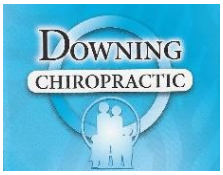


# DOWNING CHIROPRACTIC CLINIC

James W. Downing D.C.
Matthew J. Downing D.C.

105 E. Vandament
Yukon, OK. 73099
(405) 354-0994

**CONFIDENTIAL PATIENT INFORMATION**

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need assistance, please ask the receptionist.

Today's Date _____ Referred by: _____

Is your visit due to an accident? ___ Yes ___ No Date of accident: _____

Name _____ Social Security # _____

Address _____ Email: _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birth Date _____ Age _____ Marital Status _____ Number of Children _____

Employer _____ Occupation _____

Spouse _____ Phone Number _____

Nearest relative not living with you _____ Relation _____

Home / Cell Phone _____ Work Phone _____

Present Complaint – briefly describe symptoms and location of complaint _____
_____
_____
_____

Medical History – If any of the following are relevant to your medical history please check

| | | |
|---|---|---|
| __ Cancer | __ Muscular Dystrophy | __ Rheumatic Fever |
| __ Polio | __ M.S. | __ Scarlet Fever |
| __ Tuberculosis | __ Convulsions | __ Nervousness |
| __ Epilepsy | __ High Blood Pressure | __ Asthma |
| __ Heart Trouble | __ Concussion | __ Digestive Disorder |
| __ Diabetes | __ Dizziness | __ Sinus Trouble |
| __ Hepatitis | __ Arthritis | __ Backaches |
| __ Neuritis | __ Numbness | __ Pain |
| __ Swelling | __ Rheumatism | __ Anemia |

List other Doctors you have seen for this condition _____
_____

Please list all operations you have had and when _____
_____

Have you been treated by a physician for any health condition in the last year? ___ YES ___ NO

If yes, please describe: _____
_____

Are you currently taking any medications? ___ YES ___ NO

If yes, please describe: _____
_____

Date of last physical exam: _____

Are you allergic to any medications? ___ YES ___ NO

Please List: _____
_____

Are you pregnant? ___ YES ___ NO Date of last menstrual cycle: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. 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 services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Spouse/Guardian Signature _____ Date _____

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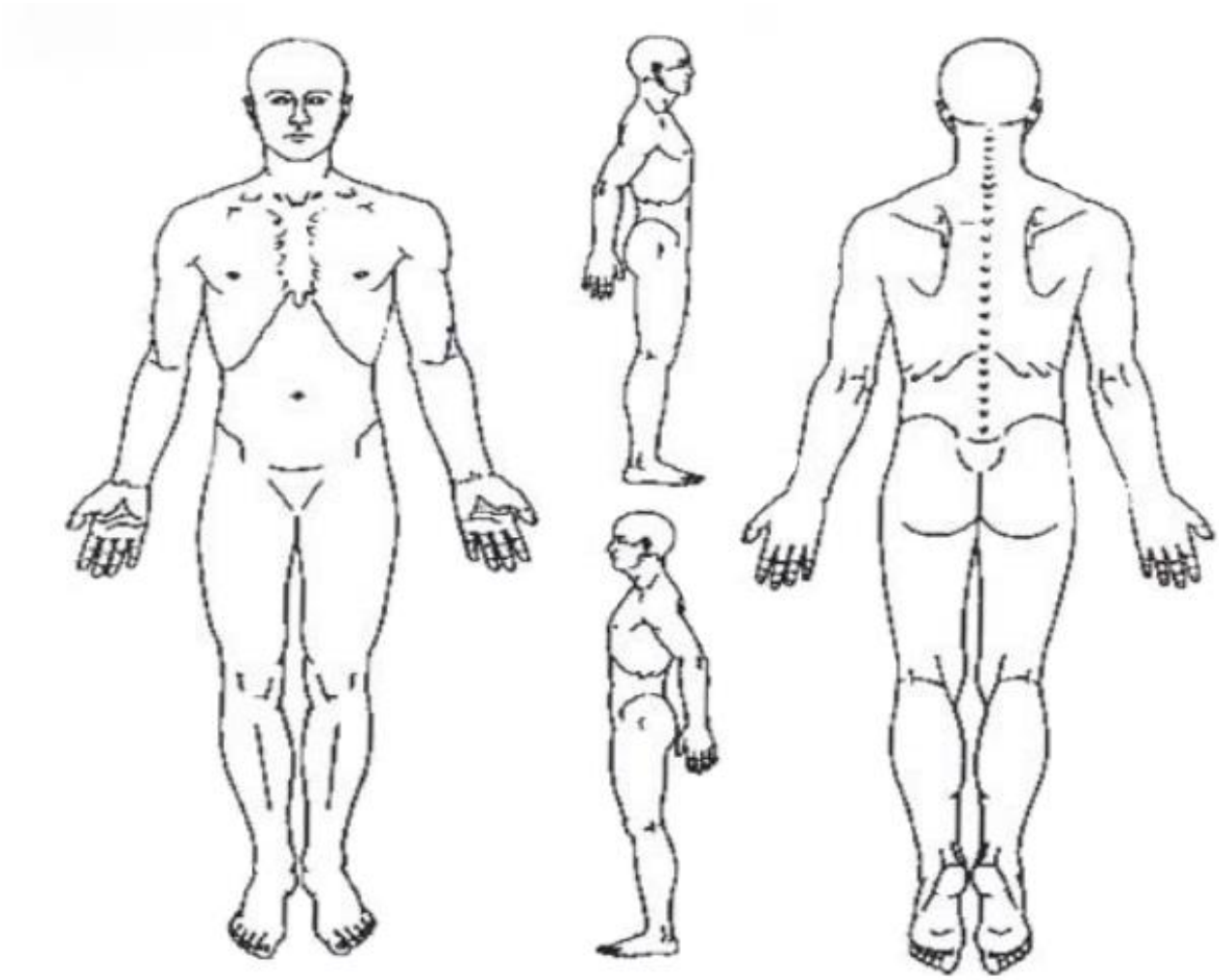
NAME: _____ AGE: _____ DOB: _____

