THE HAYDEN INSTITUTE
FOR HEALTH, NUTRITION, AND REHABILITATION

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 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**_____

Office: 281.826.2685 Fax: 281.469.8997
Chase@HaydenInstitute.com www.HaydenInstitute.com Amber@HaydenInstitute.com

THE HAYDEN INSTITUTE
FOR HEALTH, NUTRITION, AND REHABILITATION

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

Date: _____

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_____

Your Medical Insurance Information:

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_____

Your Car Insurance Information:

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? _____

Your Car Insurance Information (continued):

Medical Coverage? _____ Uninsured Motorist Coverage? _____

Underinsured Motorist Coverage?_____

Personal Injury Protection (PIP) Y N $_____

Medical expenses to date as a result of the accident? $_____

Type your text

Lost wages since accident $_____

What is the repair amount of your car? $ _____

Lawyer/ Law Firm_____ Phone #_____

Address _____City _____Zip Code _____

The Other Person's Car Insurance Information:

"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:

Address:

City, State, Zip:

Home Phone: Work Phone:

Social Security No: XXX - XX - XXXX

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.

Automobile Accident Description

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

Currently Treating? Yes ❑❑ No

X-rays done? 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

Currently Treating? Yes ❑❑ No

X-rays done? 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

Currently Treating? Yes ❑❑ No

X-rays done? 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

Currently Treating? Yes ❑❑ No

X-rays done? Yes ❑❑ No

Patient's Signature:_____ **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
   ee. 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
   h. Shoulder pain LEFT RIGHT BOTH
   i. Shoulder pain with movement L R BOTH
   j. Shoulder spasms LEFT RIGHT BOTH
   k. Sharp shoulder pain
   l. Dull shoulder pain
   m. Achy shoulder pain
   n. Pins and needles shoulder pain
   o. Shoulder pain that radiates or shoots pain into arm
   p. Other:

   _____

8. UPPER ARM PAIN: RIGHT LEFT BOTH
   e. Dull
   f. Ache
   g. Sharp
   h. Stabbing
   i. Other

   _____

9. ELBOW PAIN: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

   _____

10. FOREARM: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

   _____

11. WRIST PAIN: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

   _____

12. HAND PAIN: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

   _____

13. MID BACK PAIN OR UPPER BACK PAIN
   a. Upper or mid back pain
   b. Upper back pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
   c. Upper back pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
   d. Upper or mid back spasms

14. LOW BACK PAIN:
   a. Low back pain
   b. Low back pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
   c. Low back pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
   d. Low back spasms

15. PELVIC OR SACRAL PAIN
   a. Pelvic pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
   b. Pelvic pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
   c. Sacral pain (tail bone)
   d. Coccygeal or coccyx (tail bone) pain

16. HIP PAIN: RIGHT LEFT BOTH
   a. Hip pain
   b. Hip pain, numbness, tingling, weakness that radiates or goes down to buttock, thigh, leg or foot

17. UPPER LEG PAIN: RIGHT LEFT BOTH
   a. Upper leg pain that radiates to knee
   b. 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:

_____

_____

_____

_____

_____

_____

Activities of Daily Living

Activities of Daily Living Scale #1
Use the following 1 to 5 Scale to describe the difficulties below, down through Travelling.

1 - "I can do it without any difficulty."
2 - "I can do it without much difficulty, despite some pain."
3 - "I manage to do it by myself, despite marked pain."
4 - "I manage to do it, despite the pain, but only if I have help.
5 - "I cannot do it at all, because of the pain."

Difficulties with Self Care and Personal Hygiene Activities:
Bathing. ☐ Drying hair.. ☐ Brushing teeth.. ☐ Putting on shoes.. ☐ Preparing meals.. ☐ Taking out trash. ☐ Showering.. ☐ Combing hair.. ☐ Making bed… ☐
Tying shoes.. ☐ Eating… ☐ Doing laundry… ☐ Washing hair… ☐ Washing face… ☐ Putting on shirt.. ☐ Putting on pants. ☐ Cleaning dishes. ☐ Going to toilet.. ☐

Difficulties with Physical Activities:
Standing……. ☐ Walking.. ☐ Kneeling… ☐ Bending back. ☐ Twisting left. ☐ Leaning back… ☐ Sitting… ☐ Stooping… ☐ Reaching.. ☐
Bending left.. ☐ Twisting right… ☐ Leaning left.. ☐ Reclining… ☐ Squatting… ☐ Bending forward.. ☐ Bending right.. ☐ Leaning forward… ☐ Leaning right.. ☐
Standing for long periods… ☐ Sitting for long periods… ☐ Walking for long periods… ☐ Kneeling for long periods… ☐

Difficulties with Functional Activities:
Carrying small objects… ☐ Lifting weights off floor.. ☐ Pushing things while seated.. ☐ Exercising upper body.. ☐ Carrying large objects.. ☐ Lifting weights off table.. ☐
Pushing things while standing.. ☐ Exercising lower body… ☐ Carrying brief case.. ☐ Climbing stairs… ☐ Pulling things while seated… ☐ Exercising arms.. ☐
Carrying large purse.. ☐ Climbing inclines… ☐ Pulling things while standing.. ☐ Exercising legs… ☐

Difficulties with Social and Recreational Activities:
Bowling… ☐ Jogging. ☐ Swimming.. ☐ Ice skating.. ☐ Competitive sports.. ☐ Dating.. ☐ Golfing.. ☐ Dancing.. ☐ Skiing.. ☐
Roller skating.. ☐ Hobbies.. ☐ Dining out… ☐

Difficulties with Travelling:
Driving a motor vehicle.. ☐ As a passenger in a motor vehicle… ☐ As a passenger on a train… ☐ Driving for long periods of time… ☐ As airplane passenger. ☐

Activities of Daily Living Scale #2
Use the following 1 to 5 Scale to describe the difficulties below

1 - "This area is not affected by my condition."
2 - "This area is slightly affected by my condition."
3 - "My condition moderately restricts my ability in this area."
4 - "My condition seriously limits my ability in this area."
5 - "My condition prevents me from using this ability."

Difficulties with Different Forms of Communication:
Concentrating.. ☐ Hearing.. ☐ Listening… ☐ Speaking.. ☐ Reading… ☐ Writing… ☐ Using a keyboard… ☐

Difficulties with the Senses:
Seeing .. ☐ Hearing.. ☐ Touch.. ☐ Taste.. ☐ Sense of Smell. ☐

Difficulties with Hand Functions:
Grasping… ☐ Holding… ☐ Pinching… ☐ Percussive movements.. ☐ Sensory discrimination.. ☐

Difficulties with Sleep and Sexual Activity:
Being able to have a normal, restful nights sleep..... ☐
Being able to participate in desired sexual activity… ☐

Additional Activities of Daily Living Information:

Patient's Signature:_____ **Date:**_____

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_____

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