Doll Chiropractic P.C.
1220 N. Midkiff Ste B
Midland TX. 79701

PATIENT REGISTRATION CASE# _____

Name: (Last) ____________ (First) ____________ (MI) ______ ______ Date: ________

Address: ______________________ City: __________ State: __________ Zip: ________

Home Phone: ______________ Cell Phone: ______________ SSN#: ______________

Date of Birth: ____________ Age: _____ Sex: M F Martial Status·: S M D W SP

Employer: ______________________ Occupation: ______________ Work Phone# ____________

Spouse's Name: ______________ Phone# ______________

Emergency Contact: ______________ Relationship: __________ Emergency Contact Phone#: ____________

Please Circle Payment Method: Medicare Medicaid Cash Insurance PIP Attorney Name: ______________

Minor Patient: Mother Name: ______________ Phone #: ______________ May we contact: Y N

Fathers Name: ______________ May we contact: Y N May be treated in you're absence by Dr. Doll Y N

Patient Referred by: _____ Yellow Pages _____ Attorney _____ Insurance _____ Family,Friend Name: ____________

Due to HIPAA Guidelines please list any person & relationship we may inform about you medical conditions, healthcare, including treatment, payment, balance. We will only communicate with whom is listed.

1. ______________ 2. ______________ 3. ______________

Family Physician: ______________ Phone#: ______________ Are you disabled: Y N

Have you had Past Chiropractic Care? Y N Dr. Name : ______________ When ______________

Do you have medication allergies: Y N ______________ Are you Pregnant? Y N Last Menstrual Cycle ________

Exercise: None Moderate Daily Type: __________ Have you had any Surgeries? Y N List: ____________

Habits & How much per day: Smoking _____ Alcohol ________ Caffeine ________ Substances ________

Are you taking Medications? ______________________ Do you have implants? Y N ____________

Do you have past history of serious illnesses or injuries: Y N Explain: ______________

Family History: Please circle all that apply to your family.
Diabetes Heart/HBP Kidney Cancer Back/Neck Pinched Nerve Disc/Joint Arthritis Headaches

Please list any family condition you feel Dr. Doll should know about: ______________

Have you had any of the following? Please Circle: Appendicitis Whooping Cough Diabetes Pleurisy Polio Pneumonia Anemia Cancer Alcoholism Lumbago Rheumatic Fever Measles Heart Disease Epilepsy Eczema Mental Disorder Mumps Goiter Arthritis HIV Positive Tuberculosis Chicken Pox Influenza(Flu) Other _______

PURPOSE OF THIS VISIT

Relating to Primary Complaints (Please be very detailed in your answers list all areas pain)

Reason for this visit-Main Complaint ____________________

Type of Pain: Sharp Dull Ache Burning Throbbing Spasm Numbness Tingling Shooting

1. Where is your pain? __________ How Long? ______ Rate pain on scale 1 to 10 (Hospital) ____
2. Where is your pain? __________ How Long? ______ Rate pain on scale 1 to 10 (Hospital) ____
3. Where is your pain? __________ How Long? ______ Rate pain on scale 1 to 10 (Hospital) ____

Have you ever had previous episodes? Y N Explain: ____________________

Do you know how symptoms occurred? ____________________

Does the pain radiate into another area? Y N Where: __________ Is the condition getting worse: Y N

Does anything make your pain better? (Sitting, Laying, standing etc) ____________________

Does anything make the pain worse? (Sitting, Laying, standing etc) ____________________

Have you tried Ice? Y N Have you tried Heat? Y N Pain at worse: 1-10: ______ Pain at Best: 1-10 ______

Are your current injuries due to accident? Y N Date: ______ Explain: ____________________

____

How often do you experience these conditions throughout the day: 100% 75% 25% 10% Only with Activity

Is there anything that has relieved the pain? Y N Describe ____________________

Does your complaint interfere with ___Work ___Sleep ___Hobbies ___Daily Routine Explain: __________

Have you been seen for this condition? Y N Explain ____________________

What did they do for treatment? Explain ____________________

Did you go to the Hospital? Y N Where: ____________________ City, State: __________

List of any medications and what they were prescribe for: ____________________

Circle Any Current Symptoms: Headaches Neck Pain Chest Pain Loss of Taste Constipation Tension Lights Bother Eyes Cold Feet Cold Sweats Loss of Balance Face Flused Shortness of Breath Fatigue Stiff Neck Nervousness Loss of Memory Numbness in Toes Numbness in Fingers Fever Dizziness Cold Hands Head Seems Heavy Loss of Smell Pins & Needles in Arms Fainting Back Pain Depression Sleeping Problems Diarrhea Buzzing in Ears Ears Ring Irritability Upset Stomach Hands Heavy

I hereby authorize Dr Doll to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed that the amount paid to the Doctor for x-rays for examination only the x-ray negatives will remain I the property of his office for 10 years, being on file where they may be seen or purchased at any time while a patient at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for nay pre-existing conditions nor for any medical diagnosis.

