Patient and Insurance Information

Name email Date

Address Apt #

Town State ZIP

Home Phone Work Phone Cell

Driver's License # Birth Date SS#

Marital Status M S D Sep Spouse Name # of Children

Referred By: Age Range of Children

Employer Occupation

Address

Town State ZIP

Health Insurance Info

Carrier Ins Co phone

Address

Policy # Group #

Patient Relationship to the insured Self Spouse Child Other

If you are covered under another person's insurance…. Please complete

Name of Insured

Address of insured

Phone of insured Sex Birth date

Insured's Employer

Address

Employer Phone Plan Name

Auto Accident Insurance

Policy Number

Carrier

Address

City State ZIP Phone

Person To Contact… Claim #

Date of Accident Patient Relationship to the insured Self Spouse Child Other

PATIENT:_____ DATE: _____

EDUCATION LEVEL

- ☐ Grade 8 or less
- ☐ Partial high school
- ☐ High school graduate
- ☐ Some college
- ☐ College graduate
- ☐ Masters or higher

EMPLOYMENT STATUS

- ☐ Paid full time
- ☐ Paid part time
- ☐ Homemaker
- ☐ Student
- ☐ Unemployed
- ☐ Retired
- ☐ Other_____

WORK ACTIVITY MAIN

- ☐ Heavy labor
- ☐ Light labor
- ☐ Mostly sitting at desk
- ☐ Mostly standing
- ☐ Mostly walking/moving about
- ☐ Driving or operating vehicle

ADDITIONAL INFORMATION

Do you smoke? Yes ☐ No ☐
If yes, how many packs/day? <1 ☐ 1 ☐ 2 ☐ 3 ☐ 3>☐
Do you drink? Yes ☐ No ☐ If yes, amount_____

Have you ever had x-rays taken of :	Yes	No	Describe:
Your low back:	☐	☐	_____
Your neck:	☐	☐	_____
Your chest:	☐	☐	_____
Other:	☐	☐	_____

How many days have you lost from work due to this current problem?
_____days.

How many days have you lost from work in the past year due to your problem? _____days

Do you like your job? Yes ☐ No ☐ Really like my job ☐
No opinion ☐ Dislike my job ☐ Really dislike my job ☐

SYMPTOMS LIST: Please ch[illegible] symptoms you have from the list belo[illegible]

Date: _____

our Name: _____

EAD:

1. Headache
2. sinus (allergy)
3. entire head
4. back of head
5. forehead
6. temples
7. migraine
8. frequent and severe
9. Head feels heavy
10. Lightheadedness
11. Fainting
12. Face flushed
13. Loss of memory
14. Eye strain
15. Light bothers eyes
16. Blurred vision
17. Double vision
18. Loss of vision
19. Loss of balance
20. Dizziness
21. Loss of hearing
22. Pain in the ears
23. Ringing in the ears R L
24. Buzzing in the ears R L
25. Loss of taste
26. Loss of smell
7. Sinus trouble

CK:

30. Neck pain
31. Neck stiffness
32. Neck pain and stiffness
33. Moderate to severe neck pain
34. Neck pain with movement
35. forward
36. backward
37. turning to the left
38. turning to the right
39. bending to the left
40. bending to the right
41. Pinched nerve in the neck
42. Neck feels "out of place"
43. Muscle spasms in the neck
44. Grinding sounds in the neck
45. Arthritis in the neck

OULDERS:

50. Pain in shoulder joint R L
51. Pain across shoulders
52. Pain between shoulder blades
53. Stiffness in shoulder R L
. Tension in the shoulders
55. Pinched nerve - shoulder R L
56. Muscle spasms - shoulder R L
57. Unable to raise arm R L
58. above shoulder level R L
59. over head R L

ARMS & HANDS:

