THE HAYDEN INSTITUTE
FOR HEALTH, NUTRITION, AND REHABILITATION

Welcome To Our Office!

About Ft0Chase Hayden, DC, QN, ACN, PAK'cpf 'Ft0'Tggeg'Jc{fgp.'FE.'CEP.'SP'Kpvgtp.'Cewrwpewtkuv:
We are Holistic Practitioners. We specialize in Complementary and Alternative Medicine through the use of Clinical Nutrition, Quantum Neurology Rehabilitation, Professional Applied Kinesiology, Acupuncture, and Chiropractic care. These techniques create a focus on a drug-free, non-surgical approach to the individual patient. Our vision is to guide and mentor patients to achieve their health and wellness goals through supporting the underlining cause of the patient's symptoms.

At your appointment:
We appreciate the fact that our patients have schedules to maintain, so **we do our best to run on time**. This insures that you know when your appointment begins and ends and can make plans accordingly. This also insures that you get the full time with the doctor. In order to maintain scheduled office appointments, nutritional and rehabilitative office sessions are not performed in the same appointment.

Cancellation Policy:
If for some reason you have to reschedule or cancel your existing patient appointment we do ask that you give us **24 hours notice**. (If we do not answer the phone, please leave a message because the machine will identify the date and time that you called.) By giving us 24 hours notice, it allows us to fill the spot with another patient on our waiting list. If we do NOT receive 24 hours notice you could be subject to a percentage of the scheduled visit that was missed. ($50 for existing patient, $150 for new patient)

Office Fees:
Our fees are based on the time that you spend with the doctor and services rendered. A new patient office visit is approximately 1-1.5 hours with the doctor and existing patient office visits or phone consults are 15-30 minutes. Due to the complexity of the injuries in each individual, we cannot guarantee a time frame for each office visit.

Patients that present with doccumentation of the accident, and have confirmed Personal Injury Protection on their policy will not have initial out of pocket expenses. Those that do not have confirmed coverage, will have a $500 cap of services before care can continue, or financial arrangements can be made.

* New Patients seen within 48 hours of scheduling their initial exam MUST pre-pay for their visit.
* X-rays and laboratory tests, if needed, are performed outside of our office.

Referrals:
Our office has been built on friendly referrals. We appreciate you telling your family, friends, and coworkers about the services we offer, and the progress you make while helping you achieve your health and wellness goals. *As a way to say "Thank You" to our existing patients, a $10.00 coupon will be credited to your account to be used on your next office visit when a New Patient cites you as their referral source.*

Payment:
Payment is due at the time of services rendered, unless PIP coverage has been determined.We accept cash, check, and credit cards (No American Express). We provide the 3rd party payer the information needed for payment.

I have read and understand the above information and I accept the policies of The Hayden Institute.

Signature____ **Date**____________________

NW Houston: 281.826.2685 Fax: 281.469.8997 Pearland: 832.273.5442
Chase@HaydenInstitute.com www.HaydenInstitute.com Reece@HaydenInstitute.com

DOCTOR-PATIENT INFORMED CONSENT

HEALTH AND WELLNESS

We want our patients to be informed about our goals and philosophies, and what to expect from The Hayden Institute in regards to how we work to achieve health and wellness for you and your family. It is our premise that nutrition, and a properly functioning nervous system are the building blocks of life. When these foundational aspects are balanced, it allows the body the opportunity to use its own naturally occurring recuperative abilities. With this in mind, we seek to restore health through a natural means without the use of drugs or surgery (If medication or surgery is warranted we advise the patient accordingly). We do this by balancing the nutritional needs and restoring optimal neurological communication through a variety of techniques. We believe by supplying our patients with the building blocks of life, we give their body the maximum opportunity to utilize its inherent recuperative powers. We do not claim to treat or cure any specific disease or condition. The doctors at The Hayden Institute provide a specialized, unique, non-duplicating health service and are licensed by the state of Texas in their special areas of practice.

