**MANNING WELLNESS CLINIC**
**2702 McKinney Ave #202 Dallas, TX 75204**
**PH 214-720-2225 Fax 214-720-2288**

# ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants, and conveys, to **Manning Wellness Clinic**, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

**Release of Information**: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment for services rendered to me.

**Irrevocable Assignment of Rights**: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21,55 of the Texas Insurance Code to corporate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request

**Demand for Payment**: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy, This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18 penalty, court cost, and interest from judgment, upon violation, I further instruct the provider to make all checks payable to:

Manning Wellness Clinic
2702 McKinney Ave #202
Dallas, TX 75204

**Third Party Liability**: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to **Manning Wellness Clinic** and to send any and all checks to:

Manning Wellness Clinic
2702 McKinney Ave #202
Dallas, TX 75204

**Statute of Limitations**: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred, Limited Power of Attorney: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment form any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I

agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

**Rejection in Writing**: I hereby authorize the physician/facility named above to establish a PIP or UMlUIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the physician/facility named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

**Termination of Care**: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my treating physician at this Clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other physician; I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

Date: ________________ ___________________________________ _________________________________

Print Patient Name Patient/Legal Guardian

Signature_______________________________________

**Manning Wellness Clinic**
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**Dallas, TX 75204**
**PH (214) 720-2225 Fax (214) 720-2288**
**www.manningwellness.com**

**Date**____________________

**Name** ______________________________________________________ **Marital Status: S M D W**

**Date of Birth** _________________**Age** ______ **Social Security#** _________-________-_________ **M / F**

**Street Address** ______________________________________________________ **APT #** ________________

**City** ____________________________________________**State** __________ **Zip** __________________

**Email Address:** ______________________________________________________________________________

**Home#: (________)** ______________**Cell#: (________)**______________ **Work#: (______)** _______________

**Occupation**_______________________**Employer (name/address)** ________________________________

**Spouse Name:** ___________________________**Spouse Occupation:**________________________________

**Children: Names and Ages**

______________________________________________________________________

**Who is your primary care physician?**

_____________________________________________________________

**Have you ever received Chiropractic Care? Y/N When, Where?_-**

_______________________________________

**Have you ever received Massage therapy Y/N How often:** _____________________________________

**Emergency Contact:** (Name) ________________________ **Relationship** ____________
**Phone**_________________

**How did you find out about Manning Wellness Clinic?**

___________________________________________________________

## INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I Hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various physical therapy modalities, and if necessary, diagnostic x-rays, on me by the doctor of chiropractic and/or anyone working in this clinic authorized by the doctor.

I have had the opportunity to discuss with the doctor and/or other office personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some

risks to treatment, including but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read the above. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above mentioned chiropractic procedures. I intend this consent form to remain valid throughout my course of treatment in this office.

Print___________________________________ Signature________________________________Date ____________
(Print patient's name) (Signature of patient (or parent/guardian)

## About Your Health

The human body is designed to be healthy. Unfortunately, for most of us, that is not always the case. Throughout life, events occur which damage and interfere with our good health.

Beginning with your examination and throughout your lifetime of regular chiropractic care, we will work together to remove these interferences and allow you to live the healthy, active life you deserve. This case history will reveal the layers of damage that have resulted in your current state of health.

## General Health History

| Yes | No | | If Yes, explain | Dr's notes |
|---|---|---|---|---|
| | | **1. Was Your Birth Traumatic?** | | |
| ❑ | ❑ | Was the delivery long? Difficult? | __________ | __________ |
| ❑ | ❑ | Caesarian/ Breach/ cephalic? | __________ | __________ |
| | | **2. Growth and Development** | | |
| ❑ | ❑ | Did you suffer from ear infections? | __________ | __________ |
| ❑ | ❑ | Did you suffer from colic? | __________ | __________ |
| ❑ | ❑ | Did you ever fall out of bed? | __________ | __________ |
| ❑ | ❑ | Childhood: Sicknesses? Accidents? Surgery? | __________ | __________ |
| ❑ | ❑ | Did you fall down the stairs? | __________ | __________ |
| ❑ | ❑ | Other physical traumas? What? When? | __________ | __________ |
| ❑ | ❑ | Were you involved in sports? | __________ | __________ |
| | | **3. Current Health** | | |
| ❑ | ❑ | Have you been in **any** accidents? | __________ | __________ |
| ❑ | ❑ | Surgeries? (please list type and dates) | __________ | __________ |
| ❑ | ❑ | Teeth, eye, hearing problems? | __________ | __________ |
| ❑ | ❑ | Do you exercise regularly? How often? | __________ | __________ |
| ❑ | ❑ | Do you suffer physical and/or mental stress? | __________ | __________ |
| ❑ | ❑ | What are your hobbies? | __________ | __________ |
| ❑ | ❑ | Which device (cell phone, tablet, laptop) used regularly? | __________ | __________ |
| ❑ | ❑ | Have you suffered sports injuries? | __________ | __________ |

## Lifestyle habits:

Do you use tobacco? (Smoke / Dip) amount per day? __________________

**Sleep** How many hours per night?_________ Do you wake up rested? __________
Sleeping posture q side q stomach q back Insomnia? Y / N Excessive? Y / N Nightmares? Y / N

Are you currently taking any prescription medications: (If yes, please list)______________________________________________________

Over the counter:
_____________________________________________________________________________________________

Supplements: ______________________________________________________________________________

**Eating/Drinking habits**:

How many (if any) do you consume per day?