65. Pain in the upper arm R L
66. Pain in the elbow R L
67. Tennis elbow R L
68. Pain in forearm R L
69. Pain in hands R L
70. Pain in fingers of R L hand
71. Sensation of pins & needles in the arm R L
72. Sensation of pins & needles in the fingers R L
73. Numbness in arms R L
74. Numbness in fingers R L
75. Fingers go to sleep R L
76. Hands get cold
77. Swollen joints in fingers
78. Stiffness in fingers R L
79. Loss of grip strength R L

MID-BACK:

82. Mid-back pain
83. Mid-back stiffness
84. Mid-back pain and stiffness
85. Mid-back muscle spasms
86. Pain in kidney area

CHEST:

90. Chest pain
91. Shortness of breath
92. Pain around the ribs
93. Breast pain
94. Irregular heartbeat

ABDOMEN:

100. Nervous stomach
101. Nausea
102. Gas
103. Constipation
104. Diarrhea
105. Hemorrhoids

LOW BACK:

110. Low back pain
111. Low back stiffness
112. Low back pain and stiffness

Low back pain is worse when:

114. working
115. lifting
116. stooping
117. standing
118. sitting
119. bending
120. coughing
121. lying down (sleeping)
122. walking

125. Low back feels out of place
126. Muscle spasms in low back

HIPS, LEGS & FEET:

130. Pain in buttocks R L
131. Pain in the hip joint R L
132. Pain down the leg R L
133. Pain down both legs
134. Leg cramps R L
135. Cramps in feet R L
136. Knee pain R L
137. inside R L
138. outside R L
139. Pins & needles in legs R L
140. Numbness of leg R L
141. Numbness of feet R L
142. Numbness of toes R L
143. Swollen ankles R L
144. Swollen feet R L
145. Feet feel cold

WOMEN ONLY:

150. Menstrual pain (where) _____
151. Menstrual cramping
152. Irregular period
153. Abnormal discharge
155. Tumors

MEN ONLY:

160. Urinary frequency
161. Difficulty in starting urination
162. Night urination
163. Prostate pain/swelling

GENERAL:

170. Anxiety
171. Nervousness
172. Irritable
173. Difficulty in prolonged riding in an automobile
174. Depression
175. Fatigue
176. Generally feel run down
177. Difficulty sleeping
178. Loss of weight _____ lbs.
179. Gain weight _____ lbs.
180. Excessive perspiration
181. Pallor
182. Tremors

Write in your own symptoms: _____

Please use the following key to accurately mark the areas in which you feel the described sensations. Use the appropriate symbols and include all affected areas.

