PATIENT PERSONAL / CONFIDENTIAL DATA

Date: _____

Patient Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____**Cell #**: _____

Employer: _____

How did you learn about this clinic (Google, Instagram, FaceBook, TikTok, Family & Friends, Dr. referral) : _____

Email Address:_____

Are you? Married ☐ Divorced ☐ Single ☐

If married: Spouse's / Partner's name _____

Do you have kids? Yes ☐ No ☐

If yes, how many and age _____

Purpose of this appointment and list your complaints:

_____

_____

Date of Injury: _____ Time: _____A.M. or P.M.

Location: _____

How did the accident occur? ☐ Auto ☐ on the Job ☐ Other, _____

Please describe the circumstances and what makes the condition(s) better or worse.

_____

_____

Have you seen another Doctor for this condition? Yes or No Doctor's Name: _____

Your primary Doctor: _____ Phone #: _____

What is your commitment level to improve your health: _____%

Insurance Information

I understand and agree the health and accident insurance policies are and agreement between the insurance carrier and myself. Furthermore, I understand that this chiropractic Office will prepare necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Office Will be credited to my account upon receipt, However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional serviced rendered to me will immediately do and payable.

Patient's Signature: _____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic service that he/she deems necessary in my case. As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. These complications include fractures, disk injuries and stroke. I further authorize him/her to disclose all or any part of my (patients) records to any persons or corporation in which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature: _____

Patient's or Guardian's Signature: _____

HEALTH QUESTIONNAIRE

MUSCULO SKELETAL VASCULAR SYSTEM

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain

GENITO-URINARY SYSTEM

- ☐ Bladder
- ☐ Excessive Urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

GASTRO-INTESTIONAL SYSTEM

- ☐ Poor Appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult Swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

CARDIO-VASCULAR SYSTEM

- ☐ Chest Pain
- ☐ Pain over heart
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

Nervous System

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscles jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

Eye, Ear, Nose AND Throat

- ☐ Eye stain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noise
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficult breathing through nose
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw pain

HABITS

- ☐ Cigarettes
- ☐ Alcohol Abuse
- ☐ Coffee or Tea
- ☐ Drug Abuse
- ☐ _____

FEMALE

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

ARE YOU PREGNANT?

☐ **YES** ☐ **NO**

Patient's Signature _____

Patient Accepted? ☐ **Yes** ☐ **No**

Doctor's Signature _____

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at the worst.

PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES HOW YOUR TYPICAL PAIN LEVEL AFFECTS THESE SIX CATEGORIES OF ACTIVITIES.

1 Family/ at home responsibilities such as yard work, chores around the house or driving the kids to school –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — **TOTALLY UNABLE TO FUNCTION**

2 Recreation including hobbies, sports or other leisure activities –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — **TOTALLY UNABLE TO FUNCTION**

3 Social activities including parties, theater, concerts, dining – out and attending other social functions –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — **TOTALLY UNABLE TO FUNCTION**

4 Employment including volunteer work and homemaking tasks –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — **TOTALLY UNABLE TO FUNCTION**

5 Self- care such as taking a shower, driving or getting dressed –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — **TOTALLY UNABLE TO FUNCTION**

6 Life- support activities such as eating and sleeping –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — **TOTALLY UNABLE TO FUNCTION**

PATIENT NAME _____ **DATE**_____

Patient Consent / HIPAA Understanding

I understand that, under the Health Insurance Portability & Accountability of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can/will be used to:

- Conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from the third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Tricare Chiropractic has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing any time, except to the extent that you have taken action relying on this consent.

I understand that by signing below I give my consent to be examined and treated by Dr. Tien Adrian Trinh and any/all other staff of Tricare Chiropractic. All staff members at Tricare Chiropractic are dedicated to treat me with the utmost respect and professionalism. They will strive to provide me with the best chiropractic care and associated therapies they are able to provide. If I have any comments, complaints, or concerns associated with this facility, I will discuss these issues with the Office Manager on site immediately.