ANALYSIS AND APPROACH

Your doctor will conduct a functional analysis for the express purpose of determining the nutritional, and/or neurological deficiencies that hinder you from optimal wellness. Through various Complementary and Alternative Medicine techniques, your doctor will identify any nutritional, neurological, or structural imbalances that are contributing to the symptoms that you are experiencing. The doctor will utilize the aforementioned safe, drug free and non-invasive techniques to help you achieve your **wellness goals**.

RESULTS

The purpose of our office visits is to promote natural health through the stabilization of the nutritional, neurological, and structural systems of your body. Due to the individuality of each patient, it is difficult to predict the healing time needed for your specific presentation. For most patients, a response is seen quickly, however, in some cases there is a more gradual change in their symptoms. Two or more similar conditions may respond differently to the same type of care and actual response time is unpredictable. Many medical difficulties have found significant benefit through the approach we use at The Hayden Institute. Our doctors will work with you to help you make an informed decision prior to being accepted as a patient in our office.

DIAGNOSIS

Although the doctors at The Hayden Institute are experts in the analysis of the nutritional, neurological, and structural aspects of the human body, they will not make a diagnosis outside of their scope of practice. Patients that require additional testing (MRI, XRAY, Blood Stool, etc) will be informed and have access to those reports at any time.

INFORMED CONSENT - OFFICE SERVICES

By signing this page the patient gives the doctor permission and authority to use Complementary and Alternative Medicine techniques to assist in the achievement the patient's desired level of wellness. It is the responsibility of the patient to make any diagnosed or observed deformities, injuries, illnesses, or other pathological conditions known to the doctor in order to receive the most optimal care.

INFORMED CONSENT - TESTIMONIALS AND RESEARCH

The patient also gives permission to utilize audio, video, and written information, according to HIPAA guidelines (no use of complete names, address, etc), for research, presentations, promotional material, and other office applications should the doctor deem the case appropriate. Promotional testimonials may be edited for print and online distribution if needed.

By signing below, I agree to all of the above statements.

Signature:____ Date:____________________

The Hayden Institute

For Health, Nutrition, and Rehabilitation

MVA/PIP Patient Information

Personal Information

Full Name:			D.O.B: (mm/dd/yy)
Street Address:			
City, State Zip:			
Email:			Receive Office Newsletter: Y N
Home Phone:			Cell Phone:
Age:	Height:	Weight:	Occupation:
Marital Status: M W S D		Pregnant: Y N	Preferred To Be Called:
Blood Type: A B AB O		**Referred By:**	
Emergency Contact Information:			

Primary Health Concerns

List Your Health Concerns According To Severity	Rate of Severity 1 = Minimal 10 = Unbearable	When Did It Begin?	Have You Ever Had This Before?	% of the Day That Symptoms Are Present?	Better? Worse? Same?
1.)					
2.)					
3.)					
4.)					
5.)					

Diagnostic Tests (Please bring ALL reports with you, or fax to 281-251-8997)

Type of Test (Blood Work, XRay, MRI, etc)	Date of Test	Positive Findings
1.)		
2.)		
3.)		
4.)		

Received A Diagnosis For <u>ANY</u> Condition By Another Health Care Provider? Y N
If Yes, What Was The Diagnosis? ______________________________
Who Provided the Diagnosis? ______________________________

Daily Activities

Please describe in detail the affects that the health concerns or Diagnosis have on your daily life: For example: work, pleasure, recreation, hobbies, sleeping, etc.¨

The Hayden Institute

For Health, Nutrition, and Rehabilitation

Accidents, Surgeries, Hospitalizations, Injuries, Major Scars

Area of Body	Date

Other Health Care Providers (Even if your concerns are unrelated to the doctor's specialty.)

