Welcome to Advanced Pain and Injury Centre

Medical Care and Psychological Counseling are available within this facility by appointment. Chiropractic Care is available on an ongoing basis.

Each Doctor is Independent of the other, but may consult with each other to determine the best course of Health Care for you.

We will only accept you as a patient if, after appropriate examination. we truly believe we can help you, and you agree to the terms of treatment and payment.

The doctors reserve the right to decline offering you health care if you decline to reasonably follow recommendations he or she has given to you.

We believe that a patient will respond best to appropriate care for his or her condition, therefore, Thorough and Appropriate Examination and History-Taking is essential before recommending appropriate treatment of any kind. We are NOT psychic, and rely on these.

Regarding Chiropractic Care, Preliminary Treatments and observance of your body's reaction to them are necessary to help determine what care is appropriate before a Report and Recommendations can be given for the best course of Treatment in your case.

WE BELIEVE THAT EVALUATIONS SHOULD NOT BE RUSHED, LEST IMPROPER CONCLUSIONS SHOULD BE REACHED.

You will be given a Written Recommendation for course of Health Care, with costs involved for Chiropractic Care.

Original records and X-rays are the property of this Health Care Centre.

Copies of your records can be sent to another doctor of your choice at any time. X-rays can be loaned to them but must be returned within ten working days.

We may refer you to appropriate outside Health Care Specialists if deemed necessary by the doctor, or if requested by you.

CHARGES BY EACH DOCTOR ARE AT HIS OR HER DISCRETION.

REGARDING CHIROPRACTIC CHARGES: WE ARE OUT OF NETWORK ON ANY INSURANCE PLAN.

MEDICARE: WE DO NOT CHARGE FOR WHAT MEDICARE PAYS FOR, ONLY WHAT IT DOES NOT PAY FOR, THEREFORE SAVING YOU THE DEDUCIBLE AND CO-INSURANCE.

MEDICAID: WE DO NOT ACCEPT MEDICAID.

YOU WILL BE PRESENTED WITH A REPORT CONTAINING OUR CHARGES FOR SERVICES WE BELIEVE YOU NEED. FILL IN WHAT YOU CAN AFFORD TO PAY, AND YOU WILL BE REQUIRED TO SIGN IT.

I have read the above and understand.

Patient Signature: _____ Date: _____

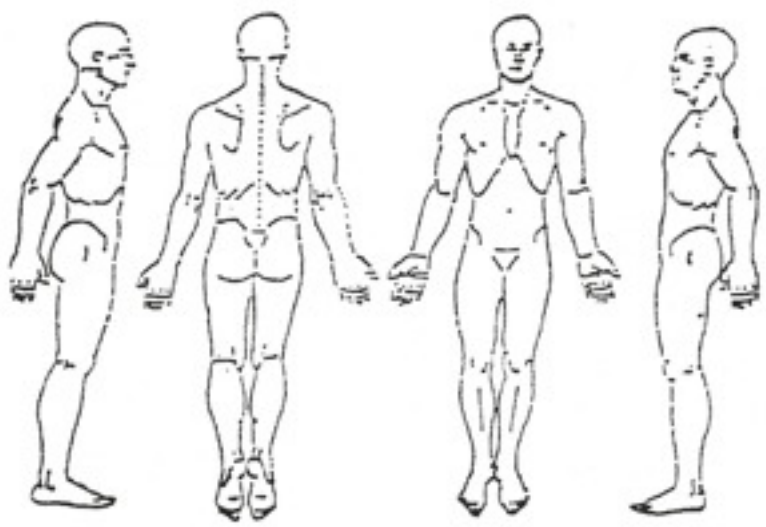
PATIENT INFORMATION FORM

DATE: ____/____/_____
AGE: ____
SSN: _____-____- _____

DO YOU DESIRE LASTING CORRECTION? YES ___ NO ___

PLEASE CHECK HERE IF YOU WANT THE DOCTOR TO SELECT THE TYPE OF CARE HE FEELS IS BEST: ___

NAME: _____ DATE OF BIRTH: ____/____/_____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: (_____) _____-_____ OTHER PHONE: (_____) _____-_____
EMAIL: _____ WHO REFERRED YOU TO OUR OFFICE? _____
MARITAL STATUS: MARRIED __ SINGLE __ WIDOWED __ DIVORCED __ SEPARATED __
EMPLOYED? IF SO, WHERE? _____ DAYS OFF? _____
SPOUSE'S NAME: _____ # OF CHILDREN: ____ AGES: _____
SPOUSE'S EMPLOYER? _____ DAYS OFF? _____
WHO IS RESPONSIBLE FOR BILL? SELF __ SPOUSE ___ EMPLOYER ___ OTHER ___
HOW WILL PAYMENT BE MADE? CASH __ CHECK __ CREDIT CARD ___ INSURANCE ___
TYPE OF INSURANCE: WORKERS COMP __ HEALTH __ CASH __ AUTO __
INSURANCE COMPANY: _____
POLICY#: _____ PHONE NUMBER: (_____) _____-_____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____



PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAM BELOW:

PRIMARY COMPLAINT: _____
_____
_____
SECONDARY COMPLAINT: _____
_____
_____
OTHER COMPLAINT(S): _____
_____
_____
HOW DID THIS CONDITION DEVELOP? _____
_____
WHEN DID YOU FIRST NOTICE THE PROBLEM? _____
_____
HAS IT BECOME:
BETTER __ WORSE __ SAME __

WHAT MAKES YOUR CONDITION WORSE? _____
WHAT MAKES YOUR CONDITION BETTER? _____
CURRENT MEDICATION TAKING: PAIN KILLERS __ MUSCLE RELAXERS __ PEP PILLS __
TRANQUILIZERS __ INSULIN __ BIRTH CONTROL __
NONE __ OTHER (PLEASE LIST BELOW) __
_____
_____

HAVE YOU CONSULTED A CHIROPRACTOR BEFORE? YES ____ NO ____
NAME: _____ DATES: _____
WHY? _____
ANY MEDICAL DOCTORS OR OSTEOPATHS? YES ___ NO ___
NAME: _____ DATES: _____
WHY? _____
PAST SURGERIES? NO ___ YES ___ DATES: _____
EXPLAIN: _____
PAST SERIOUS INJURIES? NO ___ YES ___ DATES: _____
EXPLAIN: _____
PREVIOUS BROKEN BONES? NO ___ YES ___ DATES: _____
EXPLAIN: _____
EVER BEEN KNOCKED OUT? NO ___ YES ___ DATES: _____
EXPLAIN: _____
AUTO ACCIDENTS? NO ___ YES ___ DATES: _____
EXPLAIN: _____
WORK-RELATED INJURIES? NO ___ YES ___ DATES: _____
EXPLAIN: _____

DO YOU?
- SLEEP WELL? YES ___ NO ___
- EASILY TIRE? YES ___ NO ___
- FEEL LOVED BY YOUR FAMILY? YES ___ NO ___
- LIKE YOURSELF? YES ___ NO ___

ARE YOU OVERWEIGHT? YES ___ NO ___
ARE YOU UNDERWEIGHT? YES ___ NO ___
WHEN WAS YOUR LAST MEAL? _____
WHAT DID YOU EAT? _____
WHEN WAS YOUR LAST BOWEL MOVEMENT? _____

FOR WOMEN:
- LAST MENSTRUAL CYCLE: ____/____/_____
- ANY CHANCE OF BEING PREGNANT? NO ___ YES ___
- ANY PRIOR MISCARRIAGES? NO ___ YES ___ DATE(S): _____
- DO YOU OR HAVE YOU HAD BREAST OR OTHER IMPLANTS? YES ___ NO ___
  - SPECIFY: _____

IF YOUR ANSWER IS NO, NONE, OR NOT APPLICABLE: LEAVE BLANK.
IF YOUR ANSWER IS POSITIVE. PLEASE CHECK THE APPROPRIATE BOX:
L-LEFT SIDE R-RIGHT SIDE C-CONSTANT
I-INFREQUENT O-OCCASIONALLY Y- YES

	L	R	C	I	O	Y
HEADACHE						
MIGRAINE						
BLURRED VISION						
JAW PAIN/CLICKING						
RINGING IN EARS						
ITCHING SCALP						
SINUS PROBLEMS						
HAY FEVER						
CONCENTRATION PROBLEMS						
SWEAT (CONSTANT)						
TOOTHACHE						
TONGUE, COATED						
DIZZINESS						
KNOCKED UNCONSCIOUS						
CONVULSIONS						
PAIN INSIDE SHOULDERS						
PAIN IN MID BACK						
ANGINA						
BREAST BONE PAIN						
OVULATION						
MENSTRUATION						
CHEST PAIN						
CONGESTION						
HEART PALPITATIONS						
ASTHMA						
HEART ATTACK						
BRONCHITIS						
TUBERCULOSIS						
COLD HANDS						
COLD FEET						