Dull NNN

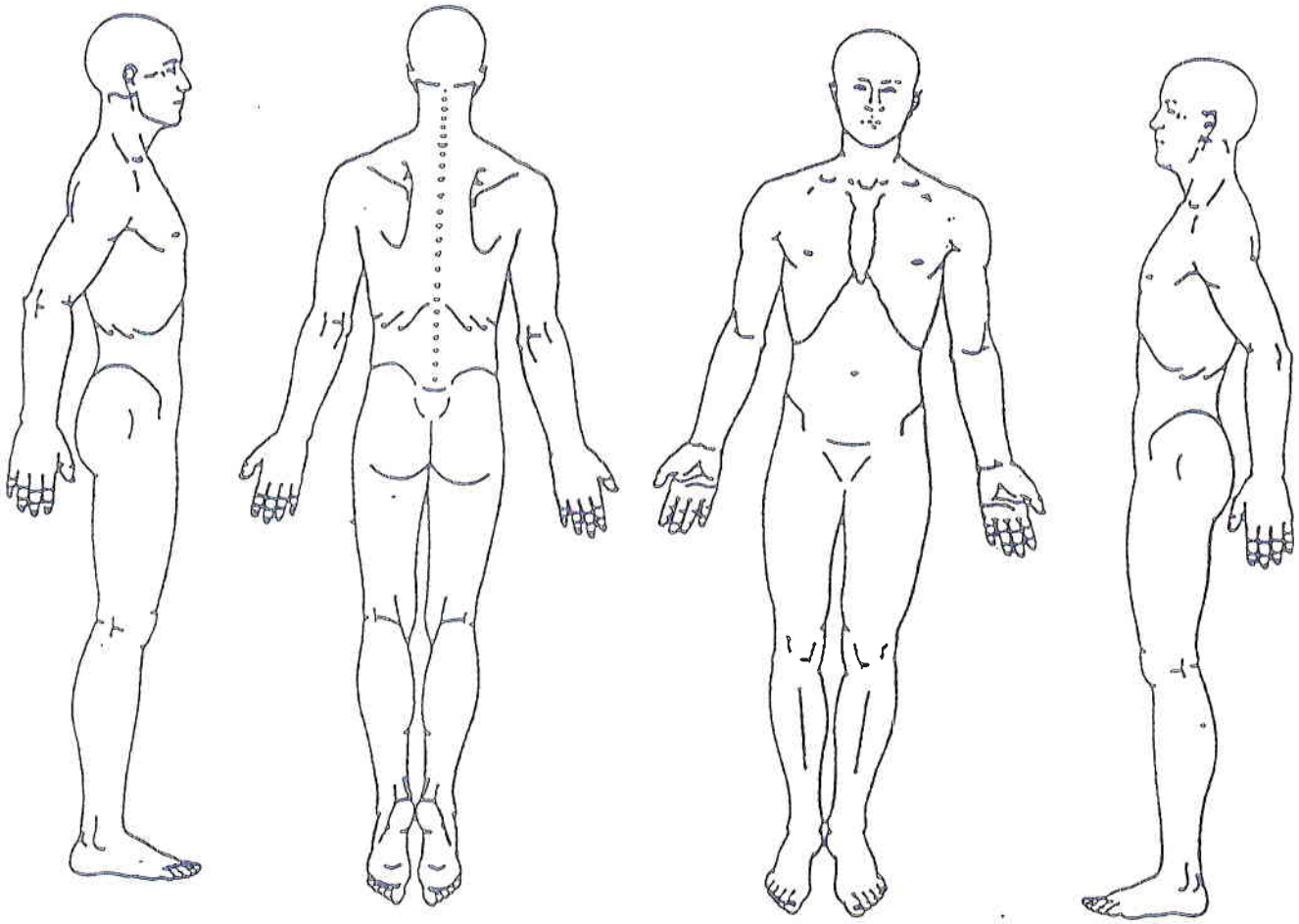
Numb = = =

Stabbing/Cutting /// /// ///

Tingling (Pins & Needles) : : : : :

Burning XXX

Cramping SSS



Please rate your pain using the following scale: (0 = no pain and 10 = worst possible pain)

	0	1	2	3	4	5	6	7	8	9	10
Current pain intensity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Average pain intensity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Worst pain intensity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name:_____ Today's Date:_____

Date of Accident:_____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:

❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon ❑Bus
❑Other_____

Vehicle size:

❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Mid-size ❑Light
❑Heavy ❑Other_____

Your position in the vehicle:

❑Driver
❑Passenger -------- Location-------- ❑Left ❑Middle ❑Right
❑Other _____ ❑Front Passenger ❑Rear Passenger ❑Third Seat (rear)

Speed of your vehicle:

❑Stopped ❑Moving Moderately
❑Parked ❑Moving Fast
❑Slowing ❑Moving at apprx ____MPH
❑Moving Slowly

Why Vehicle was slowed or stopped:

❑Traffic Signal ❑Parking
❑Pedestrian ❑Traffic
❑Stop Sign ❑Busy Intersection

Collision Type:

❑Driver Side Impact ❑Head On Collision
❑Passenger Side Impact ❑Rear Impact
❑Front Impact ❑Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon ❑Bus
❑Other_____

Vehicle size:

❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Mid-size ❑Light
❑Heavy ❑Other_____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

❑Full daylight
❑Dusk
❑Night

Road Conditions:

❑Dry
❑Damp
❑Wet
❑Snow covered
❑Ice covered
❑Patchy Ice/Snow

Visibility:

❑Excellent
❑Good
❑Fair
❑Poor

Visibility compromised by:

❑Brightness
❑Darkness
❑Rain
❑Snow
❑Fog
❑Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...