Name:	Type of Doctor:
Address:	
Reason For Care:	
Did It Help:	Are You Still Seeing Them:
What Did They Do:	

Name:	Type of Doctor:
Address:	
Reason For Care:	
Did It Help:	Are You Still Seeing Them:
What Did They Do:	

Family Health History (You, Children, Parents, Grandparents, Siblings)

- ADD/ADHD
- Arthritis
- Asthma
- Auto-Immune Disorder
- Bi-Polar Disorder
- Bleeding Disorder
- Blood Pressure Problems
- Cancer
- Childhood Diseases
- Chronic Fatigue
- Diabetes
- Dizziness
- Emotional Distress
- Fibromyalgia
- Hearing Problems (not age related)
- Heart Disorder
- Hepatitis
- Hernia
- Liver Disorder
- Memory Problems
- Nausea/Vomiting
- Neurologic Disorder
- Numbness
- Osteoporosis/Bone Density
- Pacemaker
- Pneumonia
- Restless Leg Syndrome
- Seizures
- Stomach Pain/Discomfort
- Suicidal Thoughts/Actions
- Thyroid Problems
- Tremors/Shaking
- Tumors/Growths
- Vision Problems
- Other__________________
- Other__________________

Health Goals (What *YOU* wish to achieve by being a patient in our office)

I have read, and agree to, the provided "Policy" and "Informed Consent" pages. I consent to a professional and complete nutritional, neurological and structural physical examination, and subsequent rehabilitation office sessions. I understand the office procedures regarding payment at time of service.

Signature: ____ Date: ______________________

Parent/Guardian if minor: ____

NW Houston: 832.704.9554 Fax: 281.469.8997 Pearland: 832.273.5442

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MEDICATIONS AND SUPPLEMENTS

Please list ALL medications and supplements that you are taking, the reason you are taking them, and the person that prescribed them to you (including yourself). This includes over the counter, prescription, recreational, vitamins, herbs, etc.

MEDICATIONS	PRESCRIPTION?	WHO PRESCRIBED?	REASON
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		

SUPPLEMENTS	REASON

Patient Basic Information

Automobile Accident Description

Personal Information:

First Name:

Last Name:

Middle Initial:

Address:
City, State, Zip:

Home Phone: Work Phone:

Social Security No:

Date of Birth:

Date of Injury/Onset:

Dominant Hand: ❍ Right ❍ Left ❍ Both

Insurance Information:
Policy Holder (if different than patient):

Policy No: Claim No:

Description of Accident/Injury/Onset
If this is an automobile accident, you can use the MVA Section.

During and after accident details
Enter details of your condition during and after the injury/onset.

Your Vehicle Type:
❍Car ❍S.U.V. ❍Van ❍Bus
❍Large Truck ❍Pickup Truck

Other Type:_____________

Your Position in Vehicle
❍Driver ❍Front Passenger
❍ L.Rear Passenger ❍ R.Rear Passenger

Other Position:_____________

Time/Speed/Damage
Time of Accident: Your Speed
Their Speed

Damage to your vehicle:
❍Mild ❍Moderate
❍Totaled

What was your vehicle doing at time of accident?
❍ Stopped at intersection ❍ Stopped at intersection ❍ Stopped at a light
❍ Making a right turn ❍ Stopped a left turn ❍ Parking
❍ Proceeding along ❍ Slowing down ❍ Accelerating

Other:____

Details of Accident:

Point of Impact:
❍ Head-On ❍ Rear-End
❍ Left front ❍ Right front
❍ Left rear ❍ Right rear

Other:________________

Who hit who/what:
❍ You hit other vehicle
❍ Other vehicle hit you
You hit….(Type in object below)

Other:________________

Additional Accident Information:
In the case of a motor vehicle accident, write any additional info here.