_____
Patient Name

_____ _____
Signature Date

_____
Relationship to Patient(IF under 18)

_____ _____
Witness Date

Tricare Chiropractic, P.A.
800 W Arbrook Blvd. Suite 110
Arlington, TX 76015

Tricare Chiropractic
Our promise, patient first

800 W. Arbrook Blvd., Suite 110
Arlington, TX 76015
O: 817-987-4150 F: 817-987-4151

Patient's Accident Report

Name: _____ Date: _____

Locationof accident: _____ City: _____

Date of accident: _____ Time: _____ Was police report made? _____

Were you? ____Driver ____ Passenger Were you wearing seatbelts? _____

Were you struck from? _____ Behind _____ Right side _____ Left side _____ Front

Direction of your travel _____ Other car _____ Approximate speed of your car _____ Other car _____

Kind of car you were in _____ Approximate Damages $ _____

Other car _____ Approximate Damages $ _____

How did the accident occur? _____

_____

_____

In the space provided, draw a diagram of how the accident occurred:

How did you feel after the accident? _____

_____

_____

Since this impact, did this accident affect your work or home activities? _____

_____

_____

Have you received first aid or any other treatment for this injury? _____

If yes, from whom?_____ City _____

Were you hospitalized? _____ If yes, how long? _____ Name of hospital _____

Were you off work because of this injury? _____ If yes, the first day you were unable to work _____

Have you returned to work? _____ If yes, on what date? _____

Patient's Signature _____

ASSIGNMENT, LIEN, AND AUTHORIZATION
FOR DIRECT PAYMENTS BY MY PAYERS TO TRICARE CHIROPRACTIC, P.A.

Purpose. The purpose of this Assignment is to improve the ability of the Office to collect my Charges directly from various Payers. Accordingly, I agree to the following and direct all Payers as follow:

Definitions. In this Assignment, the following terms shall have the following meaning: " Office" and "Clinic" shall refer to **TRICARE Chiropractic, P.A. located at 800 W. Arbrook Blvd., Suite 110 Arlington, Texas, 76015**; "Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds, either now or in the future; "Proceeds" shall include without limit the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse , the proceeds relating to " health-care-insurance receivables" and/or "payment intangibles " as such are defined by the applicable Uniform Commercial Code, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Medicaid, workers' compensation , disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, loss wages, lost services, property damage, errors & omissions, and malpractice; "Charges" shall include without limit the full fees for the Office's services (including without limit treatment, diagnostic services, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony, whether rendered before or after the date of this Assignment & Lien), any Collection Cosis Incurred by the Office, delinquency penalties and interest to the maximum extent permitted under law or all the annual rate of eighteen percent (18%), whichever is greater, and any other charges incurred by me at the Office; "Collection Costs" shall include without limit any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, fees or costs associated with requests for reconsideration, independent reviews, appeals, mediation, arbitration, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from me or from any Payer.

Assignment and Lien Terms. I hereby assign to the Office to the extent permitted by law, but only to the extent of my Charges, all of my rights, remedies, and benefits relating to any Payer, including without limit a primary, non-contingent right to receive Proceeds from any Payer now or in the future, and any and causes of action that I might have against any Payer now or in the future, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as Office sees fit. I agree that this assignment shall be effective as of the date and time my condition first arose. I further intend for this Assignment & Lien to create a secured interest under the applicable Uniform Commercial Code. According, I hereby grant to the Office a primary, non-contingent secured interest in all Proceeds to the extent permitted by law for the purpose of securing payment of my Charges, which secured interest shall attach and also be automatically perfected effective as of the date and time that any condition first arose. I further authorize the Office to file the form(s) normally filed with the secretary of state or other govemmental agency relating to such secured interest, and to make such fillings in all relevant jurisdictions as the Office sees fit in its sole discretion. I agree that once payments in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also defined by my agreement with the Office, such secured Interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Services Certified Mail. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to immediately to, and exclusively in the name of the Office to the full extent of my Charges. To the extent that any law, including without limit a lien statue, purports to limit, reduce, or modify the distribution of Proceeds in any manner inconsistent with this Assignment & Lien including without limit through the reservation of a portion of the Proceeds exclusively to me, I hereby waive such limits, reductions, or modifications. Such waiver shall not adversely affect or prejudice any rights which the Office may have and elect to exercise under said law.