❑Totally unaware that the accident was impending
❑Aware that the accident was impending
❑Aware that the accident was impending and braced for it

Restraints: (check all that apply)

❑Seat belt
❑Shoulder harness
❑No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? ❑Yes ❑No ❑Knocked off by impact

Was the air bag deployed?
- ❑Car not equipped with air bag
- ❑Air bag deployed
- ❑Air bag not deployed

What position was YOUR headrest in?
- ❑High position
- ❑Middle position
- ❑ Low position

Position of YOUR head at time of impact?
- ❑Facing straight ahead
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your head thrown...?
- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left ❑To the left then the right
- ❑To the right ❑To the right, then the left

Position of Your body at time of impact?
- ❑Straight
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your body thrown...?
- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left ❑To the left then the right
- ❑To the right ❑To the right, then the left
- ❑Across the vehicle
- ❑Outside the vehicle ❑Under the vehicle

Damage to vehicle YOU were in:
- ❑Incurred minimal damage
- ❑Incurred moderate damage
- ❑Incurred severe damage
- ❑Was totalled
- ❑Not known

Citations:
- ❑None issued
- ❑Yourself
- ❑Driver of vehicle patient was a passenger of
- ❑Driver of other vehicle
- ❑Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Left Arm
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Right Arm
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat

Torso
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat

❑Left door ❑Backseat ❑Left door ❑Backseat

Left Leg

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

Right Leg

❑Steering wheel ❑Right door
❑Dashboard ❑Left window
❑Windshield ❑Right window
❑Armrest ❑Console
❑Headrest ❑Gear shift
❑Rear view mirror ❑Front seat
❑Left door ❑Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

❑Yes
❑No

Immediately following the accident, did you feel...?

❑Dizzy ❑Weak
❑Dazed ❑Nervous
❑Disoriented ❑Nauseated

Were you able to walk unaided?

❑Yes
❑No

Where did you go...?

❑Drove home ❑Drove to work
❑Was driven home ❑Was driven to work
❑Drove to hospital ❑Drove to school
❑Was driven to hospital ❑Was driven to school
❑Taken to hospital via ambulance

Next day discomfort...?

❑increased ❑decreased ❑same

Did your major complaints exist before the accident?

❑Yes ❑ No

In what areas did you IMMEDIATELY feel pain?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑Low Back ❑Pelvis

In what areas did you experience lacerations (cuts)?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑Low Back ❑Pelvis

At the hospital, what areas were x-rayed?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑Low Back ❑Pelvis

Where did you experience pain on the day FOLLOWING the accident?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑ Low Back ❑Pelvis

Patient's Signature:_____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical modalities and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and informed that, as in the practice of medicine, the practice of chiropractic posses some risks to treatment, including, but not limited to, fracture, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. Therefore, I wish to rely on the Doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, and is in my best interest.

I have read, or have read to me, the above consent I have also had and opportunity to ask questions about its content, and by signing below 1 agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

All charges incurred at Hillsboro Chiropractic Clinic are my total Responsibility regardless of payment by my insurance policy or not.

If this account is placed with an attorney for collection, I am aware of having additional attorney fees added. If the attorney should have to pursue litigation, I also understand I will be responsible for additional court cost or attorney fees.

Print Patient's Name: _____

Patient's Signature: _____

Patient's Representative's Signature: _____

Date Signed: _____/_____/_____

FINANCIAL POLICY FOR AUTOMOBILE CLAIMS

This office requires that you file on your Personal Injury Protection (PIP) or make daily payments at each visit of $20.00, unless other arrangements have been made. PIP coverage is on all full coverage policies unless you specifically rejected it. You will need to call your agent to set up your claim. State law prohibits carriers from raising your policy premium when using PIP. PIP does not subrogate liability (this means that you do not have to pay PIP back to your carrier once you make settlement with the other responsible party).

