RESTORATION

CHIROPRACTIC

AUTO ACCIDENT

WELCOME! WE ARE HONORED TO SERVE YOU!

Please bring all your completed paperwork along with the following items to your first appointment:

VALID DRIVER'S LICENSE
PHOTOS OF INJURY/VEHICLE
POLICE REPORT
YOUR HEALTH INSURANCE CARD
YOUR AUTO INSURANCE CARD

QUESTIONS?

CALL US
972-818-5820

EMAIL US
team@gorestorationtx.com

Restoration Chiropractic
1061 N Coleman St Ste 130
Prosper, TX 75078

ACCIDENT QUESTIONNAIRE

AUTO INSURANCE INFORMATION

****Your car insurance will only release information to you, the policy holder. Please call <u>your car insurance provider</u> to obtain this information.***

Do you have med pay? ◯ Yes ◯ No

If so, how much? ______________________

Do you have uninsured motorists insurance?
◯ Yes ◯ No

If so, what's the limit? ___________________

Patient Name: ________________________________

<u>YOUR</u> Insurance Company: ____________________

<u>YOUR</u> Claim #: ________________________________

Adjuster: ____________________________________

His/Her Phone #: ______________________________

ATTORNEY INFORMATION

FIRM: ______________________________________

DATE OF INJURY: _______________________________

ATTORNEY: __________________________________

PHONE #: ____________________________________

CASE MANAGER: ______________________________

PHONE #: ____________________________________

OTHER INSURANCE INFORMATION (TYPICALLY THIS IS THE AT FAULT DRIVER INFORMATION)

INSURANCE COMPANY: _________________________

CLAIM NUMBER: _______________________________

ADJUSTER: ___________________________________

CONTACT NUMBER: _____________________________

COMMENTS: ____

____

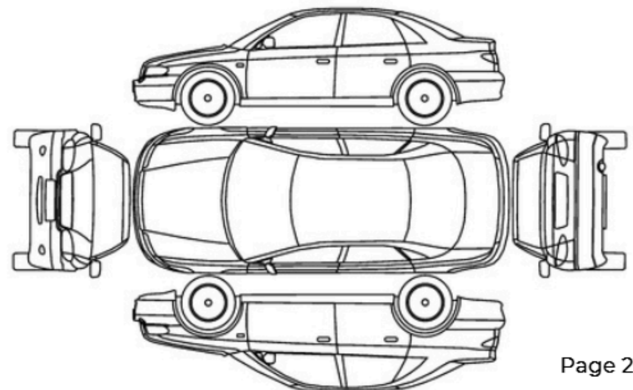
YOUR VEHICLE DAMAGE

On a scale of 1-10, rate the damage to your vehicle:
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Total Cost of Damage: $_________________________

Was the vehicle drivable after the accident?
◯ Yes ◯ No

Circle Areas of Damage:



AUTOMOBILE ACCIDENT FORM

PATIENT DEMOGRAPHICS

Last: ______________________ First: _________________ M.I. _____ MALE / FEMALE Date of Birth: ____________

Address: ______________________________________ City: _________________ ST: ____ Zip: _________

Phone: __________________ Email: ___________________________ Social Security #: _______________

WORK STATUS: FULL TIME ◯ PART TIME ◯ DISABLED ◯ RETIRED ◯ UNEMPLOYED ◯

Occupation: ____________________________ Employer: ____

ACCIDENT DETAILS

Please describe the accident in detail: ____
____
____

Was anyone else in the car with you? _________________________ Date of Accident: __________________

Time of Accident: ________ am / pm Road conditions at the time of the accident: WET / DRY / OTHER: _____

Were you in a company vehicle? YES / NO Was the accident on the job? YES / NO

Location of the Accident: ____

Were you aware of the approaching collison prior to the impact, or did it catch you by surprise?