	L	R	C	I	O	Y
LEG CRAMPS						
STOMACH CRAMPS						
ANKLE SWOLLEN						
ULCERS						
UPSET STOMACH						
A - AFTER EATING						
B - ACID IN THROAT						
C - FEEL BLOATED						
DIARRHEA						
CONSTIPATION						
INTESTINAL WORMS						
HEMORRHOIDS						
JAUNDICE						
HEPATITIS A __ B __ C __						
LIVER PROBLEMS						
GALLBLADDER PROBLEMS						
CUTS SLOW TO HEAL						
BOILS						
NUMBNESS/TINGLING IN						
A - ARMS						
B - LEGS						
TIRED/EXHAUSTED						
CONSTANT PAIN						
POOR HEALTH						
MALARIA						
ANEMIA						
SCARLET FEVER						
DIABETES						
GOITER						
TUMOR						
CANCER						
RHEUMATISM						
ARTHRITIS						
CHRONIC DISEASE						

	L	R	C	I	O	Y
VARICOSE VEINS						
AIDS/HIV POSITIVE						
PNEUMONIA						
NECK PAIN						
LUMP IN THROAT						
SORE THROAT						
STREP INFECTION(S)						
MUCUS IN THROAT						
TONSILLITIS						
TROUBLE SWALLOWING						
HIGH BLOOD PRESSURE						
LOW BLOOD PRESSURE						
COLD FLASHES						
HOT FLASHES						
PAIN RADIATING TO:						
A - SHOULDER						
B - ELBOW						
C - WRIST						
D - HAND						
LOW BACK PAIN						
TAIL BONE PAIN						
HIP PAIN						
MENSTRUAL CRAMPS						
VAGINAL DISCHARGE						
FREQUENT URINATION						
PAIN WITH URINATION						
BLOOD WITH URINATION						
VENEREAL DISEASE						
BLADDER OR KIDNEY						
A - INFECTION						
B - DISEASE						
PROSTATE:						
A - INFLAMMATION						
B - DISEASE						

	L	R	C	I	O	Y
PAIN DOWN:						
A - FRONT OF LEG						
B - BACK OF LEG						
C - INSIDE OF LEG						
D - OUTSIDE OF LEG						
RADIATING TO:						
A - KNEE						
B - ANKLE						
C - FOOT						
PAIN IN:						
A - BICEP						
B - TRICEP						
C - SHOULDER						
D - ELBOW						
E - FOREARM						
F - WRIST						
G - HAND						
H - THUMB						
I - FINGERS						
J - TENNIS ELBOW						
CARPAL TUNNEL SYNDROME						
PAIN IN:						
A - KNEE						
B - ANKLE						
C - FOOT						
TRICK KNEE						
TRICK ANKLE						
FALLEN ARCH						
ARCH TOO HIGH						
FALLEN TRANS ARCH						
WEAR HIGH HEELS						
WEAR EARTH SHOES						

_____ _____

PATIENT SIGNATURE DATE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

We are required by law to:

- maintain the privacy of your Personal Health Information;
- provide you this notice of our legal duties and privacy practices with respect to your Personal Health Information; and
- follow the terms of this notice.

We **protect** your Personal Health Information from inappropriate use or disclosure. Our employees, and those of companies that help us service Your health care needs, are required to comply with our requirements that protect the confidentiality of Personal Health Information. They may look at your Personal Health Information only when there is an appropriate reason to do so, such as to administer our products or services.

We will **not disclose** your Personal Health Information to any other company for their use in marketing their products to you. However, as described below, we will use and disclose Personal Health Information about you for business purposes relating to your Health insurance coverage.

The main reasons for which we may **use** and may **disclose** your Personal Health Care Information are to evaluate and process any requests for Coverage and claims for benefits you may make or in connection with other health-related benefits or services that may be of interest to you. The Following describe these and other uses and disclosures, together with some examples.

- **For Payment:** We may use and disclose Personal Health Information to pay for benefits under your Health Insurance coverage. For example, we may review Personal Health Information contained on claims to reimburse the Advanced Pain and Injury Centre for services rendered. We may also disclose Personal Health Information to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose Personal Health Information to a health plan or an administrator of an employee welfare benefit plan for various payment-related functions, such as eligibility determination, audit and review or to assist you with your inquires or disputes.