Soft drinks(diet/regular) ________ Coffee ________ Energy drinks ________ Alcohol ________ Water ________

How many meals per day _________ Snacks ________

Number of servings per day: Fruits: _________ Vegetables: Green ______ Yellow/orange/red ______ Bread/grains/cereals ______

Proteins _______ Fatty or fried foods _________ Processed foods________ Artificial sweetener _________

**Personal or Family history of:**

Heart Disease: **Y / N** Arthritis: **Y / N** Cancer: **Y / N** Diabetes: **Y / N** Other: ___________________________________________

## Symptoms and Ill Health (Present State of Health)

Please list the symptoms you are now experiencing or have recently experienced.

**1.**_______________________________________________________________________ Date began ______________

❑ Sharp ❑ Dull ❑Constant ❑Intermittent

Indicate current pain/discomfort level (0 = none and 10 = unbearable):

0_______ 1_______ 2_______ 3_______ 4_______ 5_______ 6_______ 7________ 8________ 9________ 10________

**2.**___________________________________________________________________________ date began ______________

❑ Sharp ❑ Dull ❑Constant ❑Intermittent

Indicate current pain/discomfort level (0 = none and 10 = unbearable):

0_______ 1_______ 2_______ 3_______ 4_______ 5_______ 6_______ 7________ 8________ 9________ 10________

What activities aggravate symptoms?

__________________________________________________________________________

What activities lessen symptoms?

____________________________________________________________________________

Is condition worse or better during certain times of day?

___________________________________________________________

Is this condition interfering with Work? **Y / N** Sleep? **Y / N** Daily routine? **Y / N** Other? ____________________________

Is this condition getting progressively worse?

__________________________________________________________________

Other doctors seen for this condition?

__________________________________________________________________________

Any medications or surgeries for this condition?
_______________________________________________________________

Any home remedies?
_____________________________________________________________________________________

Are you experiencing other symptoms?
______________________________________________________________________

- ❑ Headaches
- ❑ Neck Pain/ stiffness
- ❑ Sleeping Problems
- ❑ Back Pain
- ❑ Pins & Needles in Arms or Legs
- ❑ Numbness in Fingers or Toes
- ❑ Cold Hands/ Feet
- ❑ Chest Pains
- ❑ Shortness of Breath
- ❑ Fainting
- ❑ Tension
- ❑ Irritability
- ❑ Fatigue
- ❑ Depression
- ❑ Dizziness/ Loss of Balance
- ❑ Loss of Memory
- ❑ Ringing/ Buzzing in Ears
- ❑ Loss of Smell/ Taste
- ❑ Stomach Upset
- ❑ Diarrhea/ Constipation
- ❑ Fever

Other concerns / notes:
___________________________________________________________________________________
____________________________________________________________________________________________________

## About Your Care

What results do you hope to achieve from our office?

____ **Relief Care-** Relieve/reduce symptoms and increase comfort.

____ **Corrective Care-** Move beyond pain relief to correct the problem, improve function and allow your body to stabilize.

____ **Wellness Care** – Maintain the care you've received and allow your body to continue to rebuild and become healthier.

***Wellness Care focuses on prevention, wellness and overall good health.***

## Health Information Practices

**Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

**If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.**

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. This may be via mail, telephone or email.

**May we leave a message either on voicemail or with the person answering the call? YES / NO**

**Print Name of patient**

_______________________________________________________________________

**Signature of patient or guardian** ________________________________________ **Date** ________________________

# Office Fee Schedule and Financial Policy

**Service**

| Service | Fee | Service | Fee |
|---|---|---|---|
| Consultation | $ n/c | Massage Therapy | $35-$95 |
| Exams | $52-125 | Therapy modalities | $17-$48 |
| X-Rays | $50 per area | Therapeutic Laser | $31 |
| Adjustments | $50-$75 | Acupuncture | $75-$100 |

**Financial Policy**

We are committed to providing you the best care possible in a caring environment, and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care *at the time service until your report of findings*. At your report of findings, we will discuss various payment options based on your recommended care plan.

Health Insurance: If you have insurance that covers chiropractic in our office, we will file claim forms for you to get reimbursed quickly.

I have read and I understand the above policies.

______________________________ ______________________________

Print patient's name Signature of patient (or parent/guardian)

Date ____________________

## X-Ray Consent

During your examination, the doctor may feel that x-rays will be needed in order to fully diagnose your condition, and to administer proper treatment.

**Please Choose One:**

________ I understand that my doctor may need x-rays in order to diagnose my condition and I give permission for all needed diagnostic tests.

________ I understand that my condition may require my doctor to take x-rays to further diagnose my symptoms. I choose **not** to have any x-rays at this time and release my doctor of all liabilities.

**FEMALES ONLY:**

I understand that if I am pregnant and have x-rays taken which expose me to radiation, it is possible to injure the fetus.

I am advising my doctor that (please circle one): I am pregnant I could be pregnant I am not pregnant

______________________________ ______________________________ ______________

Print patient's name Signature of patient (or parent/guardian) Date