AWARE / SURPRISED Did you hit the head rest during the accident? YES / NO

Did you lose consciousness upon impact? YES / NO

Which way was your head pointing at the time of impact? STRAIGHT / LEFT / RIGHT

Which way was your body pointing at the time of impact? STRAIGHT / LEFT / RIGHT

Were you wearing a hat or glasses at the time of impact? NO / HAT / GLASSES / BOTH

If so, were they still on after the accident? YES / NO Other: ______________________________________

AFTER ACCIDENT TREATMENT

Did you go to the hospital? YES / NO Which hospital? ____

Did you go to the hospital the same day? YES / NO If no, when? ____________________________________

How did you get to the hospital? AMBULANCE / DROVE / OTHER: ______________________________

Did the hospital take imaging? XRAYS / CT SCAN / MRI / NONE

What areas? HEAD / NECK / MID BACK / LOW BACK / OTHER: _____________________________

What did they recommend for follow-up care? ____

Please list any other doctors/treatments you have had for this injury: _____________________________

Please list any previous injuries or trauma: ____

ACCIDENT COMPLAINTS

Rate the symptoms that have started since the accident/injury from 1-10 (1=mild, 10=extreme)

_____ Neck pain
_____ Mid back pain
_____ Low back pain
_____ Chest pain
_____ Abdominal pain
_____ Headaches/ Migraines
_____ Fainting

_____ Arm Pain L or R
_____ Shoulder pain L or R
_____ Leg pain L or R
_____ Knee pain L or R
_____ Hip pain L or R
_____ Wrist pain L or R
_____ Ankle pain L or R
_____ Elbow pain L or R

_____ Numbness in arms
_____ Numbness in legs
_____ Numbness in hands
_____ Numbness in feet
_____ Irritability
_____ Depression
_____ Anxiety

_____ Loss of smell
_____ Loss of taste
_____ Loss of hearing
_____ Loss of vision
_____ Fatigue
_____ Trouble sleeping
_____ Shortness of breath

1st COMPLAINT **DESCRIBE THIS ONE COMPLAINT ONLY**

Body Part: ____ Date symptom first appeared: ____________________

How often do you experience this symptom? CONSTANT / FREQUENT / INTERMITTENT / OCCASIONAL

What makes the symptom feel worse? ____

What makes the symptom feel better? ____

Type of pain? ACHING / THROBBING / STABBING / BURNING / NUMBING / DULL / SHARP

On a scale of 1-10, rate the intensity of this symptom (1=mild, 10=extreme):

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Where does the pain radiate to? ____

BEFORE THE ACCIDENT

Have you ever had this complaint before? YES / NO If yes, when? ____

On a scale of 1-10, rate the intensity of this symptom before the accident (1=mild, 10=extreme):

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Where did the pain radiate to? ____

What was the condition affecting you from doing? (Work, sports, home, etc.) ______________________________

____

2nd COMPLAINT **DESCRIBE THIS ONE COMPLAINT ONLY**

Body Part: ____ Date symptom first appeared: ____________________

How often do you experience this symptom? CONSTANT / FREQUENT / INTERMITTENT / OCCASIONAL

What makes the symptom feel worse? ____

What makes the symptom feel better? ____

Type of pain? ACHING / THROBBING / STABBING / BURNING / NUMBING / DULL / SHARP

On a scale of 1-10, rate the intensity of this symptom (1=mild, 10=extreme):

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Where does the pain radiate to? ____

BEFORE THE ACCIDENT

Have you ever had this complaint before? YES / NO If yes, when? ____

On a scale of 1-10, rate the intensity of this symptom before the accident (1=mild, 10=extreme):

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Where did the pain radiate to? ____

What was the condition affecting you from doing? (Work, sports, home, etc.) ______________________________

____

3rd COMPLAINT **DESCRIBE THIS ONE COMPLAINT ONLY**

Body Part: ______________________________ Date symptom first appeared: ______________

How often do you experience this symptom? CONSTANT / FREQUENT / INTERMITTENT / OCCASIONAL