Please bring in your PIP application upon completion, so that we can attach the doctor's report form along with your initial medical bills.

In some cases we will file your auto claim with your health insurance carrier. This office does not give PPO or HMO discounts when using your health insurance on an auto claim. Most health insurance policies subrogate (this means that you have to pay your health insurance carrier back when you reach settlement with the third party carrier). You must inform your health insurance company to make arrangements for them to pay your medical bills while you are under treatment.

If you have contacted an attorney to represent you, our financial policy remains the same regardless of attorney representation unless other arrangements have been made. Please have a letter of protection faxed to Dr. Johnson at (254) 580-0708.

Third party liability claims are not settled until the patient has been released from care. Upon release, we will submit an itemized statement along with your medical records to the carrier. There is an additional fee for a narrative report starting at $200.00.

Dr. Johnson allows three months from release of care to make settlement of your claim before full payment is expected. You will be required to make monthly payments in the amount of $100 towards your balance regardless of PIP exhaustion, attorney representation, or health insurance status, unless other arrangements have been made.

You or your attorney will need to contact the third party carrier to settle your claim. This office has no contact with the carrier regarding your settlement. The liability carrier will usually write one check to the patient for medical and "pain and suffering". The check will be issued directly to you or your attorney. **The insurance company does not pay this office directly. It is your responsibility to see that Dr. Johnson is paid regardless of PIP, attorney representation, or health insurance.** This office does not reduce our charges regardless of PIP, attorney representation, or health insurance. This office does not reduce our charges nor make financial arrangements with the insurance carrier or the attorney.

If your settlement is not enough to make full payment, contact our office for payment arrangements. We have payment plans to fit your financial needs.

I have read the above policy and acknowledge my obligations.

Patient Signature:_____ Date:_____

Staff Signature:_____ Date:_____

PERSONAL INJURY ASSIGNMENT AND LIEN

PROVIDER:
M. Scott Johnson, D.C.
Hillsboro Chiropractic Clinic
211 East Franklin Street
Post Office Box 706
Hillsboro, Texas 76645

Office 254-580-0701
Fax 254-580-0708

Provider Type: Doctor of Chiropractic
Tax ID # 32-0063210

Patient Name: _____

SSN: _____ **Date of Injury:** _____

Description of Accident: _____

Patient confirms rights to claim benefits and/or liability claims from the following Insurance Companies:

Name of Company: _____
Policy Number: _____ Type Insurance: _____
Claim Number: _____
Date of Certified Mailing: _____

ASSIGNMENT OF CONTRACTUAL BENEFITS: As a condition of and in consideration for receiving reasonable and necessary healthcare from the above named provider, I assign to the Provider all rights I may have under such policy to make claims and apply for and receive benefits under any insurance policy or benefit plan which I am qualified to receive, including: PIP, UM, UIM, Group Health, PPO, and HMO insurance benefits. This assignment includes and I give my power of attorney to the Provider to act on it's own, or in my name in collecting available benefits, signing payment checks, submitting information forms, and communicating, in any manner, with any insurance representative, including submission of records and billing statements as required under any insurance policy I agree to cooperate with provider and providers representatives to collect any and all amounts owed.

CONTRACTUAL LIEN ON LIABILITY/UM/UIM INSURANCE SETTLEMENT FUNDS: In exchange for health care to be provided, I give provider named above a contractual lien on any and all funds paid from any policy of liability insurance or first party uninsured/underinsured motorists insurance as part of any settlement or advance payment, which shall be effective and enforceable immediately upon payment of any such funds. All parties to any settlement, who have notice, are responsible for protecting provider's right to be paid any unpaid balance on patient's account at the time of payment. Violation of provider's contractual lien rights may result in additional claims against all parties paying or receiving funds for conversion, misapplication of funds, and/or breach of fiduciary duty as the holder of funds protected by lien. Venue is agreed to be in the county of Provider's office in which health care has been rendered. All applicable statutes of limitations are extended for four years after provider receives written notice that a settlement payment has been made. Provider is assigned my right to receive funds from any settlement until the lien is satisfied.

