LMC Chiropractic, PLLC — Confidential Case History

How do you wish to be addressed in our office? □ First name □ nickname □Mr. □Mrs. □Ms. □Miss □Dr.

Full Legal Name _____ SS# _____ □Male □Female

Date of Birth _____ Age _____ Email: _____

Mailing Address _____ Apt. ____ City _____ Zip code _____

Physical Address _____ Apt. ____ City _____ Zip code _____

Cell Phone _____ Home Phone _____ Work Phone _____

Occupation _____ Employer _____

□Married □Single □Divorced □Widowed How Many Children _____

Spouse's Name _____ Employer _____ Telephone _____

Insurance Company _____ Insured's SS# _____ Insured's Date of Birth _____

Does your insurance plan have an associated Flex Plan or Health Savings Account (H.S.A)? □Yes □No □Unsure

How did you happen to choose our office? _____

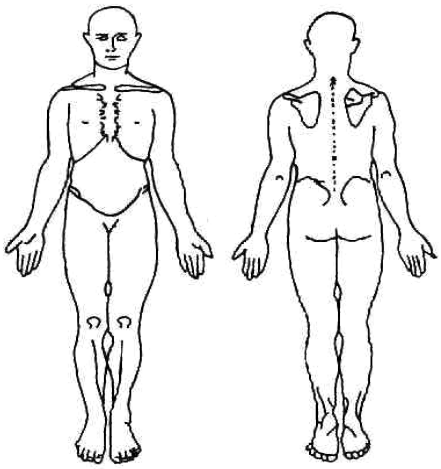
Have you ever been to a chiropractic doctor before? □Yes □No If Yes, when was your last visit? _____

What is your major complaint? _____

List other doctors seen for this condition: _____

Have you been involved in a recent automobile accident or on the job injury? □Yes □No If so, when? _____

Please mark areas of pain or discomfort below



Do you frequently suffer from any of the following?

□Asthma	□Headaches	□Dizziness
□Backache	□Migraines	□High Blood Pressure
□Neck Pain	□Digestive Upset	□Blurred Vision
□Allergy	□Constipation	FEMALES ONLY:
□Arthritis	□Sleep Problems	□Painful menstruation
□Low Energy	□Depression	□PMS
□Foot Pain	□Sinus Trouble	Are you pregnant? □Yes □No

Do you feel you are: □overweight, □underweight, □ideal weight?

Please list all vitamins & nutritional **supplements** currently taken: _____

_____

Please list all prescription & non-prescription **drugs** currently taken: _____

_____

Additional information: _____

_____

Signature: _____

Date: _____

Partial Assignment of Cause of Action, Assignment of Proceeds, Contractual Lien and Treatment Agreement

Consideration. In order to facilitate the ability of the Office to collect its Charges directly from various Payers and thereby to enhance the patient-provider relationship, I, the undersigned, as consideration for the Office's services, agree to the following and direct all Payers as follows:

Partial Assignment of the Cause of Action, Assignment of Proceeds, and Contractual Lien. I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to the Office., as well as any and all causes of action that I might have now or in the future against any Payer to the extent of my Charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further assign my right to receive any Proceeds from any Payer to the Office and further grant a contractual lien to the Office with respect to my Charges. I understand that these assignments of rights and contractual lien may effectuate, automatically or otherwise, a secured interest under the applicable Uniform Commercial Code. I intend for this Agreement to effectuate such a lien and hereby authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such lien. Except as provided herein, nothing in this Agreement shall be construed as an election or waiver by the Office to a secured interest under any other statutory lien law. Consistent with these rights, I hereby direct any and all Payers, to pay the Proceeds directly and immediately to, and exclusively in the name of, the Office in the amount of my Charges.

