Welcome To Our Office!

About Dr. Chase Hayden, DC, QN, ACN, PAK and Dr. Amber Horsley, DC, Acupuncturist:
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 underlying 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 documentation 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____________________
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: ____________________

Office: 281.826.2685   Fax: 281.469.8997
Chase@HaydenInstitute.com   www.HaydenInstitute.com   Amber@HaydenInstitute.com
# NEW PATIENT INFORMATION

- **Patient’s First Name**: ___________________
- **Middle**: ___________________
- **Last**: ___________________
- **Address**: ____________________________
- **City**: ___________________  
- **Zip Code**: __________
- **Home Phone**: _________________________
- **Cell Phone**: __________________________
- **E-mail**: ____________________________
- **Employer Name**: ______________________
- **Job Title**: ____________________________  
- **Work Phone #**: _______________________
- **Date of Birth**: __________  
- **Age**: ____  
- **Gender**:  
  - [ ] Male  
  - [ ] Female
- **Handedness?**:  
  - [ ] R  
  - [ ] L
- **Weight**: __________  
- **Height**: __________  
- **Marital Status**:  
  - [ ] S  
  - [ ] M  
  - [ ] W  
  - [ ] D
- **Spouse’s Name**: ______________________
- **Person responsible for this account**: ______________________
- **Patient Health Insurance Company**: ____________________  
- **Phone number**: ______________________
- **Policy/Member ID #**: ______________________  
- **Group #**: ______________________
- **Address**: ____________________________  
- **City**: ___________________  
- **Zip Code**: __________
- **Adjuster**: ________________________  
- **Phone Number**: ______________________
- **Name of the insurance card holder**: ______________________
- **Birth date of the Primary Insured/Card Holder**: ______________________
- **Name of their employer**: ______________________  
- **Employer Phone #**: ______________________
- **Children names and ages**: ______________________

# Patient Car Insurance Company

- **Address**: ____________________________  
- **City**: ___________________  
- **Zip Code**: __________
- **Adjuster**: ________________________  
- **Phone #**: ______________________
- **Agent**: ________________________  
- **Phone #**: ______________________
- **Policy #**: ________________________  
- **Claim #**: ______________________
- **Drivers License #**: ______________________
- **Name of Insured on your Car Policy**: ______________________  
- **Date of Loss/Accident?**: __________

**Date**: _________________
Medical Coverage? ___________ Uninsured Motorist Coverage? ____________________________
Underinsured Motorist Coverage?_____________________________________________________
Personal Injury Protection (PIP)  Y   N  $___________________________________________
Medical expenses to date as a result of the accident? $____________________________________
Lost wages since accident $_________________________________________________________
What is the repair amount of your car? $ ______________________________________________
Lawyer/ Law Firm_______________________________________ Phone #____________________
Address ___________________________________City _________________Zip Code __________

“Other” Car Insurance Company From Accident___________________________________________
Address ______________________________________ City _______________ Zip Code __________
Adjuster _______________________________________ Phone #_________________________
Policy # ____________________________________ Claim # ___________________________
Drivers License # __________________________________________________________________

In case of emergency, whom should we contact?__________________________________________
Phone #__________________________________________________________________________
Family physician___________________________ Phone #_________________________________
Address__________________________________ City_______________ Zip Code_____________

Date you first saw any Doctor after accident _____________________________________________
Is this Workman’s Compensation? _______________ Is this Personal Injury?____________________
Have you received any medical treatment since your accident?    Y   N
Hospital___________________________________________ Cost___________________________
Medical Doctor _____________________________________ Cost___________________________
Chiropractor_______________________________________ Cost____________________________
Other____________________________________________Cost____________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
### Patient Basic Information

**Personal Information:**
- **First Name:**
- **Last Name:**
- **Middle Initial:**
- **Date of Birth:**
- **Date of Injury/Onset:**

**Address:**
- **City, State, Zip:**
- **Home Phone:**
- **Work Phone:**
- **Social Security No:**
- **Policy No:**
- **Claim No:**

**Insurance Information:**
- **Policy Holder (if different than patient):**
- **Other Position:**
- **Additional Accident Information:**
- **Additional Accidental Information:**
- **Follow-up Instructions:**
- **Doctor's Additional Data on This Patient**