What makes the symptom feel worse? ______________________________

What makes the symptom feel better? ______________________________

Type of pain? ACHING / THROBBING / STABBING / BURNING / NUMBING / DULL / SHARP

On a scale of 1-10, rate the intensity of this symptom (1=mild, 10=extreme):

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Where does the pain radiate to? ______________________________

BEFORE THE ACCIDENT

Have you ever had this complaint before? YES / NO If yes, when? ______________________________

On a scale of 1-10, rate the intensity of this symptom before the accident (1=mild, 10=extreme):

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Where did the pain radiate to? ______________________________

What was the condition affecting you from doing? (Work, sports, home, etc.) ______________________________

____

4th COMPLAINT **DESCRIBE THIS ONE COMPLAINT ONLY**

Body Part: ______________________________ Date symptom first appeared: ______________

How often do you experience this symptom? CONSTANT / FREQUENT / INTERMITTENT / OCCASIONAL

What makes the symptom feel worse? ______________________________

What makes the symptom feel better? ______________________________

Type of pain? ACHING / THROBBING / STABBING / BURNING / NUMBING / DULL / SHARP

On a scale of 1-10, rate the intensity of this symptom (1=mild, 10=extreme):

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Where does the pain radiate to? ______________________________

BEFORE THE ACCIDENT

Have you ever had this complaint before? YES / NO If yes, when? ______________________________

On a scale of 1-10, rate the intensity of this symptom before the accident (1=mild, 10=extreme):

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Where did the pain radiate to? ______________________________

What was the condition affecting you from doing? (Work, sports, home, etc.) ______________________________

____

At the time of the accident, did you experience any of the following?:

◯ Confusion ◯ Disorientaion ◯ Lightheadedness ◯ Dizziness

◯ Nausea ◯ Blurred Vision ◯ Loss of Balance ◯ Ringing in Ears

Do you have any of those symptoms now? YES / NO If yes, which ones? ______________________________

____

____

PATIENT NAME:____

Please list your allergies: ◯ NONE (please check if no known allergies)

Allergy ______________________ Reaction ____

Allergy ______________________ Reaction ____

Allergy ______________________ Reaction ____

Allergy ______________________ Reaction ____

Please list any surgeries you have had: ◯ NONE (please check if no prior surgeries)

Date ________________________ Type ____

Date ________________________ Type ____

Date ________________________ Type ____

Date ________________________ Type ____

Please list any medical conditions you currently have: ◯ NONE (please check if none)

____

____

____

List any medication you are currently taking: ____

SOCIAL HISTORY

EXERCISE: ◯ DAILY ◯ WEEKLY ◯ MONTHLY ◯ RARELY ◯ NEVER

CHILDREN: YES / NO If so, how many?_________

DO YOU SMOKE? YES / NO If so, how many packs per day?_________ For how many years? _________

OTHER NICOTINE PRODUCTS? YES / NO If yes, which? __________________

DRINK ALCOHOL? ◯ DAILY ◯ 1-2 WEEK ◯ 1-2 MONTH ◯ 1-2 YEAR ◯ NEVER

LIFESTYLE (Hobbies, recreational activities,etc.) ____

____

FAMILY HISTORY

If yes, please specify which family member on the line provided)

ARTHRITIS?	YES / NO	______________________________
BLOOD CLOTS? / EXCESSIVE BLEEDING?	YES / NO	______________________________
HYPERTENSION?	YES / NO	______________________________
DIABETES?	YES / NO	______________________________
CANCER?	YES / NO	______________________________
MENTAL HEALTH DISORDERS?	YES / NO	______________________________
CARDIAC DISORDERS?	YES / NO	______________________________

ACTIVITIES OF LIFE

Please rate how each activity affects you. Write "N/A" for any activity not applicable to you.

