562 KINGWOOD DRIVE
KINGWOOD, TX 77339
281-354-8330

Accident Application Form

WELCOME TO OUR OFFICE. We specialize in helping people achieve their highest level of health through our Neurological, Brain-Based, and Metabolic corrective programs. Our approach is unique and advanced from other rehabilitative programs; therefore, we have strict requirements in accepting new patients. This approach allows our patients to achieve far superior results compared to most other systems.

In order to be seen, you agree to:

1. Fill out the following forms as thoroughly as possible so that we can determine whether we can accept your case. **These forms must be completed and brought with you to your scheduled appointment.**
2. Wear loose fitting clothing (preferably without metal) so Dr. Clark can access from your elbows down and your knees down as he is going to be doing a complete structural and neurological examination and may need to take x-rays.
3. Please bring copies of all lab studies and diagnostic test results that you have had within the last year along with this packet.

I agree to the above terms and understand that should I NOT meet these terms I will be asked to reschedule my appointment.

Patient Introduction

Personal History:

Your Name: _____
First Middle Last

Your Address:

_____

_____

_____

Telephone: Home:_____ Cell: _____

Email Address (office use only): _____

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

Marital Status:_____ Spouse's Name: _____

Occupation: _____

Employer: _____

Previous Chiropractor: _____ City: _____

Last visit to this Chiropractor:_____

Reason for leaving:

_____

Present MD: _____ City: _____

Referred to our office by:

_____

Auto Consultation History

Your Name: _____

Date of accident_____ Hour_____Am_____Pm_____

Location_____

What is the cost of the repairs to the vehicle you were in?_____

Were you_____driver _____passenger _____ pedestrian.

What is the make_____Year_____of the vehicle you were in?

Were you struck from_____behind_____front_____right side_____left side_____auto was parked.

What specifically struck you?_____

Did your car strike others involved?_____yes_____no Or, did the other car strike yours?_____yes_____no

List the extent of your injuries as you know them:_____

List other people in the car: _____.

Did you require post-accident hospital care?_____yes_____no If yes, where?_____

Have you lost time from work?_____yes_____no If yes, dates missed from _____to_____

Your Main Complaint: _____

Please circle the Quality of the complaint / pain: dull aching shooting burning throbbing deep nagging other _____

Grade Intensity / Severity (No complaint / pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain / complaint imaginable)

What is the pattern of this problem? Constant ___, Intermittent ___, Occasional ___ Cyclic ___

Do symptoms interfere with: _____work _____sleep _____ Hobbies _____ Daily Routine

Whom have you seen for this? _____

What did they do for your symptoms? _____

How did you respond? _____

Have you become discouraged about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____

Does handling this problem cause stress for you? _____

What do you do that makes this problem worse? _____

What gives you some temporary relief? _____

Are you on any type of medication?_____, Please list all: _____

_____

Please check any health condition you may be experiencing, now or in the past.

CERVICAL SPINE (NECK):
Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience.. ?

☐ Neck Pain
☐ Dizziness
☐ Visual disturbances
☐ Sinusitis
☐ Weakness in grip
☐ Headaches
☐ Pain into your shoulders/arms/hands ___L ___R
☐ Numbness/tingling in arms/hands ___L ___R
☐ Low Energy/Fatigue
☐ Thyroid conditions
☐ Recurrent colds/Flu
☐ Coldness in hands
☐ TMJ/Pain/Clicking
☐ Hearing problems ☐

THORACIC SPINE (UPPER BACK):
Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…?

☐ Heart Palpitations
☐ Heart Murmurs
☐ Tachycardia
☐ Heart Attacks/Angina
☐ Upper Back Pain
☐ Shortness Of Breath
☐ Pain On Deep Inhalation/Exhalation
☐ Recurrent Lung Infections/Bronchitis
☐ Asthma/Wheezing

THORACIC SPINE (MID BACK):
Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience ..?

☐ Mid Back Pain
☐ Pain Into Your Ribs/Chest
☐ Indigestion/Heartburn
☐ Reflux
☐ Nausea
☐ Ulcers/Gastritis
☐ Hypoglycemia
☐ Tired/Irritable after eating or when you haven't eaten for a while

LUMBAR SPINE (LOW BACK):
Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience ...?