During the Accident:

Body Position, etc.
Did you see the accident coming?….. Yes ❑❑ No
Were you braced for the impact?…….Yes ❑❑ No
Did you have a seat belt on?………… Yes ❑❑ No
Did you have a shoulder harness on? Yes ❑❑ No
Did the driver's front air bag deploy?.. Yes ❑❑ No
Did passenger front air bags deploy? Yes ❑❑ No
Did the side air bags deploy?……… Yes ❑❑ No
Does your vehicle have headrests?… Yes ❑❑ No

Headrest Position?
❍ Even with top of head
❍ Even with bottom of head
❍ Even with middle of the neck

What was the direction of the head at the time of impact?
❍ Facing straight forward ❍ Turned to the right ❍ Turned to the left

Did your body strike the inside of your vehicle?………Yes ❑❑ No
If Yes, describe:

Did you lose consciousness during the injury?……….Yes ❑❑ No
If Yes, for how long?

Your vehicle's Estimated Damage:

Damage to their vehicle:
❍ Mild ❍ Moderate ❍ Totaled

Did police show up at the scene?
Yes ❑❑ No

Was an accident report filled out?
Yes ❑❑ No

Emergency Room?
Where did you go after the accident?
❍ Home ❍ Work
❍ Hospital ER ❍ Private doctor

How did you get there?
❍ Drove Self ❍ Ambulance
❍ Somebody Else ❍ Police

X-rays done? Yes ❑❑ No **Was lab work done?** Yes ❑❑ No

Body parts X-rayed? What lab work?

The x-rays revealed..

Treatments: ❑ Cervical Collar ❑ Ice Other

Medications:

Follow-up Instructions:

After the Accident:
Check off the symptoms right after and a few days following the accident.

❑ Headache ❑ Loss of smell ❑ Tension ❑ Loss of taste ❑ Diarrhea
❑ Neck pain ❑ Dizziness ❑ Irritability ❑ Toe numbness ❑ Depression
❑ Neck stiffness ❑ Nausea ❑ Mid back pain ❑ Constipation ❑ Anxious
❑ Fainting ❑ Confusion ❑ Low back pain ❑ Cold hands ❑ Chest pain
❑ Ringing in ears ❑ Fatigue ❑ Nervousness ❑ Cold Feet
❑ Pain behind eyes ❑ Shortness of breath ❑ Sleeping problems

Others:

Doctor's Additional Data on This Patient
NOTE: This will be entered into the chart, but will not appear in Reports

Patient's Signature:____ **Date:**______________________

Historical Information — Prior Treatment Information

Prior Similar Symptoms:
- ❍ I have NOT had prior similar symptoms to current complaints.
- ❍ My current complaints DID exist before, but had been dormant.
- ❍ My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Symptoms?
- ❍ My history HAS contributed to my current symptoms.
- ❍ My history HAS NOT contributed to my current symptoms.
- ❍ I'm NOT SURE if my history has contributed to my symptoms.

My Most Recent Prior Similar Symptoms (if applicable)

My most recent prior similar symptons occurred…

____ ❍ Months ❍ Years…ago **OR** on (Date) ____

Medical History Section:
Enter additional Medical Historical data here.

Surgical Historical Section:
Enter any Surgical Historical data here.

Treatment History 1:
Fill in any other doctor(s) seen prior to your first visit to this office.

2. Name: ____ Specialty: ____

First Visit Date ____ Last Visit Date ____

Types of Treatments Received: ____

How many Tx's Received? ____ Did Tx's help? Yes ❑❑ No X-rays done? Yes ❑❑ No

Currently Treating? Yes ❑❑ No

Medications History Section:
Enter any Medications Historical data here.

Occupational History Section:
Enter Occupational History, e.g. lost work, etc. Here.

Treatment History 2:
Fill in any other doctor(s) seen prior to your first visit to this office.

2. Name: ____ Specialty: ____

First Visit Date ____ Last Visit Date ____

Types of Treatments Received: ____

How many Tx's Received? ____ Did Tx's help? Yes ❑❑ No X-rays done? Yes ❑❑ No

Currently Treating? Yes ❑❑ No

Familial History Section:
Enter relevant Familial History here.