- **For Health Care Operations:** We may also use and disclose Personal Health Information for our insurance operations. These purposes include evaluating a request for Health Insurance products or services, administering those products or services, and processing transactions requested by you. We may also disclose Personal Health Information to Affiliates, and to business associates outside of the Advanced Pain and Injury Centre, if they need to receive Personal Health Information to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of Personal Health Information. Examples of business associates are: billing companies, data processing companies, Or companies that provide general administrative services. Personal Health Information may be disclosed to reinsures for underwriting, audit or claim review reasons. Personal Health Information may also be disclosed as part of a potential merger or acquisition involving our business in order to make an informed business decision regarding any such prospective transaction.

- **Where Required by Law or for Public Health Activities:** We disclose Personal Health Information when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing Personal Health Information to a governmental agency or regulator with health care oversight responsibilities. We may also release Personal Health Information to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death.

- **To Avert a Serious Threat to Health or Safety:** We may disclose Personal Health Information to avert a serious threat to someone's health or safety. We may also disclose Personal Health Information to federal, state, or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.

- **For Health-Related Benefits or Services:** We may use Personal Health Information to provide you with information about benefits available to you under your current coverage or policy and, in limited situations, about health-related products or services that may be of interest to you.

- **For Law Enforcement or Specific Government Functions:** We may disclose Personal Health Information in response to a request by law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose Personal Health Information about you to federal. officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **When Requested as Part of a Regulatory or Legal Proceeding:** If you or your estate are involved in a lawsuit or a dispute, we may disclose Personal Health Information about you in response to a court or administrative order. We may also disclose Personal Health Information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the Personal Health Information requested. We may disclose Personal Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

- **Other Uses of Personal Health Information:** Other uses and disclosures of Personal Health Information not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose Personal Health Information about you, you or your legally authorized representative may revoke that authorization, in writing, at any time, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition or obtaining your Health Insurance coverage. You should understand that we will not be able to take back any disclosures we have already made with authorization.

Your Rights Regarding Personal Health Information We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your Personal Health Information. Should you have questions about a specific right, please write to the administrator of your Health Insurance coverage as follows:

- **Right to Inspect and Copy Your Personal Health Information:** In most cases, you have the right to inspect and obtain a copy of the Personal Health Information that we maintain about you. To inspect and copy Personal Health Information, you must submit your request in writing to the applicable administrator listed above. To receive a copy of your Personal Health Information, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. However, certain types of Personal Health Information will not be made available for inspection and copying. This includes psychotherapy notes; and also includes Personal Health Information collected by us in connection with. or in a reasonable anticipation of any claim or legal proceeding. In very limited circumstances we may deny your request to inspect and obtain a copy of your Personal Health Information. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

- **Right to Amend Your Personal Health Information:** If you believe that your Personal Health Information is incorrect or that an important part of it is missing, you have the right to ask us to amend your Personal Health Information while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to the applicable administrator listed above. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend Personal Health Information that:

    - is accurate and complete;
    - was not created by us, unless the person or entity that created the Personal Health Information is no longer available to make the amendment;
    - is not part of the Personal Health Information kept by or for us; or
    - is not part of the Personal Health Information which you would be permitted to inspect and copy.

- **Right to a List of Disclosures:** You have the right to request a list of the disclosures we have made of Personal Health Information about you. This list will not include disclosures made for treatment, payment,. health care operations, for purposes of national security; made to law enforcement or to corrections personnel or made pursuant to your authorization or made directly to you. To request this Iist, you must submit your request in writing to the applicable administrator listed above. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before February 26, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on Personal Health Information we use or disclose about you for treatment. payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, **we are not required to agree to it.** If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing to the applicable administrator listed above. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example. disclosures to your spouse or parent). We will not agree to restrictions on Personal Health Information uses or disclosures that are legally required, or which are necessary to administer our business.

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about Personal Health Information in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the applicable administrator listed above and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Right to File a Complaint:** If you believe your privacy right have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact: Diana Gonzales, HIPPA Compliance Officer, Advanced Pain and Injury Centre, Institutional Business HIPAA Privacy Office, 630-C North Central Expressway, Plano, Texas 75074. All complaints must be Submitted in writing. You will not be penalized for filing a complaint. If you have questions as to how to file a complaint please contact us at (469) 995-9907.

ADDITIONAL INFORMATION

Changes to This Notice: We reserve the right to change the terms of this notice at anytime. We reserve the right to make the revised or changed notice effective for Personal Health Information we already have about you as well as any Personal Health Information we receive in the future. The effective date of this notice and any revised or changed notice may be found on the last page on the bottom right hand comer of the notice. You will receive a copy of any revised notice from Advanced Pain and Injury Centre by mail or by e-mail, but only if e-mail delivery is offered by Advanced Pain and Injury Centre and you agree to such delivery.