PERSONAL HYGIENE & DAILY CARE

ACTIVITY	No effect	Painful (can do)	Painful (limits)	Unable to perform	ADDITIONAL NOTES
Bathing/Showering	☐	☐	☐	☐	
Grooming Hair	☐	☐	☐	☐	
Brushing Teeth	☐	☐	☐	☐	
Using the Toilet	☐	☐	☐	☐	
Dressing Upper Body	☐	☐	☐	☐	
Dressing Lower Body	☐	☐	☐	☐	

DAILY PHYSICAL ACTIVITIES

ACTIVITY	No effect	Painful (can do)	Painful (limits)	Unable to perform	ADDITIONAL NOTES
Standing	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	
Squatting	☐	☐	☐	☐	
Kneeling	☐	☐	☐	☐	
Reaching Overhead	☐	☐	☐	☐	
Bending Forward	☐	☐	☐	☐	
Turning Left	☐	☐	☐	☐	
Turning Right	☐	☐	☐	☐	
Lying to Sitting	☐	☐	☐	☐	
Sitting to Standing	☐	☐	☐	☐	
Standing to Sitting	☐	☐	☐	☐	

FUNCTIONAL ACTIVITIES

ACTIVITY	No effect	Painful (can do)	Painful (limits)	Unable to perform	ADDITIONAL NOTES
Sleeping	☐	☐	☐	☐	
Eating	☐	☐	☐	☐	
Up & Down Stairs	☐	☐	☐	☐	
In & Out of Car	☐	☐	☐	☐	
Driving	☐	☐	☐	☐	
Focusing	☐	☐	☐	☐	
Preparing Food	☐	☐	☐	☐	
Household Chores	☐	☐	☐	☐	

SOCIAL, RECREATIONAL, & OTHER ACTIVITIES

ACTIVITY	No effect	Painful (can do)	Painful (limits)	Unable to perform	ADDITIONAL NOTES
Competitive Sports	☐	☐	☐	☐	
Running / Jogging	☐	☐	☐	☐	
Hiking	☐	☐	☐	☐	
Other Rec. Activities	☐	☐	☐	☐	
Hobbies	☐	☐	☐	☐	
Sexual Activities	☐	☐	☐	☐	

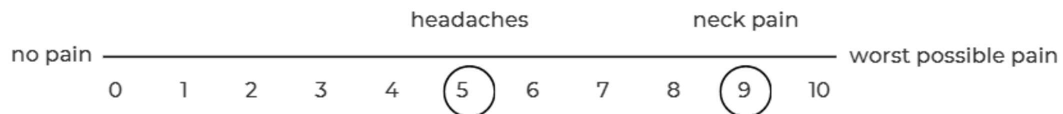
QUADRUPLE VISUAL ANALOGUE SCALE

PLEASE READ CAREFULLY

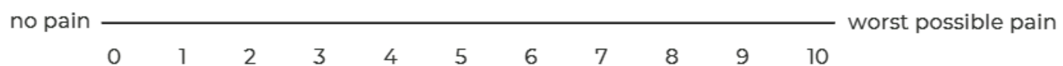
Instructions: Please check the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

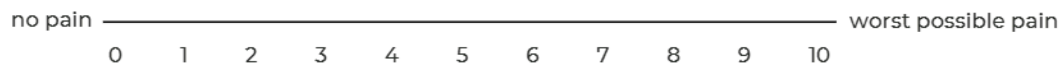
EXAMPLE:



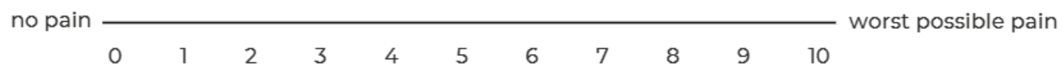
HOW WOULD YOU DESCRIBE YOUR PAIN RIGHT NOW?