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW.

KEY:
A = ACHE
B = BURNING
N = NUMBNESS
P = PINS & NEEDLES
S = STABBING
D = DULL PAIN
H = SHARP PAIN
O = OTHER

Please place the letter from the above key on the diagram representing location and sensation you are experiencing.



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# Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document "I" and "my" refers to the patient, and "Chiropractor" refers to either James W. Downing D.C. or Matthew J. Downing D.C.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidence by my signature below.

I understand that I have the right to request as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I requested, the restriction is binding by the Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted on the check-out counter at 105 E. Vandament Ave in Yukon, Oklahoma 73099. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my appointment.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____

Description of Personal Representative

_____

Date of Signing

DOWNING CHIROPRACTIC CLINIC

James W. Downing D.C.
Matthew J. Downing D.C.

105 E. Vandament
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## Release of Medical Information

Due to HIPAA law we can not discuss any medical information to anyone without your consent. Please write to whom we may discuss your information with below.

| Name | Relationship | Phone Number |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please check which information we may discuss with the person(s) listed above:

__ Appointments
__ Billing
__ Medical Information

I wish to be contacted in the following manner (Check all that apply)

__ Home Telephone
- __ Ok to leave message with detailed information
- __ Leave message with call back number only

__ Work Telephone
- __ Ok to leave message with detailed information
- __ Leave message with call back number only

__ Cellular Telephone
- __ Ok to leave message with detailed information
- __ Leave message with call back number only
- __ Ok to text (such as appointment reminder)

__ Written Communication
- __ Ok to mail to my home address
- __ OK to mail to my work/office address

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# Office Policy

We believe that a clear definition of our office policies will allow both you the patient, and us the doctors, to concentrate of the big issue --- REGAINING AND MAINTAINING YOUR HEALTH!

**APPOINTMENT POLICY:** If you are unable to keep an appointment for any reason, we require you to call immediately to reschedule your visit. Charges may also be made for broken appointments and visits not canceled with at least a 24 hour notice.

**NO SHOW POLICY:** A $40 charge will be assessed for each no show appointment. This fee will be due prior to scheduling your next appointment. Missed same-day appointments will also discourage us from scheduling same-day appointments in the future. Understand that your insurance WILL NOT cover this fee for you, regardless of your usual co-pay or deductible, therefore, you will receive a bill.

**FIRST MISSED APPOINTMENT**: Your chart will be marked as "No Show" and the above fees applied.

**SECOND MISSED APPOINTMENT**: The fees stated above will apply; a letter will be mailed to you and placed in your chart. This letter will state that you have missed a second appointment and remind you of the consequences of missing a subsequent appointment.