### Automobile Accident Description

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

**Your Position in Vehicle:**
- Driver
- Front Passenger
- L. Rear Passenger
- R. Rear Passenger

**Other Position:**

**Time/Speed/Damage Impact:**
- **Time of Accident:**
- **Your Speed:**
- **Their Speed:**
- **Damage to your vehicle:**
- Mild
- Moderate
- Toted

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

**Point of Impact:**
- Head-On
- Left front
- Right front
- Left rear
- Right rear

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

**Details of Accident:**

**During the Accident:**
- **Headrest Position:**
  - Even with top of head
  - Even with bottom of head
  - Even with middle of the neck

**During and after accident details**

**Additional Accident Information:**

**After the Accident:**
- **Headache**
- **Loss of smell**
- **Tension**
- **Loss of taste**
- **Diarrhea**
- **Neck pain**
- **Dizziness**
- **Irritability**
- **Toe numbness**
- **Depression**
- **Nausea**
- **Mid back pain**
- **Constipation**
- **Anxious**
- **Fatigue**
- **Nervousness**
- **Cold Feet**
- **Pain behind eyes**
- **Shortness of breath**
- **Sleeping problems**

**Doctor's Additional Data on This Patient**

**NOTE:** This will be entered into the chart, but will not appear in Reports
<table>
<thead>
<tr>
<th>Prior Similar Symptoms:</th>
<th>Has your History Contributed to your Symptoms?</th>
<th>My Most Recent Prior Similar Symptoms (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ I have NOT had prior similar symptoms to current complaints.</td>
<td>❑ My history HAS contributed to my current symptoms.</td>
<td>My most recent prior similar symptoms occurred…</td>
</tr>
<tr>
<td>❑ My current complaints DID exist before, but had been dormant.</td>
<td>❑ My history HAS NOT contributed to my current symptoms.</td>
<td>❑ Months ❑ Years ago OR on (Date)</td>
</tr>
<tr>
<td>❑ My current complaints ALREADY existed and were worsened.</td>
<td>❑ I’m NOT SURE if my history has contributed to my symptoms.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical History Section:</th>
<th>Surgical Historical Section:</th>
<th>Treatment History 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter additional Medical Historical data here.</td>
<td>Enter any Surgical Historical data here.</td>
<td>Fill in any other doctor(s) seen prior to your first visit to this office.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Name:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>First Visit Date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Types of Treatments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How many Tx's Received?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Currently Treating?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medications History Section:</th>
<th>Occupational History Section:</th>
<th>Treatment History 2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter any Medications Historical data here.</td>
<td>Enter Occupational History, e.g. lost work, etc. Here.</td>
<td>Fill in any other doctor(s) seen prior to your first visit to this office.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Name:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>First Visit Date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Types of Treatments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How many Tx's Received?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Currently Treating?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Familial History Section:</th>
<th>Social History Section:</th>
<th>Treatment History 3:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter relevant Familial History here.</td>
<td>Enter any relevant Social History here.</td>
<td>Fill in any other doctor(s) seen prior to your first visit to this office.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Name:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>First Visit Date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Types of Treatments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How many Tx's Received?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Currently Treating?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Historical Information Section:</th>
<th>Prior Treatment Section:</th>
<th>Treatment History 4:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summarize other treatments that were received here.</td>
<td>Summarize past treatments received here.</td>
<td>Fill in any other doctor(s) seen prior to your first visit to this office.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Name:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>First Visit Date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Types of Treatments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How many Tx’s Received?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Currently Treating?</td>
</tr>
</tbody>
</table>

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 symptoms occurred…
❑ ❑ Months ❑ Years ago OR on (Date)

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 symptoms occurred…
❑ ❑ Months ❑ Years ago OR on (Date)

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 symptoms occurred…
❑ ❑ Months ❑ Years ago OR on (Date)

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 symptoms occurred…
❑ ❑ Months ❑ Years ago OR on (Date)

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 symptoms occurred…
❑ ❑ Months ❑ Years ago OR on (Date)
SYMPTOMS

Patient’s Name ___________________________ Date of incident ___________ Today’s Date ___________

