00
97012	Mechanical Traction	$55.00
97110-59	Therapeutic Exercises	$80.00
97035	Ultrasound	$55.00

X-RAY FEES:		
72040	Cervical Spine 2-3 views	$195.00
72070	Thoracic Spine 2 views	$185.00
72100	Lumbar Spine 2-3 views	$185.00
72052	Cervical Spine Davis Series	$300.00
72050	Cervical Spine 5 views	$260.00
72020	Single Spinal View	$60.00
71100	Rib Series 2 views	$160.00
73030	Shoulder Series 2 views	$165.00
73080	Elbow Series 2 views	$140.00
73110	Wrist Series 3 views	$160.00
73130	Hand Series 3 views	$140.00
73140	Finger Series 2 views	$110.00
73510	Hip Series 2 views	$160.00
73560	Knee Series 2 views	$135.00
73610	Ankle Series 3 views	$160.00
73620	Foot Series 2 views	$130.00
73660	Toe Series 2 views	$110.00

The fees outlined above are representative of charges that may be incurred for services at White Rock Chiropractic. If a service is provided that is not reflected in the list above, you will be notified of such charge. If you have any questions regarding the meaning of any / all of the above terms, please have the doctor explain it to you.

PATIENT SIGNATURE: _____ DATE: _____