☐ Low back pain
☐ Numbness/tingling in your legs/feet ___L ___R
☐ Coldness in your legs/feet ___L ___R
☐ Muscle cramps in your legs/feet ___L ___R
☐ Pain into your hips/legs/feet ___L ____R
☐ Weakness/injuries in your hips/knees/ankles
☐ Constipation / Diarrhea
☐ Recurrent bladder infections
☐ Frequent/difficulty urinating
☐ Menstrual irregularities/cramping (females)
☐ Sexual dysfunction

Is there any other information you would like us to know?_____

_____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

SIGNATURE: _____ DATE: _____

Consent for Radiology

I, _____, give the doctors of this Chiropractic and Wellness Center my consent to take all x-rays needed to better understand my condition. I have been fully informed of the possible risks and safety standards of this office.

I also give my consent for films of my child (children) for the same reasons, if applicable.

[**For women**: To my best knowledge I am not pregnant and know of no contraindications for x-rays at this time.]

Patient Signature: _____ Date: _____

Our Fee Structure

Please note our fees for your initial visit:

Consultation	Complimentary
Examination	$ 45.00
Radiology	Variable (up to a maximum of $100.00)
TOTAL	**$ 145.00**

Please note that if you have been involved in a motor vehicle accident, our fee structure may differ due to the complexity of your needs in such cases.

I fully understand the above fees and give my consent for the doctor to perform a complete neurologic exam. I also give my consent to have the doctor take any x-rays he/she deems appropriate to better understand my problem and monitor my progress.

I have received a copy of the Notice of Privacy Practices from Clark Chiropractic.

SIGNATURE: _____ DATE: _____

(Signature of Parent/Guardian required if patient under age 18)

Thank You!

Treatment Consent Form

Before receiving consultation or treatment in our office,
Please review the principles outlined below:

1. I understand that Dr. Clark's goal is to provide me with adjunctive and supportive care for my health condition. Clark Chiropractic & Wellness does not claim to treat or cure any disease or medical diagnosis.

2. I understand that this office offers some services not covered by insurance. These services are considered experimental and may or may not be billed to my insurance. Dr. Clark will review all services that are considered covered services and those that are not. Nutritional support may also be offered for my case. Nutritional supplements are not FDA regulated and have not been proven to cure or treat any disease or illness.

3. I understand that Clark Chiropractic & Wellness' services are not a replacement for my medical treatment. Clark Chiropractic & Wellness chooses to work alongside my medical provider, as this serves me in the most effective manner.

4. Dr. Clark will never give advice on the use of my medications. Medications must be managed by my medical doctor. I must work with a medical doctor for the management of any medications I take now or in the future.

5. I completely understand that there are no guarantees of help, correction, relief, or cure, whether written, spoken, or implied. I understand that this clinic does NOT treat any disease or any medical diagnosis.

6. I am making a sane and conscious decision to seek advice as per the above understood terms for either myself and/or my dependents. In doing so, I agree to the above terms and acknowledge this with my signature.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

PERSONAL INJURY – AUTOMOBILE ACCIDENTS

It is the policy of the office to receive payment on the day that care is rendered. Charges for care rendered, because of an automobile accident, are to be paid by one of the following in the order listed below:

1st option_____	Personal Injury Protection (PIP) or Med-Pay
2nd option_____	Letter of Protection
3rd option_____	Cash—to be paid in office at beginning of plan

PATIENT INFORMATION:

Patient Name (Please Print) _____
Name of Custodial Parent or Legal Guardian (Please Print) _____
Parent/Guardian
Signature_____

RESPONSIBLE PARTY'S INFORMATION

Responsible Party's Insurance Company: _____
Policy Holder's
Name_____
Policy Number/Claim Number_____

MED-PAY/PIP VERIFICATION:

Date of Accident_____
Auto Insurance Company_____
Claim Number_____
Adjustor Name_____
Adjustor Phone Number_____

ATTORNEY:

Name_____
Phone Number_____

I, the undersigned, fully understand that one or both of the above methods of payments will be necessary to cover my expenses for treatment in this office. I, the undersigned, full understand that records or billing will not be submitted to the third party insurance company without one or more of the above methods of payment.

