Cooley Chiropractic

Personal Injury Questionnaire

Please Print Clearly **Date** _____

NAME: _____ Date of Birth _____

Male _____ Female _____

Single _____ Married _____ Spouse Name: _____

Address:

Street _____ City _____ State _____ Zip_____

Home Phone_____ Cell Phone _____

E-mail _____

In Case of Emergency please contact:

Name _____

Phone _____ Relationship _____

Place of Employment:

Occupation _____

Work Phone _____

May we contact you at work? Yes _____ No _____

Insurance Information: (Yours)

Auto Insurance Company Name _____

Address _____ City _____ State _____ Zip _____

Phone number _____

Agent Name _____ Phone Number _____

Policy Number _____ Claim Number _____

Adjuster Name _____ Phone Number _____

Third Party Information: (Other party involved)

Name of Policy Holder _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Auto Insurance Company Name _____

Policy Number _____ Claim Number _____

Phone number _____

6605 Precinct Line Rd, Suite 100B, North Richland Hills, TX 76182
www.cooleychiropractic.com
817-281-1995

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Attorney Information:

Name _____ Phone number _____

Address _____ City _____ State _____ Zip _____

Details of Accident:

Date of accident _____ Time of day _____

Were you: Driver _____ Passenger _____

Describe in detail the nature of your accident:

_____

_____

_____

Were the police notified? Yes _____ N0 _____

Were you taken to the hospital? Yes _____ No _____

If yes, what treatment did you receive? _____

_____

_____

Please list any prior physical complaints that would have been exacerbated due to this accident.

_____

_____

_____

Describe how you felt:

Immediately after the accident:

_____

_____

_____

The next day:

_____

_____

_____

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Current Symptoms you are experiencing:

_____

_____

_____

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold	☐ Neck Pain
☐ Chest Pain	☐ Shortness of Breath		☐ Buzzing in Ears	☐ Hands Cold	☐ Neck Stiff
☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset	☐ Sleeping problems	
☐ Heavy Depression	☐ Fainting	☐ Constipation	☐ Back Pain	☐ Pins & Needles in Arms	
☐ Light Bother Eyes	☐ Loss of Smell	☐ Cold Sweats	☐ Nervousness	☐ Pins & Needles in Legs	
☐ Loss of Memory	☐ I Loss of Taste	☐ Fever	☐ Tension	☐ Numbness in Fingers	
☐ Ears Ringing	☐ Diarrhea				

By signing below, you are acknowledging and certifying the above is correct and true.

Name: Print_____ Date: _____

Signature _____ Date: _____

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Terms of Acceptance

When a person seeks chiropractic care and we accept a person for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understands both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is specific adjustments to the spine.

Health: A statement of physical, mental and social well-being; not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. Our focus in this office is the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses, or treatment for the aforementioned findings we recommend that you seek another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY PRACTICE OBJECTIVE is to locate, analyze and correct vertebral subluxation by specific adjustments.

I _____ have read and fully understand the above statements.
(print name)
All questions regarding the chiropractor's objectives to my care in this office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature _____ Date _____

CONSENT TO EVALTUATE AND ADJUST A MINOR

I, _____being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Signature _____ Date _____

PREGNANCY RELEASE

This is to certify to the best of my knowledge I am not pregnant and the above doctor and his staff have my permission to perform X-rays.

Date of last menstrual period _____

Signature _____ Date _____

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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient_____ Date _____

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AUTORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION

AND

AUTHORIZATION OF ASIGNMENT OF BENEFITS

We strongly feel that all patients deserve from us the very best chiropractic care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy

Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility

1. I hereby instruct and direct the _____insurance company to pay by check made out and mailed directly to:

COOLEY CHIROPRACTIC

6605 PRECINCT LINE ROAD, SUITE 100B

NORTH RICHLAND HILLS, TEXAS 76182

I authorize this office to release or receive any information necessary to expedite insurance claims. I hereby authorize this office to bill my insurance company directly for their service. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to Dr. Kent Cooley for which these fees are payable.

2. If I discontinue care before being released by Dr. Kent Cooley, any and all bills are immediately due and payable.
3. If you are a workers compensation patient, your worker compensation carrier is responsible.

I understand that I am directly and fully financially responsible to this clinic for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgement or insurance payment by which I recover said fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment within 60 days, it is my responsibility to pay my doctor's bill directly.

I further understand and agree that if I fail to make timely payments on my account. I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney fees.

Dated the _____ day of _____Year_____

Signature of Policy Holder _____ Witness _____

Signature of Claimant _____

Cooley Chiropractic

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 Kent R. Cooley, D.C., 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 persons, 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 INFORMATIN: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor 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 loss, or other legally compensable amounts owned by an insurance company in accordance with Articles 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, whenever 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 an, and Article 21.55 of the Texas insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgement, upon violation. I further instruct the provider to make all checks payable to Cooley Chiropractic, and to send to 6605 Precinct Line Road, Suite 100B, North Richland Hills, Texas 76182.

THIRD PARY 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 Cooley Chiropractic, and to send any and all checks to 6605 Precinct Line Road, Suite 100B, North Richland Hills, Texas 76182.

STATUTE OF LIMITATIONS: I waive the right to claim any statute of limitations regarding claims from services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collections, 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/facilities 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 any 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: _____ Date _____

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