

WORKERS' COMPENSATION AUTHORIZATION FOR TREATMENT

Patient _____ Date: _____
Address: _____ City: _____
State: _____ Zip: _____
Employer: _____ Date of Accident: _____
Address: _____ City: _____
State: _____ Zip: _____

TO THE PATIENT: It is necessary that your employer sign the following Authorization for Treatment and return it to our office.
 If not, you will be responsible for payment.

TO THE EMPLOYER: I acknowledge the work-related injury of the above-named patient. You are authorized to render the appropriate care needed for this injury, and we will file the proper forms with our insurance carrier.

Authorized by: _____
Title: _____
Date: _____

PLEASE RETURN THIS FORM IMMEDIATELY TO: Doctor's / Clinic Name _____
Address: _____
City, State, Zip: _____
Telephone: () _____

INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete ALL questions. If you need help please ask the receptionist. PLEASE PRINT.

Today's Date _____

Name _____ Home Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth date _____ Marital Status: S M W D Number of Children _____

How did you hear about our office? _____

Please circle one payment type: Cash Check Master Card/Visa

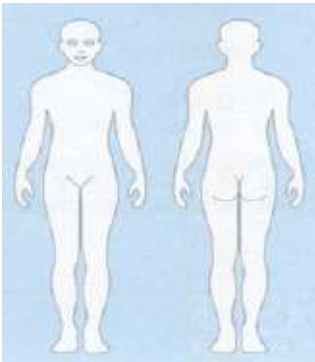
Your Employer _____ Occupation _____ Years On Job _____

Do you have Medicare? Yes ___ No ___ Do you have Medicaid? Yes ___ No ___

Name of Spouse or Parent _____ Their Birth date _____

Spouse Employed By _____ Occupation _____ Years On Job _____

Does your spouse have health insurance at work? Yes ___ No ___



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram.

What is your main complaint? _____

What event, if known, brought about this problem? _____

How long have you suffered with this problem? _____

Is the pain: Sharp? ___ Dull? ___ Throbbing? ___ Constant? ___ Intermittent? ___

What activities make your condition/pain worse? _____

What activities give you some temporary relief? _____

What have you tried that DID NOT work? _____

Is your condition interfering with work? ___ Sleep? ___ Family? ___ Routine? ___ Other? ___

Please explain: _____

On a scale of 1-10 (1=minor, 10=worst possible), please rate:

The severity of your symptoms: 1 2 3 4 5 6 7 8 9 10

Any other complaints? _____

Please list any drugs or medications you are currently taking: _____

Do you have a family history of Heart Disease? ___ Cancer? ___ Diabetes? ___ Other? ___

Have you had or do you currently suffer from any of the following:

- | | | | |
|----------------------------------------------|----------------------------------------------------|-------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Frequent Colds/Infections | <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Digestive Difficulties | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Menstrual Problems/Pain | <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Stiff Neck |

Type of Insurance: ___ Worker's Comp. ___ Health Insurance ___ Automobile Insurance ___ None

Is your condition due to an accident? Yes ___ No ___ Date of accident? _____

Type of accident? Auto ___ Work/On Job ___ At Home ___ Other _____

Have you been in an auto accident? Past Year ___ Past 5 Years ___ Over 5 Years ___ Never ___

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered will be immediately due and payable.

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

In the event that my account becomes 60 days past due and I have not responded to monthly statements, I understand that my account will be turned over to a local collection agency. I agree to pay any and all fees charged by the collection agency.

I (we) authorize Dr. Montgomery to perform diagnostic x-rays if needed in this case so that a complete analysis can be made of the present musculoskeletal problem (or illness) and to diagnose or administer whatever treatment is deemed necessary.

Patient's Signature _____ Date _____

Or Guardian Signature _____ Date _____

FOR LADIES

To the best of my knowledge, I am NOT pregnant and the above named Doctor has my permission to perform x-rays if needed for diagnostic interpretation.

Patient's Signature _____ Date _____

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 understand 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 by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of 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 those 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 objective to my care in his office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature: _____ **Date:** _____

Consent to evaluate and adjust a minor child

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. If you agree sign below.

Signature: _____ **Date:** _____



OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.
3. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check - it will not come from your insurance company. All insurance payments, regardless of which company issues a check, first, are applied to your account as long as any balance is due.

5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.
6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full immediately; regardless of any claims submitted. If patient has a credit on his or her account, refunds are processed at the beginning of the next month and are dependant on insurance reimbursement if applicable. Any refund given from a credit card payment will be charged a 3% processing fee.
8. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.
9. I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process Insurance claims by provider or agent. I designate this provider, practice and Agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.
10. I hereby authorize and direct my insurer to issue payment for services rendered by Montgomery Chiropractic Wellness Center, LLC. Regardless of my benefit, I understand that I am financially responsible for the fees for services rendered, that finance charges may accrue on past due balances, and that failure to pay will result in the account being turned over to an outside collection agency. I agree to pay all attorney fees and court costs incurred in collecting any unpaid balances for services rendered.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient's Signature

Date

AUTHORIZATION, ASSIGNMENT & RELEASE FORM
AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care from me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges you incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.
3. In the event any insurance company is obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Indiana.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continual effort until revoked by both parties.

Patient/Insured Signature

Date

RECORDS RELEASE

To _____, I hereby authorize you to release to _____ any information including the diagnosis and records of treatment or examination rendered to me or all care during the period from _____ to _____.

Date

Patient/Insured Signature

Date

Staff Signature

RELEASE FROM CARE

I, _____ hereby understand that Dr. _____ is releasing me from care, for my accident dated _____, and that I have reached [] pre-accident status or [] maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

Parent Signature _____

Date _____

Staff Signature _____