**THIRD MISSED APPOINTMENT**: Again, you will receive a letter and fees. This letter will advise you that you will not be allowed to schedule appointments with Downing Chiropractic in the future, and it will advise you of the fees for a missed appointment as stated above. While this might seem extreme to some, realize that this will help ensure that you can be seen when needed. Most of you will not miss and appointment, so this will not be an issue. If you call and give us at least the requested 24 hours notice, we can fill your spot with another patient that may have been denied an appointment due to scheduling limitations. Remember, it may be you in need of an appointment the next time. If you have any questions, please talk to any of the staff, including the doctors.

**FINANCIAL POLICY:** It is our office policy that all services rendered are charged directly to you, the patient, and that you are ultimately responsible for all payments regardless of whether or not this office accepts insurance assignment. I understand that I will be responsible for any and all fees.

1. *Patient with no insurance*: All payments are expected at the time services are rendered. This way we can keep the cost down to you, the cash patient.

2. *Patients with insurance*: Deductibles and co-payments are expected at the time services are rendered.

**INSURANCE POLICY:**

1. Our office will verify your insurance coverage in an effort to determine exactly what Chiropractic coverage is available to you under your policy. We DO NOT guarantee that the information given to us by you insurance company is accurate.

2. If your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim. After 90 days you will be responsible for payment in full for any outstanding balance.

3. This office does not promise that an insurance company will pay for the usual and customary charges of this office, nor will this office enter into any dispute with an insurance company over reimbursement or the amount of reimbursement.

4. Should you discontinue care for any reason other than discharge by the doctor, any and all balances will become immediately due and payable in full by you regardless of any claims submitted.

When making a health care decision, it is important to remember that you, the patient, are ultimately financially responsible for any services rendered.

Lastly, it is the goal of this office to provide you with the finest quality Chiropractic care available. If you have any questions with regard to your health care or and of our policies, please feel free to ask us.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

DOWNING CHIROPRACTIC CLINIC

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**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR**
**PRIVATE, GROUP, ACCIDENT AND HEALTH INSURANCE**
**IRREVOCABLE AUTHORIZATION**

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to Dr. James W. Downing or Dr. Matthew J. Downing as payment for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY.** This payment will not exceed my indebtedness to the above mentioned assignees, and I have agreed to pay, in a current manor, any balance of said professional service charges over and above the insurance payment. I understand that whatever amounts you do not collect from insurance proceeds, whether it be all or part of what is due, I personally owe to Dr. James W. Downing or Dr. Matthew J. Downing.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney in order to process any claim for reimbursement of charges incurred.

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

I waive the Statue of Limitations regarding Dr. Downing's right to recover.

Dated: _____ Signed: _____

Witness: _____

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# AUTHORIZATION TO PERFORM X-RAYS

DATE: _____

I have been informed by Dr. James W. Downing or Dr. Matthew Downing that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem.

I do understand that any x-rays taken in this office will remain the property of Downing Chiropractic Clinic and should I ever need copies, they will be provided for me for a $30.00 charge. However, I understand that I must give Downing Chiropractic Clinic a 72 hour notice in writing and pay the fee of $30.00 for this service before copies can be provided.

I authorize Dr. James W Downing or Dr. Matthew Downing to perform such radiographic examination necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present condition.

SIGNED: _____

WITNESS: _____

To the best of my knowledge I am NOT pregnant and Dr. Downing has my permission to x-ray me for diagnostic interpretation.

SIGNED: _____

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# Informed Consent for Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working with, or associated with or serving as back-up for the doctor of chiropractic named above, including those working at other Chiropractic Partners offices. I have had an opportunity to discuss with the doctor of chiropractic named above, and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as with the practice of medicine chiropractic carries some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I consent to rely on the doctor's best judgment, exercised during the course of treatment that is in my best interest, based upon the known facts. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present conditions(s) and for any future condition(s) for which I seek treatment.

To be completed by patient:

_____ _____
Print Patient Name Date Signed

_____
Patient Signature

To be completed by Patient's representatives, if necessary, e.g. if patient is a minor or is physically or mentally incapacitated.

_____ _____
Print Patient Name Date Signed

_____
Signature of Patient's Representative