Treatments are done in open bays unless there is a procedure or consultation that needs to be done in a private room. _____ (Initial)

Name or Names of anyone you want to have information given to and initial beside each name.

Effective {01/04/2012}

I have read, fully understand, and agree to this document.

_____
Patient Signature

_____
Date

CONSENT OF SERVICES

Initial beside each service listed below.

___ Chiropractic Manipulation

___ X-Ray Diagnostics

___ Exam Procedures

___ Massage/Myofascial Release

___ Active Care

___ Therapeutic Exercise

___ Physical Modalities (i.e.: ultrasound, electric stimulation, stretch activities)

I understand that chiropractic treatment is not an exact science and that there is no guarantee that the outcome of my treatment will be what I want it to be. I consent to all necessary testing and treatment while I am here at the Advanced Pain and Injury Centre. By signing this form, I fully understand the new patient procedure, its conditions, and consent to services to be performed by or on me, or my charge (if guardian is signing).

Patient Signature: _____ Date: ____/____/_____

Doctor Signature: _____ Date: ____/____/_____

Alan R. Bonebrake, D.C.
630-C N. Central Expressway
Plano, TX 75074
Office: 469-995-9907 Fax: 972-692-5174
Board Qualified Chiropractic Orthopedist-National College of Chiropractic
Diplomate in Personal Injury and Spinal Trauma-Physician's Academy
Master of Science in Biology- Emphasis in Human Nutrition-University of Bridgeport
Fellow - International Academy of Clinical Acupuncture
Master of Herbology-Emerson College of Herbology
Certificate for Collision Reconstruction for the Medical Practitioner-Texas A&M University

Authorization and Assignment

In consideration of your undertaking of care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any Insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.

2. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

3. In the event any insurance company (obligated by contractual agreement to make payment to me or to you for the charges made for your services) refuses to make such payment upon demand by you, I hereby assign and transfer you to the cause of action that exists in my favor against any such company (the name(s) of which is/are believed to be correctly set forth under pertinent data). I also authorize you to compromise, settle or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance company proceeds, whether it be all or part of what is due, I personally owe you.

4. In addition to the above, I hereby waive the statue of limitations on collection and/or recovery in this state, TEXAS.

5. I further agree that this Authorization and Assignment is irrevocable and non-rescindable until all moneys owed are paid in full.

6. Any settlements from Auto or Personal Injury are considered full and final payment unto themselves, but not limited to: PIP, Medpay, Uninsured Motorist, Underinsured Motorist and personal health insurance.

_____ _____

Signature Date

ASSIGNMENT OF BENEFITS FORM, a request made by the patient to have payment of their benefit sent to a designated representative. Referenced in Title 29 CPR 2560-503-1.

I hereby authorize Alan Bonebrake, D.C., or his medical billing representative, to submit claims, on my behalf, to the insurance company listed on the copy of the current and valid insurance card I have provided Alan Bonebrake, D.C., in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure that the bill for medical services is paid in full.

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

_____	_____	_____
Patient Name Printed	Patient Signature	Date

AND

AUTHORIZATION FORM TO BE PERSONAL REPRESENTATIVE, designating personal representative to submit any and all appeals for adverse determinations, any and all requests for benefit information, and initiate formal complaints.

I authorize Alan Bonebrake, D.C. or his medical billing representative, to be my personal representative, which allows Alan Bonebrake, D.C. to: (1) submit any and all appeals when my insurance company performs an adverse benefit determinations as defined in 29 CFR 2560-503-1, (2) submit any and all requests for benefit information from my employer and/or health insurance company, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my benefits.

I fully understand and agree that I am responsible for full payment of the medical debt l owe Alan Bonebrake, D.C., if my insurance company has refused to pay 100% of my benefits, within ninety (90) days of any and all appeals or request for information.

I also agree that any fines levied against my insurance company will be paid to Alan Bonebrake, D.C. for acting as my personal representative.

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

This would be the first step in the appeals process.

_____	_____	_____
Patient Name Printed	Patient Signature	Date

I HEREBY AUTHORIZE MY Summary Plan Description TO BE SENT TO:

Alan Bonebrake, D.C.
630-C North Central Expressway
Plano, Texas 75074
469-995-9907 Office
972-692-5174 Fax

_____
Patient Name Printed

_____
Patient Signature

_____
Date