Specific Direction to Any Attorney I Retain, such as in Accident Cases. In the event that I retain one or more attorneys to assist me in collection any Proceeds, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of any Proceeds received by the attorney shall be primary to pay my Charges. If I have a dispute regarding the Charges, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the Office. I further agree to and herby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to reduce its Charges or balance by proportionate or weighted shared of my attorney's fees, costs, and other expenses of pursuing collection of my claims, including the Office's Charges.

Disclosure Directives. I hereby direct each and every Payer to immediately release to the Office any Pertinent Information relation to (a) any coverage I may have and (b) any Determination by the Payer relating to the Office's Charges. "Pertinent Information" shall include without limit the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information" shall also include without limit copies of all documents, records and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny, or delay payment of any Proceeds relating to the Office's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I futher authorize and direct the Office to release any information relating any services rendered to or for me by the Office to all Payers, including without limit copy of my Charges and a copy of this Assignment & Lien.

Miscellaneous. Except as provided in this paragraph, this Assignment & Lien shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent the terms of any previously signed documents, but only to the extent those terms conflict with terms of this Assignment & Lien. I agree that each and every provision of this Assignment & Lien is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Assignment & Lien be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other pardons and provisions of this Assignment & Lien shall, nevertheless, remain in full force and effect. This Assignment & Lien shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment & Lien, hereby consent to personal justification and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statue of limitations which may apply in any action based upon this Assignment & Lien.

I have read, understood, and agree to the terms of this Assignment.

Patient Name (print): _____

Patient Signature: _____ Date: _____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (print): _____

Parent/ Guardian Signature: _____ Date: _____

CLAIM #: _____

Disclosure of Fee's/Payment Policy

99201	Brief Exam 10 min	$ 75.00
99202	Intermediate Exam 20 min	$ 100.00
99203	Detailed Exam 30 min	$ 160.00
99204	Comprehensive 45 min	$ 180.00
99211	Brief OV/ Re-exam 5 min	$ 55.00
99212	Limited OV/ Re-exam 10 min	$ 75.00
99213	Detailed OV/ Re-exam 15 min	$ 105.00
98940	CMT 1-2 Regions	$ 55.00
98941	CMT 3-4 Regions	$ 60.00
98942	CMT 5 or more Regions	$ 65.00
98943	Extra spinal one or more	$ 45.00
97010	Cold/Hot Pack	$ 20.00
97012	Mechanical Traction	$ 30.00
97014	Electrical Stimulation	$ 30.00
97035	Ultrasound	$ 30.00
97110	Therapeutic Exercise each 15 min	$ 45.00
97112	Neuromuscular Re-education	$ 45.00
97124	Massage each 15 min	$ 45.00
97140	Manual Therapy / MFR each 15 min	$ 45.00
97530	Therapeutic/Kinetic	$ 40.00

I have read the above codes and fees's and understand the cost of my care with treating doctor. I understand that I am responsible for payment of all deductibles, co-insurance and co-payments related to my care. If my balance is not paid in a timely fashion, I promise to pay any and all collection, court, and attorney's fees in the collection of my account. I understand that if a check or debit is returned for insufficient funds, I will be charged a $25.00 service charge.

I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case.

I further understand that if my insurance company declines payment, I authorize Dr. Trinh to file small claims on my behalf against my insurance company as a method of collection. I further understand that I will be present at the court date if needed.

I have read and fully understand the above financial terms and prices.

Signed_____ Date_____