CIRCLE ALL YOU COMPLIANTS

3. DO YOU HAVE LACERATIONS, CUTS OR BRUISING?:
   a. Head or Face
   b. Neck
   c. Seat belt bruising
   d. Cuts or bruising on your chest
   e. Cuts or bruising on arms
   f. Cuts or bruising on legs
   g. Other: ______________

4. HEAD INJURIES: (now or at the time of the accident)
   a. Were you knocked out or unconscious
   b. Headaches
   c. Face pain
   d. Pupils different sizes
   e. Dizziness
   f. Difficulty walking
   g. Balance problems
   h. Room spins
   i. Disoriented Confusion
   j. Day dreaming
   k. Attention problems
   l. Hearing problems
   m. Change in sense of smell or taste
   n. Difficulty speaking
   o. Memory problems
   p. Very tired or fatigued
   q. Appetite change
   r. Sleep difficulties
   s. Visual Disturbances, blurry or double vision
   t. Flashbacks to accident
   u. Problems to read or write
   v. Problems adding or subtracting
   w. Problems learning new things
   x. Problems understanding
   y. Problems remembering numbers
   z. Difficulty Concentrating
   aa. Difficulty remembering things
   bb. Difficulty making decisions
   cc. Change in Sexual Functioning
   dd. Nausea / Vomiting
e. Change of personality
ff. Wanting to be alone
gg. Mood swings
hh. Sadness
ii. Agitation
jj. Anger
kk. Helplessness
ll. Reduce confidence
mm. Apathy
nn. Irritability
oo. Sleepiness
pp. Frustration
qq. Impatience
rr. Other head related issues

5. JAW PROBLEMS:
   a. Jaw pain
   b. Clicking
   c. Pain while chewing
   d. Pain while talking
   e. Pain while yawning
   f. Pain while moving jaw from side to side

6. NECK INJURIES:
   h. Neck pain
   i. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
   j. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
   k. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT UPPER BACK
   l. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT UPPER BACK
   m. Neck pain that causes headaches
   n. Neck spasms or shoulder spasms
   o. Popping, clicking or clunking sound with neck movement
7. **SHOULDER INJURIES**
   - Shoulder pain \text{LEFT} \ \text{RIGHT} \ \text{BOTH}
   - Shoulder pain with movement \text{L} \ \text{R} \ \text{BOTH}
   - Shoulder spasms \text{LEFT} \ \text{RIGHT} \ \text{BOTH}
   - Sharp shoulder pain
   - Dull shoulder pain
   - Achy shoulder pain
   - Pins and needles shoulder pain
   - Shoulder pain that radiates or shoots pain into arm
   - Other:

8. **UPPER ARM PAIN**: \text{RIGHT} \ \text{LEFT} \ \text{BOTH}
   - Dull
   - Ache
   - Sharp
   - Stabbing
   - Other

9. **ELBOW PAIN**: \text{RIGHT} \ \text{LEFT} \ \text{BOTH}
   - Dull
   - Ache
   - Sharp
   - Stabbing
   - Other

10. **FOREARM**: \text{RIGHT} \ \text{LEFT} \ \text{BOTH}
    - Dull
    - Ache
    - Sharp
    - Stabbing
    - Other

11. **WRIST PAIN**: \text{RIGHT} \ \text{LEFT} \ \text{BOTH}
    - Dull
    - Ache
    - Sharp
    - Stabbing
    - Other

12. **HAND PAIN**: \text{RIGHT} \ \text{LEFT} \ \text{BOTH}
    - Dull
    - Ache
    - Sharp
    - Stabbing
    - Other

13. **MID BACK PAIN OR UPPER BACK PAIN**
    - Upper or mid back pain
    - Upper back pain, numbness, tingling, weakness that radiates or goes down to \text{RIGHT} shoulder, arm, forearm or hand
    - Upper back pain, numbness, tingling, weakness that radiates or goes down to \text{LEFT} shoulder, arm, forearm or hand
    - Upper or mid back spasms

14. **LOW BACK PAIN**:
    - Low back pain
    - Low back pain, numbness, tingling, weakness that radiates or goes down to \text{RIGHT} buttock, thigh, leg or foot
    - Low back pain, numbness, tingling, weakness that radiates or goes down to \text{LEFT} buttock, thigh, leg or foot
    - Low back spasms