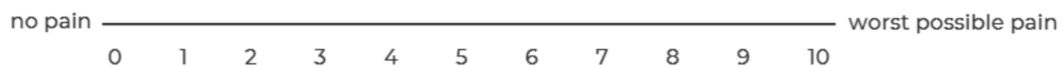
WHAT IS YOUR AVERAGE OR TYPICAL PAIN?



WHAT IS YOUR PAIN LEVEL AT ITS BEST?
(HOW CLOSE TO 0 DOES YOUR PAIN GET AT YOUR BEST?)



WHAT IS YOUR PAIN LEVEL AT ITS WORST?
(HOW CLOSE TO 10 DOES YOUR PAIN GET AT YOUR WORST?)



If This Health Profile Is For A Minor/Child, Please Fill Out And Sign Below Written Consent For A Child

Name of practice member who is a minor/child: ____

I authorize Dr. Jacob Schumann, Dr. Stephanie Rodriguez, Dr. Olivia Thomas and all Restoration Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Restoration Chiropractic.

Guardian Signature ____

Relationship to Minor/Child _______________________Date: ____________

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

I authorize and request payment of insurance benefits directly to Jacob Schumann, D.C., Stephanie Rodriguez D.C., Olivia Thomas D.C.. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print Name: ____

Signature: _______________________________Date: ______________

Terms of Acceptance

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by Doctors of Chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other types of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic care.
G. We invite you to speak frankly to the doctor on any matter related to your health care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Signature: ____ Date: __________________

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide digital copies of your x-rays via email to the email address on file. Digital x-rays will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctors of Restoration Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Name: ____ Date of Birth: _____________

Signature: ____ Date: ___________________

FEMALES ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time the x-rays are taken at Restoration Chiropractic.

Signature: ____ Date: ___________________

DO NOT WRITE BELOW THIS LINE ● DO NOT WRITE BELOW THIS LINE ● DO NOT WRITE BELOW THIS LINE

Cervicals (cm)	Thoracics (cm)	Lumbars (cm)
Lateral Cervical:	Lateral Thoracic:	Lateral Lumbar:
AP Cervical:	AP Thoracic:	AP Lumbar:
APOM:		
Flexion / Extension:		
Obliques:		

Medical Information Release Form
(HIPAA Release Form)

Name: ____ Date of Birth: ____________________________

Release of Information:
[ ] I authorize the release of information including the diagnosis, records; examination rendered to me, appointment times, and claims information. This information may be released to:

[ ] Spouse
[ ] Child(ren)
[ ] Other ____________________________________
[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages:
Please call [ ] my home [ ] my work [ ] my mobile number:

If unable to reach me(please select all that apply):

[ ] you may leave a detailed message
[ ] you may leave a message asking me to return your call
[ ] you may send information regarding my treatment via text message
[ ] Other: ____

The best time to reach me is (day)_______________ between (time) ________________

Signature: ____ Date: ____________________

Witness: ____ Date: ____________________

RESTORATION

CHIROPRACTIC

NOTICE OF DOCTORS LIEN

Dr. Jacob Schumann, Dr. Stephanie Rodriguez, & Dr. Olivia Thomas

1061 North Coleman St Ste 130

Prosper, TX 75078

972-818-5820

Patient: ____ Date of Accident: _________________________

I do hereby authorize Dr. Jacob Schumann, Dr. Stephanie Rodriguez, and Dr. Olivia Thomas to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgement, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctors for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

I acknowledge that Restoration Chiropractic LLC is not required to permit me the option to postpone or make payments toward of services rendered, and that it is being done solely as a courtesy. As such, Restoration Chiropractic may, at any time, seek payment for any and all amounts owed by me while this lien is in force. Additionally, if my attorney fails to acknowledge this lien in favor of Restoration Chiropractic LLC, the entire balance related to this personal injury treatment is my sole responsibility, and Restoration Chiropractic LLC may demand payment immediately.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

Patient Signature: ____ Date: ___________________

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

Attorney Signature ____ Date: ___________________

Assignment of Benefits Form

DIRECTION TO PAY: Restoration Chiropractic LLC

MAIL PAYMENT TO:

RESTORATION CHIROPRACTIC LLC
1061 North Coleman St Ste 130
Prosper, TX 75078

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICE RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Known by all these present that: the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint RESTORATION CHIROPRACTIC LLC and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and RESTORATION CHIROPRACTIC LLC which checks, drafts or money orders are made payable for services which have been made RESTORATION CHIROPRACTIC LLC at the request of with the knowledge and approval of the undersigned and/or maker of the check, draft or money order.