Other Terms. I consent to evaluation, x-rays and treatment and I understand that I remain personally responsible for my charges. Consistent with law or contract, I agree to pay the full amount of my charges to the Office upon its demand. Unless mutually agreed to in writing, the receipt and processing of partial payments by the Office shall not constitute a waiver of the Office's right to receive payment-in-full upon demand and shall not constitute an accord and satisfaction of my charges, irrespective of any restrictions indicated on any payments. I understand that at anytime, I can request a copy of my total charges. Prepayment for services planned but not yet delivered may be cancellable by either party at any time for any reason without penalty of any kind. Upon providing written request to the Office, a refund of any unused payment amounts will be processed within 30 days of final adjudication of all claims by all Payers. I hereby waive any statute of limitations which may apply to the collection of my charges.

In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I direct each attorney to issue an irrevocable letter of protection to the Office regarding my charges. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office.

I authorize and direct the Office to submit my charges to any and all Payers including, without limit, my health benefit plan. I understand, however, that in the event that my Charges are submitted to more than one Payer, I hereby authorize and direct the Office to apply any Proceeds received from one Payer to any reductions, write-offs, or discounts, issued by another.

I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my charges to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

For any written, audio or video testimonial I provide, I release such information, along with my photograph and video, to be edited and used in part, or in its entirety, for the purpose of in-office patient education and any other type of promotion and advertising by the Office.

This Agreement shall not be modified or revoked without the mutual written consent of the Office and myself. I hereby revoke the terms of any previously signed documents to the extent those terms conflict with the terms of this Agreement.

This Agreement shall be governed under the laws of the state where the Office is located and performable in the county where the Office is located. I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless; remain in full force and effect.

Definitions. For the purposes of this Agreement, the following terms shall have the following meaning: "Office" shall refer to: Lifestyle in Motion Chiropractic, PLLC., located at 205 W. Main St. Suite D, Allen, TX 75013. "Payer" shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at fault party, tortsfeasor, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for any reason; "Proceeds" shall include, without limit the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; "Charges' shall include, without limit, the full fees for the Office's services(including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, depositions, and testimony), any Collection Costs incurred by the Office, annually compounding 18% interest on outstanding Charges, and any other charges incurred by me at the Office; "Collection Costs" shall include, without limit, any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or any payer.

Print: _____ Sign: _____ Date: _____

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISLCOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This Chiropractic Practice (the "Practice"), in accordance with the federal Privacy Rule, 45 CFR part 160 and 164 (the "Privacy Rule") and applicable state law, is committed to maintaining the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice and is often referred to as your health care or medical record. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization may use and disclose your PHI for the purpose of:

(a) Treatment – To Provide you with the health care you require, the Practice may use and disclose your PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan and manage your health care. For example, a chiropractor treating you for lower back pain may need to know and obtain the results of your latest physician examination or test results.
(b) Payment – To get paid for services provided to you, the Practice may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including insurance companies and health plans. If necessary, the Practice may use your PHI in other collection efforts with respect to all persons who may be liable to the Practice for bills related to your care. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that in can determine whether or not it will cover the treatment expense.
(c) Health Care Operations – To operate in accordance with applicable law and insurance requirements, and to provide quality and efficient care, the Practice may need to compile, use and disclose your PHI. For example, the Practice may use your PHI to evaluate the performance of the Practice's personnel in providing care to you.

OTHER EXAMPLES OF HOW THE PRACTICE MAY USE YOUR PROTECTED HEALTH INFORMATION

(a) Advise of Appointment and Services. – The Practice may, from time to time, contact you to provide appointment reminders of information about treatment alternatives or other health-related benefits that may be of interest to you. The following appointment reminders may be used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.
(b) Sign-In-Log. – The practice maintains a sign-in log at its reception desk for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office. The information may be seen, and is accessible to, others who are seeking care of services in the Practice's offices.
(c) Family/Friends. – The Practice may disclose to a family member, or other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:
    (i) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.
    (ii) If you are not present, the practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests, and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