Patient Printed Name (Parent if Minor): ____________________ Date: __________

Patient/Parent's Signature: ____________________ Date: __________

Financial Agreement~ Doll Chiropractic P.C.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. This includes insurance copays and/or good faith estimates toward deductibles. If your account is not paid within 90 days from the date of service (or from notification of patient responsibility by insurance) and no financial arrangements have been made, you may be held responsible for legal fees, collection agency fees and any other expenses incurred in collecting your account.

GROUP OR INDIVIDUAL INSURANCE
Your insurance policy is an agreement between you and your insurance company, not between your insurance company and this chiropractic office. As a courtesy to our patients, our office will complete any necessary insurance claims, and file them with your company to help you collect if our office excepts the insurance you are contracted with. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible. We encourage you to verify your chiropractic benefits directly with your insurance company to understand what services and limits may apply. You are responsible for your copay at the time of service, and we ask that patients with deductible policies pay toward their visits until the deductible has been met. The quote given at the time of service, is just that a quote not a guarantee of benefits. Our office has no way of knowing your benefits until the explanation of benefits comes back. It there is a difference you will be charged for the difference.

"ON THE JOB" INJURY~ OUR OFFICE DOES NOT TREAT WORK RELATED ACCIDENTS OR CASES BILLED TO WORKERS COMPENSATION.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
OUR OFFICE DOES NOT EXCEPT THIRD PARTY INSURANCE~ MUST BE YOUR INSURANCE
Injuries as a result of an auto related incident will be submitted to under a personal injury claim. Please provide your claim number and adjuster's contact information so that we can process your claims promptly. If an attorney is handling your case, please notify the front desk as soon as possible. Although you are ultimately responsible for your bill, our office will wait for settlement to be paid as long as you are an active patient. If you suspend or terminate care, any fees for services are due immediately. Once your care is completed you will contact your attorney with any questions to your case. You are more then welcome at any time to get a current statement, any medical records you request there will be a charge for.

PATIENTS WITHOUT INSURANCE
For patients who do not have health insurance, are seeking wellness care or elect not to use it, we have a cash time of service discount option. Please ask the front desk to review these with you. We require all cash patients to pay at the time of service.

MEDICARE/MEDICAID
We are providers of Medicare and most Medicaid. For chiropractors this includes only manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met, and the patient will be required to pay the remaining 20% if it is not covered by a secondary insurance. The intitial New Patient Visit is not covered by Medicare or Medicaid and will be your responsibility. Our office will complete the necessary forms and file them with the Medicare/Medicaid provider at no charge.

XRAY/MEDICAL RECORDS REQUEST
If for any reason you would like a copy of any records from our office there will be a charge for any records. Original xrays films will remain in our office for 10 year minimum. We can provide you with a copy if requested at a fee. There is a charge for duplication of xrays with a 10 day advance notice required. All imaging CD's, reports and xrays taken and or ordered by Dr. Doll are to remain in our office.

I HAVE READ AND/OR BEEN EXPLAINED THE ABOVE FINANCIAL POLICY AND AGREE TO ACCEPT THE TERMS AND CONDITIONS.

SIGNED: ______________________________ DATE: ___________

WITNESS: ________________________________

Assignment of Proceeds, Release of Records, Consent to Treat
Doll Chiropractic P.C.

PATIENT NAME______________________________ Date___________

Assignment of Insurance Proceeds

By agreeing to this assignment we will direct your insurance company to make any payments for your chiropractic, physiotherapy, physical rehabilitation, x-rays, diagnostic testing or any other reimbursable treatment or evaluations you receive to our clinic directly. In exchange for these services and supplies rendered, I do assign Dr. David Doll with Doll Chiropractic P.C.; any insurance proceeds, including accident and health insurance, auto insurance benefits and liability claim awards up to the amount of any unpaid balance on my account. In giving this assignment, I acknowledge that I will be responsible for the amount of any remaining balance with interest.

Printed Patient Name______________________________

Patient/Parent Signature______________________________ Date_________________

Records Release Authorization

To: Dr. David Doll, DC with Doll Chiropractic P.C.

You are authorized to release any information contained in my file to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred for services rendered to me by you or any member of your clinic acting on your behalf including any contracted billing services.

Printed Patient Name______________________________

Patient/Parent Signature___________________________ Date______________

Consent to Treat/ Consent to Treat Minor

I voluntarily consent to the rendering of care, including chiropractic adjustments, physiotherapies, acupuncture and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physicians.

Printed Patient Name______________________________

Patient/Parent Signature___________________________ Date______________

Privacy

I have signed and been provided a copy of my privacy rights. I understand what my rights are to privacy and by signing below acknowledge that this information was provided to me by Doll Chiropractic P.C. and I have been informed that at anytime I will be provided additional copies at my request.

Printed Patient Name______________________________

Patient/Parent Signature___________________________ Date______________

Notice of Privacy Practice ~ Doll Chiropractic P.C.

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Our practice is dedicated to, and we are required by applicable federal and state laws to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of April 14, 2003, and will remain in effect until we replace it. Changes to notice: We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Permitted uses and disclosures of health information:

TREATMENT, PAYMENT, HEALTH CARE OPERATIONS: You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment and healthcare operations. Examples of these activities are as follows:

Treatment: We may use or disclose your health information to other health care providers providing treatment to you. Payment: We may use and disclose your health information to obtain payment for services we provide to you. Health care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include clinical education, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance and other business operations.

1. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.
2. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care.
3. MARKETING: We will not use your health information for marketing communications without your written authorization.
4. USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes.
5. PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
6. LAW ENFORCEMENT/NATIONAL SECURITY: Under certain circumstances, we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances, we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody

of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal official's health information required for lawful intelligence, counterintelligence and other national security activities.

7. APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

Patient rights:

1. ACCESS TO RECORDS: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. If you request copies, we will charge you our standard copying fee for each page and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.
2. ACCOUNTING OF CERTAIN DISCLOSURES. Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
3. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and health care operations purposes. Depending on the circumstances of your request we may or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.
4. AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing and must explain why the information should be amended. We may deny your request under certain circumstances.
5. ELECTRONIC NOTICES. If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and complaints:

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure or access to your health information you may complain to us using the contact information listed below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Patient/Parent Name Printed: ______________________________

Patient/Parent Signature: ______________________________ Date: ______________

ASSIGNMENT OF PROCEEDS

DR. DAVID J. DOLL DC DBA HOLLANDER CHIROPRACTIC OF MIDLAND

CONTRACTUAL LIEN & AUTHORIZATION ("Assignment" or "Assignment / Lien" - Revised 01-01-2009)

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 follows: Definitions. In this Assignment, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to Dr. David J. Doll, DC - DBA Hollander Chiropractic of Midland; "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 to me, either now or in the future, for any reason; "Proceeds" shall include, without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, 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, lost wages, lost services, property damage, and malpractice, regardless of whether such Proceeds relate directly to my Charges or not; "Charges" shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony), any Collection Costs incurred by the Office, interest and delinquency penalties to the extent permitted by law, 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, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Assignment of Proceeds, and Contractual Lien. I hereby assign to the Office, insofar as 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 my right to receive Proceeds from any Payer now or in the future, and any and all 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 the Office sees fit. I further grant a contractual lien to the Office with respect to my Charges. I further intend for this Agreement to create a secured interest under the applicable Uniform Commercial Code and hereby direct the Office to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such lien. Consistent with these provisions, 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 extent of my Charges.

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 collecting 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 is to pay my Charges.

Other Disclosure Authorization. I hereby direct all Payers to release to the Office any pertinent information regarding any coverage I may have including without limit the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize and direct the Office to release any information regarding my treatment or pertinent to my case(s), including without limit a copy of my Charges and a copy of this Assignment, to all Payers in order to facilitate collection of my Charges.

Miscellaneous Provisions. Except as provided in this paragraph, this Assignment 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 the terms of this Assignment. I agree that each and every provision of this Assignment is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Assignment be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment shall, nevertheless, remain in full force and effect. This Assignment 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, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens as such term is defined by law. I further waive any statute of limitations which may apply in any action based upon this Assignment.

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

Patient Name (print): ______________________________

Patient Signature: ______________________________

Custodial Parent, Legal Guardian (please print): ______________________________

Claim# or Policy# ______________________________

Office Staff Signature ______________________________

Date: ______________________________

INSURANCE AGREEMENT DIRECT PAYMENT ASSIGNMENT & INFORMATION RELEASE

I hereby name the Doctor and/or Medical Practice given below, hereafter referred to as DOCTOR, as my assignee. I instruct my insurance company, plan provider, to pay the DOCTOR directly for all professional and medical services provided. Payment should be made by means of by check(s)
made payable to and mailed directly to the DOCTOR:

Doll/Hollander Chiropractic of Midland
Dr. David J. Doll, DC
1220 N. Midkiff Ste B.
Midland, Texas 79701
432-520-0773 Phone
432-520-0774 Fax
NPI# 1659306751
Tax ID# 61-1504979

Or if current policy prohibits direct payment to doctors, then I hereby instruct and direct the PLAN to make out all checks payable to me and mail the payments to me in care of the DOCTOR as given directly above.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS.

I grant the DOCTOR a limited Power of Attorney to sign my/our name(s) in order to deposit and negotiate any payment received from the INSURANCE and apply the funds received toward my outstanding balance. These payments will not exceed my indebtedness to the above designated DOCTOR. I agree to promptly pay any remaining balance due on all professional and medical service charges over and above payment(s) from the INSURANCE. This assignment shall remain in effect until cancelled in writing by the DOCTOR. A photocopy of this agreement, or a electronic facsimile thereof, shall be considered as effective as the original. I understand that personal information about me will be needed by the DOCTOR and the INSURANCE to determine and communicate what services or benefits are covered by the INSURANCE, and to submit or process a claim for payment on service rendered and for the DOCTOR to collect all fees owed for those services. Therefore, for the purpose of obtaining payment for services rendered, I give to the DOCTOR, the INSURANCE, their agents, and any other holder of information about me, authorization to release and/or exchange medical, billing and collection information.

Printed Name of Patient: ______________________________

Signature of Patient: ______________________________

Date: ______________________