This assignment includes but is not limited to, all rights to collect benefits directly from my insurance company for services that I have received and all rights to proceed against my insurance company in any action including legal suit if for any reason my insurance company fails to make payments of benefits due to my assignee or me. This assignment also includes any rights to recover attorney's fees and costs for such action brought by the provider as my assignee.

The undersigned by these presents does give and grant RESTORATION CHIROPRACTIC LLC as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said check and concerned as well as any other document.

A photocopy of this document shall be as binding as an original signature page.
The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do cause to be done by virtue of these

Assignment of Benefits

I, ______________________________ , hereby authorize ____________________________________
(name of insured) (name of insurance company)
to pay to and mail directly RESTORATION CHIROPRACTIC LLC the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby irrevocably assign to RESTORATION CHIROPRACTIC LLC and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Texas Statutes for any services and charges provided by RESTORATION CHIROPRACTIC LLC.

_________________________________ _________________________________ __________
PATIENT'S SIGNATURE PATIENT'S NAME DATE

RESTORATION

CHIROPRACTIC

Dr. Jacob Schumann, Dr. Stephanie Rodriguez, & Dr. Olivia Thomas

1061 North Coleman St Ste 130

Prosper, TX 75078

972-818-5820

To: ______________________________ Date: ___________________________

____

____

____

From: Restoration Chiropractic LLC

Please forward to the address above:

X-rays and Reports

Medical Reports

I, ________________________________, authorize any doctor, hospital, employer, or other person whom a signed copy or a photocopy of this authorization is delivered, to furnish any information, reports or copies of records which may be requested by Restoration Chiropractic.

Date of Birth: ___________________________________

Patient Signature: ______________________________ Date: ___________________

This form is to remain in effect until terminated by me in writing.

Restoration Rep.: ________________________________ Date: ___________________

RESTORATION CHIROPRACTIC
1061 N COLEMAN #130 PROSPER TX 75078 972-818-5820
GORESTORATIONTX.COM TEAM@GORESTORATIONTX.COM

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff.

YOUR RIGHTS:

1. To inspect or obtain a copy of your records within 15 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say “no” to your request, but we’ll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address).
4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
5. To receive an accounting of disclosures (those with whom we’ve shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

USES AND DISCLOSURES:

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or imminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient’s death.
9. For workers’ compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency – in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

COMPLAINT:

If you wish to make a complaint about how we handle your health information, please contact our privacy official using the information noted above. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

U.S. Dept. of Health and Human Services, Office of Civil Rights
200 Independence Avenue, SW, Washington DC 20201
877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued …

Please complete the following where indicated and return to our front desk staff.

Patient initials: _________ **- retaining *page 1 of 2***

I hereby acknowledge I have read and received a copy of Restoration Chiropractic Privacy Practices Notice.

I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.

I am aware an extended detail version of this "Notice" is available to me upon request.

At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: ____ Date: ________________________

Print Name: ____ Telephone: ____________________

If not signed by the patient, please indicate relationship:

_____ Parent or guardian of minor patient

_____ Guardian or conservator of an incompetent patient

_____ Beneficiary or personal representative of deceased patient

Name of Patient: ____

For Office Use Only

Signed form received by: ____

Reason acknowledgment not obtained: ____

Efforts to obtain: ____

PATIENT'S NAME: ______________________________________ HR#: _____________ DATE: __________