Social History Section:
Enter any relevant Social History here.

Treatment History 3:
Fill in any other doctor(s) seen prior to your first visit to this office.

1. Name: ____ Specialty: ____

First Visit Date ____ Last Visit Date ____

Types of Treatments Received: ____

How many Tx's Received? ____ Did Tx's help? Yes ❑❑ No X-rays done? Yes ❑❑ No

Currently Treating? Yes ❑❑ No

Additional Historical Information Section:
Summarize other treatments that were received here.

Prior Treatment Section:
Summarize past treatments received here.

Treatment History 4:
Fill in any other doctor(s) seen prior to your first visit to this office.

4. Name: ____ Specialty: ____

First Visit Date ____ Last Visit Date ____

Types of Treatments Received: ____

How many Tx's Received? ____ Did Tx's help? Yes ❑❑ No X-rays done? Yes ❑❑ No

Currently Treating? Yes ❑❑ No

Patient's Signature:________________________________ **Date:**________________________

Neck Pain Index **Total Score: _________**

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- o I have no pain at the moment. (0)
- o The pain is very mild at the moment. (1)
- o The pain is moderate at the moment. (2)
- o The pain is fairly severe at the moment. (3)
- o The pain is very severe at the moment. (4)
- o The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

- o I can look after myself normally without causing extra pain. (0)
- o I can look after myself normally but it causes extra pain. (1)
- o It is painful to look after myself and I am slow and careful. (2)
- o I need some help but manage most of my personal care. (3)
- o I need help every day in most aspects of self care. (4)
- o I do not get dressed, I wash with difficulty and stay in bed. (5)

Section 3 – Lifting

- o I can lift heavy weights without extra pain. (0)
- o I can lift heavy weights but it gives extra pain. (1)
- o Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- o Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- o I can lift very light weights. (4)
- o I cannot lift or carry anything at all. (5)

Section 4 – Reading

- o I can read as much as I want to with no pain in my neck. (0)
- o I can read as much as I want to with slight pain in my neck. (1)
- o I can read as much as I want with moderate pain in my neck. (2)
- o I cannot read as much as I want because of moderate pain in my neck. (3)
- o I can hardly read at all because of severe pain in my neck. (4)
- o I cannot read at all. (5)

Section 5 – Headaches

- o I have no headaches at all. (0)
- o I have slight headaches that come infrequently. (1)
- o I have moderate headaches which come infrequently. (2)
- o I have moderate headaches which come frequently. (3)
- o I have severe headaches which come frequently. (4)
- o I have headaches almost all the time. (5)

Section 6 – Concentration

- o I can concentrate fully when I want to with no difficulty. (0)
- o I can concentrate fully when I want to with slight difficulty. (1)
- o I have a fair degree of difficulty in concentrating when I want to. (2)
- o I have a lot of difficulty in concentrating when I want to. (3)
- o I have a great deal of difficulty in concentrating when I want to. (4)
- o I cannot concentrate at all. (5)

Section 7 – Work

- o I can do as much work as I want to. (0)
- o I can do my usual work, but no more. (1)
- o I can do most of my usual work, but no more. (2)
- o I cannot do my usual work. (3)
- o I can hardly do any work at all. (4)
- o I cannot do any work at all. (5)

Section 8 – Driving

- o I can drive my car without any neck pain. (0)
- o I can drive my car as long as I want with slight pain in my neck. (1)
- o I can drive my car as long as I want with moderate pain in my neck. (2)
- o I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- o I can hardly drive at all because of severe pain in my neck. (4)
- o I cannot drive my car at all. (5)

Section 9 – Sleeping

- o I have no trouble sleeping. (0)
- o My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- o My sleep is mildly disturbed (1-2 hours sleepless). (2)
- o My sleep is moderately disturbed (2-3 hours sleepless). (3)
- o My sleep is greatly disturbed (3-5 hours sleepless). (4)
- o My sleep is completely disturbed (5-7 hours sleepless). (5)