OTHER USE & DISCLOSURE WHICH MAY BE PERMITTED OR REQUIRED BY LAW

The practice may also use and disclose your PHI, without your consent or authorization in the following instances:

(a) De-identified Information – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.
(b) Business Associate – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.
(c) Personal Representative – The practice may use and disclose PHI: a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
(d) Emergency Situations – The Practice may use and disclose PHI: for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your are with such entities in an emergency situation.
(e) Public Health Activities – The Practice may use and disclose PHI when required by law to provide information to a public health authority to prevent or control activities.
(f) Abuse, Neglect or Domestic Violence – The Practice may use and disclose PHI when authorized by law to provide information if it believes that the disclosure is necessary to prevent serious harm.
(g) Health Oversight Activities - The Practice may use and disclose PHI when required by law to provide information in clinical investigations, disciplinary actions, or other activities relating to the community's health care system.
(h) Judicial and Administrative Proceeding – The Practice may use and disclose PHI in response to a court order or a lawfully issued subpoena.
(i) Law Enforcement Purposes – The Practice may use and disclose PHI, when authorized, to a law enforcement official. For example, your PHI may be the subject of any grand jury subpoena, or if the Practice believes that your death was the result of criminal conduct.
(j) Coroner or Medical Examiner – The Practice may use and disclose PHI to a coroner or medical examiner for the purpose of identifying your cause of death.
(k) Research – The Practice may use and disclose PHI subject to applicable legal requirements if the Practice is involved in research activities.
(l) Avert a Threat to Health or Safety – The Practice may use and disclose PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety or a person of the public and the disclosure is to an individual is reasonably able to prevent or lessen the threat.
(m) Specialized Government Functions – The Practice may use and disclose PHI when authorized by law with regard to certain military and veteran activity or if you are a member of the armed forces, as required by the military command authorities.
(n) Workers' Compensation – The practice may use and disclose PHI if you are involved in a Workers' Compensation system.

(o) National Security and Intelligence Activities – The Practice may use and disclose PHI to authorized governmental officials with necessary intelligence information for national security activities.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

You have the right to:

(a) Revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request special restriction on certain uses and disclosures of your PHI as authorized by law. In general, this relates to your right to request special restrictions concerning disclosure of your PHI regarding uses for treatment, payment and operational purposes under Privacy Rule Section 164.522(a) and restrictions related to disclosures to your family and other individuals involved in your care under Section 164.510(b). Except in certain instances, the Practice may not be obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications of PHI by alternative means or at alternative locations as provided by Privacy Rule Section 164.522(b). For instance, you may request all written communications to you marked "Confidential Protected Health Information." You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and copy your PHI as provided by federal law (including Section 164.524) and state law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in written denial notice.

(e) Amend your PHI as provided by federal law (including Section 164.526) and state law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if its not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is not longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive and accounting disclosures of your PHI as provided by federal law (including Privacy Rule Section 164.528) and state law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state at time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Receive a paper copy of this Privacy Notice from the practice (as provided by Privacy Rule Section 164.520(b) (1) (IV) (F) upon request to the Practice's Privacy Officer.

(h) Complain to the Practice or to the Secretary of HHS (as provided by Privacy Rule Section 164.520(b) (1) (VI) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy Rule Section 164.520(b) (2) (vii), you may contact the Privacy Officer, as follows:

Adam M. Stephen, D.C.
205 W. Main St. Suite D
Allen, TX 75013
(469) 212 -4548

PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
(b) Adheres to Texas law in those instances where Texas law does not conflict with federal law. See the explanation of Texas law attached.
(c) Is required to abide by the terms of this Privacy Notice.
(d) Reserves the right to change the terms of this privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
(e) Will distribute any revised Privacy Notice to your prior implementation.
(f) Will not retaliate against you for filing a complaint

EFFECTIVE DATE

This notice is in effect as of 01/01/2013

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding my agreement to its terms.

Print name: _____

Sign name: _____

Date: _____