15. **PELVIC OR SACRAL PAIN**
    - Pelvic pain, numbness, tingling, weakness that radiates or goes down to \text{RIGHT} buttock, thigh, leg or foot
    - Pelvic pain, numbness, tingling, weakness that radiates or goes down to \text{LEFT} buttock, thigh, leg or foot
    - Sacral pain (tail bone)
    - Coccygeal or coccyx (tail bone) pain

16. **HIP PAIN**: \text{RIGHT} \ \text{LEFT} \ \text{BOTH}
    - Hip pain
    - Hip pain, numbness, tingling, weakness that radiates or goes down to buttock, thigh, leg or foot

17. **UPPER LEG PAIN**: \text{RIGHT} \ \text{LEFT} \ \text{BOTH}
    - Upper leg pain that radiates to knee
    - Upper leg spasms
18. **KNEE PAIN**: RIGHT  LEFT  BOTH  
   a. Knee pain that radiates to calf  
   b. Knee pain that radiates to calf and ankle  
   c. Knee pain that radiates to calf, ankle and foot  

19. **ANKLE PAIN**: RIGHT  LEFT  BOTH  
   a. Ankle pain that radiates to foot  
   b. Ankle and foot pain  

20. **FOOT PAIN**: RIGHT  LEFT  BOTH  

21. **CHEST PAIN**  

22. **STOMACH PAIN**  

23. **OTHER SYMPTOMS NOT LISTED**:  
   __________________________________________  
   __________________________________________  
   __________________________________________  
   __________________________________________  
   __________________________________________  
   __________________________________________
The Hayden Institute, PLLC  
Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to Pain Relief Rehab., the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician / facility named above within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to The Hayden Institute, PLLC, and to send all checks to 10694 Jones Road #210, Houston, TX 77065.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable to The Hayden Institute, PLLC, and to send any and all checks to 10694 Jones Road #210, Houston, TX 77065.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician / facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician / facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician / facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my / our account or forwarded to my / our address upon request in writing to the physician / facility named above.

REJECTION IN WRITING: I hereby authorize the physician / clinic named above to establish a Med Pay, PIP or UM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider / clinic named above, any rejections in writing as they apply to my lack of Med pay, PIP or UM/UIM coverage. If my carrier is unable to provide said rejections in a timely manner, I acknowledge that I am entitled to minimum levels of coverage, as per section 1952.152 of the Texas Insurance Code, and further instruct my carrier to pay up to available limits directly to physician / clinic named above, and to send any and all checks or financial instruments to 10694 Jones Road #210, Houston, TX 77065.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician / facility immediately. I understand that failure to do so may jeopardize my case.

Signature of patient and/or responsible parties:

____________________________________________(Patient Signature)
Date ________________________________

____________________________________________(Clinic Signature)
Date ________________________________

____________________________________________(Notary Signature)
Date ________________________________
Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my health care provider ____________________________________ (insert name) to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: _____ The Hayden Institute, PLLC________________________________
Address: ___ 10694 Jones Road #210, Houston, TX 77065____________________
Fax: _______ 281-469-8997________________________________________

Purpose: I authorize the release of my health information for the following specific purpose:
_____________________________________________________________________.
(Note: “at the request of the patient” is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.1

☐ Only the following records or types of health information:
__________________________________________________________________.

Term: I understand that this Authorization will remain in effect:
☐ From the date of this Authorization until the _____ day of ________, 20___.
☐ Until the Provider fulfills this request.
☐ Until the following event occurs:________________________________________

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use

1 NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.
Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don’t sign, it will not affect the commencement, continuation or quality of my treatment at The Hayden Institute. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the office at the address listed below. The revocation will be effective immediately upon my health care provider’s receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact The Hayden Institute, PLLC for answers to my questions about the privacy of my health information at 10694 Jones Road #210, Houston, TX 77065 or by phone at 281-826-2685.

Signature ___________________________ Date _______________ Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

Name of Guardian/ Representative ___________________________ Legal Relationship ___________ Date ___________ Witness

Signature ___________________________ Date _______________