Section 10 – Recreation

- o I am able to engage in all my recreation activities with no neck pain at all. (0)
- o I am able to engage in all my recreation activities, with some pain in my neck. (1)
- o I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- o I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- o I can hardly do any recreation activities because of pain in my neck. (4)
- o I cannot do any recreation activities at all. (5)

Back Pain Index (Oswestry) **Total Score: ________**

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity
- o I have no pain at the moment. (0)
- o The pain is very mild at the moment. (1)
- o The pain is moderate at the moment. (2)
- o The pain is fairly severe at the moment. (3)
- o The pain is very severe at the moment. (4)
- o The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (washing, dressing, etc.)
- o I can look after myself normally but it is very painful. (0)
- o It is painful to look after myself and I am slow and careful. (1)
- o I need some help but manage most of my personal care. (2)
- o I need help every day in most aspects of my personal care. (3)
- o I need help every day in most aspects of self-care. (4)
- o I do not get dressed, wash with difficulty, and stay in bed. (5)

Section 3 – Lifting
- o I can lift heavy weights without extra pain. (0)
- o I can lift heavy weights but it gives extra pain. (1)
- o Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table). (2)
- o Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- o I can lift only very light weights. (4)
- o I cannot lift or carry anything at all. (5)

Section 4 – Walking
- o Pain does not prevent me walking any distance. (0)
- o Pain prevents me walking more than 1mile. (1)
- o Pain prevents me walking more than ¼ of a mile. (2)
- o Pain prevents me walking more than 100 yards. (3)
- o I can only walk using a stick or crutches. (4)
- o I am in bed most of the time and have to crawl to the toilet. (5)

Section 5 – Sitting
- o I can sit in any chair as long as I like. (0)
- o I can sit in my favorite chair as long as I like. (1)
- o Pain prevents me from sitting for more than 1 hour. (2)
- o Pain prevents me from sitting for more than ½ hour. (3)
- o Pain prevents me from sitting for more than 10 minutes. (4)
- o Pain prevents me from sitting at all. (5)

Section 6 – Standing
- o I can stand as long as I want without extra pain. ....
- o I can stand as long as I want but it gives me extra pain.
- o Pain prevents me from standing more than 1 hour.
- o Pain prevents me from standing for more than ½ an hour.
- o Pain prevents me from standing for more than 10 minutes.
- o Pain prevents me from standing at all.

Section 7 – Sleeping
- o My sleep is never disturbed by pain. (0)
- o My sleep is occasionally disturbed by pain. (1)
- o Because of pain, I have less than 6 hours sleep. (2)
- o Because of pain, I have less than 4 hours sleep. (3)
- o Because of pain, I have less than 2 hours sleep. (4)
- o Pain prevents me from sleeping at all. (5)

Section 8 – Sex life (if applicable)
- o My sex life is normal and causes no extra pain. (0)
- o My sex life is normal but causes some extra pain. (1)
- o My sex life is nearly normal but is very painful. (2)
- o My sex life is severely restricted by pain. (3)
- o My sex life is nearly absent because of pain. (4)
- o Pain prevents any sex life at all. (5)

Section 9 – Social Life
- o My social life is normal and cause me no extra pain. (0)
- o My social life is normal but increases the degree of pain. (1)
- o Pain has no significant effect on my social life apart from limiting my more energetic interests (i.e. sports). (2)
- o Pain has restricted my social life and I do not go out as often. (3)
- o Pain has restricted social life to my home. (4)
- o I have no social life because of pain. (5)

Section 10 – Traveling
- o I can travel anywhere without pain. (0)
- o I can travel anywhere but it gives extra pain. (1)
- o Pain is bad but I manage journeys of over two hours. (2)
- o Pain restricts me to short necessary journeys under 30 minutes. (3)
- o Pain prevents me from traveling except to receive treatment. (4)
- o I cannot travel at all. (5)