Signature of Patient/Parent/Legal Representative: I have read and agree to the terms stated above.

Signature: _____ Date: _____

Signature: _____ Date: _____

Receipt by Insurance Representative: By signing below, I confirm receipt of this form.

Signature: _____ Date: _____

Signature: _____ Date: _____

Receipt by Patient's Attorney: By signing below, I confirm receipt of this form.

Signature: _____ Date: _____

As authorized representative of the health provider named above, I certify a copy of this document was delivered to the following parties as follows:

Name of Party: _____ Date Noticed: _____
Method of Notice: _____ Certified Mail Number: _____
Page (s): _____

Signature of Provider Representative: _____ Title: _____ Date: _____

NOTICE TO ALL RECIPIENTS
PLEASE SIGN AND FAX BACK TO PROVIDER @ 254-580-0708

HILLSBORO CHIROPRACTIC CLINIC
LIABILITY PATIENT INFORMATION FORM
AND PAYMENT AGREEMENT

Name: _____ Date of Birth: ____/____/____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____
Driver's License: _____ SS#_____-_____-_____
Marital Status: _____ Occupation _____
Employer: _____ Work Number: _____
Name nearest relative: _____ PH#_____

FINANCIAL POLICY REGARDING THIRD PARTY INJURIES

PERSONAL INJURY PROTECTION: (Your Policy) This is insurance that is not required by the State of Texas, but most owners carry on their policy. It may be used to cover medical expense or a % of lost wages. It is unlawful for the insurance company to raise your premium or request that you pay this back to insurance company when filed against. YOU will need to call your insurance agent and request a PIP application. These are sent to you in about 7-10 days. Fill out the form and bring to the insurance department ASAP.

Company Name: _____ Adjuster: _____
Address: _____ Phone. _____
Claim #: _____ DOB: ____/____/____ Insured Name: _____

UNLESS WE FILE PIP, ALL VISIT S REQUIRE A PAYMENT AT EACH VISIT TOWARD THE BALANCE OF YOUR ACCOUNT. Upon release, monthly payments of $100 are required. We will allow three months to settle your account.

I agree to the above policy and will file my personal injury protection or make payment on a daily visit and understand that I am allowed three months to settle my case upon release before full payment is expected. I will also make payment of $100 monthly during the three months that I am trying to settle my case.

Patient Signature: _____ **Date:** _____/_____/_____

THIRD PARTY (the person's who is responsible for your injury)
Company: _____ Adjuster: _____
Address: _____ Phone: _____
Claim #: _____ Insured Name: _____

ATTORNEY: _____ **PHONE:** _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient: _____
Employer: _____
Claim / Group #: _____
SS# / ID#: _____

I hereby instruct and direct the _____ insurance company:

To pay by check made out and mailed directly to:

Hillsboro Chiropractic Clinic
Post Office Box 706
Hillsboro, Texas 76645
(O) 254-580-0701
(F) 254-580-0708

OR

I request you issue a **2-Party Check** made **BOTH** to the claimant (_____) and Dr. M. Scott Johnson. It is understood that Dr. Johnson and I both need to endorse this check before it can be cashed and tendered. The balances of my medical expenses are to be paid from the funds cashed from this 2-party check.

OR

If my current policy prohibits direct payment to doctor, then I hereby instruct and direct you to make out the check to me and mail it as follows:

C/O

Hillsboro Chiropractic Clinic
Post Office Box 706
Hillsboro, Texas 76645

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated at _____ the _____ day of _____ 20_____

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant, if other than Policyholder

FAXED TO INSURANCE COMPANY: _____
Date of Transmission

Staff Initials: _____

_____
Insurance Adjustor Signature