Patient Signature: _____ Date: _____

_____ _____

Patient Name (please print) Insurance Company

_____ _____

Name:

Date of Injury:

Claim #

LEGAL ASSIGNMENT OF BENEFITS AND
RELEASE OF MEDICAL AND PLAN RECORDS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to **Clark Chiropractic and Wellness Center, 562 KINGWOOD DR KINGWOOD, TX 77339,** medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical or benefit payments. **I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to such doctor and clinic any and all plan documents, insurance policy, and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement, or any applicable remedies.** I authorize the use of this signature on all my insurance and/or health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan claim, choose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement, and any applicable remedies. Furthermore, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/Guardian Date

NOTICE OF DOCTOR'S LIEN

Patient: _____
Date of Accident: _____
Claim#:_____

I do hereby authorize LEWIS M. CLARK DC to furnish you, _____, the 3rd party adjustor, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby assign, authorize, and direct you, the 3rd party adjustor, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement as may be necessary to adequately protect and compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, which may be paid by you, the 3rd party adjustor, 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 doctor for all medical bills submitted to him for service rendered me and that this agreement is made solely for doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, 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 or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if the 3rd party adjustor does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Date:_____ _____
Patient's Signature

The undersigned being the 3rd party adjustor of record for the above patient does hereby agree to observe all of the terms of the above and agrees to withhold such sums for any settlement as may be necessary to adequately protect and fully compensate said doctor above named.

Date:_____ _____
Adjustor's Signature

Clark Chiropractic Wellness Center

Lewis M. Clark, D. C.
562 KINGWOOD DR
KINGWOOD, TX 77339
281-354-8330

We at Clark Chiropractic Wellness Center hope that the following information will help you understand how your Personal Injury Protection (PIP) works for you. Please review the information, and if you have any questions, please ask one of our Chiropractic Assistants.

General Overview

PIP stands for "Personal Injury Protection." This covers the authorized driver of the vehicle, the owner, all members of the owner's family, and anyone riding in the vehicle at the time of the accident. PIP covers injuries in and around the vehicle, and even covers pedestrians. (Tx. Auto Ins. Law Art. 5. 06-3b)

PIP is automatically on all policies written in the state of Texas, unless it is denied by the policyholder in writing. (TX. Auto Ins. Law Art. 5. 06-3b) Protection can be purchased in the following three amounts: $2.500, $5,000, or $10,000. This coverage is per accident, any new claim starts with the set coverage amount.

PIP also pays for 80% of lost wages (including homemakers), pain and suffering, and loss of consortium. An injured person should always file a PIP claim regardless of liability.

The first policy on which a claim is filed is on the car involved in the accident. However, stacking policies – once benefits are exhausted – is perfectly legal. PIP has no right of subrogation (Tx. Auto Ins. Law Art. 5. 06-3b). Your PIP is required by law to pay claims as they arise. Penalty of non-payment may be assessed at 12%, plus interest and legal fees. (Tx. Auto Ins. Law Art. 5. 06-3b and subsection 3)

Your PIP can request that a patient have an independent medical exam. The statute of limitation on PIP is 3 years.

Verification

Look at the "Declaration Sheet," which is the cover sheet of the automobile insurance policy, or you may call you insurance agent.

Filing a Claim

You must first call your agent and file an "Application for Benefits" with your insurance carrier before benefits can be paid. If you are not "insured" on the policy, you may apply as the injured party. This office will then file all necessary claim forms directly to your insurance company each week. We will also file any required "Physician's Reports."

Covered Charges

PIP pays 100% of “reasonable and necessary” medical services.

Considerations:
You may ask, “Why should I file on my PIP when it wasn't my fault”? You should file on your PIP to keep from having to pay out of pocket medical expenses. Contrary to what you may think, your insurance premiums will not be raised or cancelled due to your claim. (TX Auto Ins. Law Art.5.06-3) Your PIP benefits are available regardless of liability on a claim.

Insurance rates are based on a variety of factors, such as the county in which you live. No one can guarantee rates, even for drivers who have never had an accident, gotten a ticket, or ever filed a claim.

Your PIP benefits are bought and paid for. If you are not going to file for benefits, perhaps you should consider dropping this coverage from your policy.

Our office policy states that when PIP benefits are available, you must file a claim. If you still do not want to file a claim, you will need to pay cash, unless we have a letter of protection from your attorney on your liability claim.

I, _____have read and understand how my PIP claim will be processed at Clark Chiropractic Clinic. Date: _____