Section 11 – Previous Treatment
Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

o No o Yes (if yes, please state the type of treatment you have received)

____

____

____

____

Legal Assignment of Benefits and Release of Medical and Plan Documents

Medical group name: The Hayden Institute, PLLC

Are your present symptoms or conditions related to or, the result of any auto accident, work-related injury or other personal injury for which someone else might be legally liable? Yes No Your initials:______________

Responsible party (Insurance Company, Attorney, etc): ____
Contact Person:______________________________ Phone number:______________________________
Fax: ____________________________________ Address:____________________________________ City, State, Zip:__________________

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

Medical Group may bill my insurance on my behalf. Although Medical Group may have verified benefits for the patient, the verification is not a guarantee of benefits and ultimate coverage and payment lies in the sole discretion of the insurance company based on policy guidelines. Ultimately, the Patient/Beneficiary is responsible for the charges, except contrary to federal or state law and will pursue any disputes with my insurance company, self-insured employer or other third party payor to enable proper health coverage benefits to be paid. I hereby authorize the above named physician and/or its affiliates to appeal claims under Employee Retirement Income Security Act (ERISA) and/or state laws with applicable as situations occur.

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

I, the Patient/Beneficiary, hereby authorize medical group to release to my attorney, my insurance provider, my worker's compensation provider, or my referring physician any and all medical information pertinent to medical services provided by medical group.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provisions within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

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 do fully understand this agreement.

INSURANCE PAYMENT INFORMATION

As medical group may not be a plan provider for your insurance provider, please be advised that your insurance provider may forward payment or payment information directly to you the Patient/Beneficiary.

When written communication from your insurance regarding medical services provided by medical group is received, I, the undersigned insured, promise to send a copy to medical group immediately.

In the event a benefits check for medical services provided by medical group is received, I promise to endorse the check immediately and forward to medical group by certified mail, or to send a personal check within 48 hours for the value of the benefits check. In the event I send a personal check, I promise to also send a copy of the explanation of benefits from my insurance carrier, explaining the payment received by me.

I, the Patient/Beneficiary, understand that failure to reimburse medical group for insurance benefits received for medical services rendered will cause the full open balance of all charges to become due and payable immediately, and that I will be responsible for legal or collection fees if incurred.

Medical group is willing to await your payment from your insurance carrier before requiring your direct payment by you to us for the medical services, and ordered by your physician.

Signature of Responsible Party/Guardian: ____Date:____________________

DESIGNATION OF PERSONAL REPRESENTATIVE

Patient name:____ MR#__________________

I hereby designate the following individual(s) as my personal representative, who may act on my behalf for the purpose of:

- Consenting to use and disclosure of my health information.
- Authorizing use and disclosure of my health information.
- Receiving information that otherwise would be sent me.

Name:____ Relationship: ____________________

Address:____________________________________City, State, Zip: _________________________

Telephone:____________________Cell Phone_________________ Power of Attorney ☐Yes ☐ No

Name:____ Relationship: ____________________

Address:____________________________________City, State, Zip: _________________________

Telephone:____________________Cell Phone_________________ Power of Attorney ☐Yes ☐ No

If I am incapacitated, my personal representative may sign any form (such as authorization, revocation of authorization, and request for access to information), the uses of which are described in privacy policies and procedures.

My personal representative may receive my health information necessary to carry out the representative's legal duties to me (for example, providing an informed consent to treatment, or for enforcing an advance directive concerning life support). My personal representative may receive my health information in the following way(s):

☐ In person ☐ Voicemail message ☐ Mail/fax ☐ E-mail message

I understand that although I may designate the above individual(s) as my personal representative(s), a person who is identified in my medical record as having medical power of attorney or other legal authority to act on my behalf will be recognized as my personal representative.

I understand that I have the right to revoke this authorization at any time. Revoking of this authorization must be made in writing, signed, and dated.

Patient signature:____Date:________________