COBB WELLNESS CLINIC

MVA INTAKE FORMS - PERSONAL HISTORY

Today's Date: _____

PATIENT INFORMATION

Name (*First MI Last*): _____ Preferred Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Mobile: _____ Work: _____
Email: _____

Marital Status: (*Single/Married/Other*): _____ Gender: M / F Date of Birth: _____

Type of Work: _____ Employer: _____

*Referred By (*Name*): _____ Family / Friend / Co-Worker / Doctor / Other

EMERGENCY CONTACT INFORMATION

Name *(First MI Last)*: _____
Home Phone: _____ Mobile: _____
Relationship: Child / Parent / Spouse / Other: _____

Primary Care Physician: _____ Doctor's Phone: _____

AUTOMOBILE INSURANCE INFORMATION (*if using patient's own auto policy*)

Driver of the Vehicle: _____ Insurance Company: _____
Relationship to the Insured: Self / Spouse / Parent / Child / Other: _____
Policy #: _____ Claim #: _____
Contact Phone: _____ Fax: _____

ATTORNEY INFORMATION (*if providing a letter of protection*)

Attorney's Name: _____ Company: _____
Contact Phone: _____ Fax: _____

Office Use Only

Weight: _____ BP: _____/_____
Height: _____ HR: _____

MVA INTAKE FORMS – ACCIDENT INFORMATION

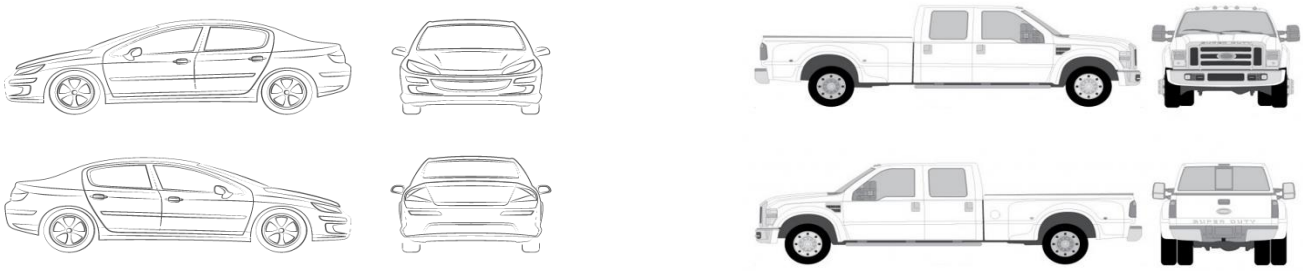
VEHICLE INFORMATION

YOUR VEHCILE

Make: _____ Model: _____ Year: _____ Airbags Deployed: □Yes □No

Estimated speed at time of impact: _____ Estimated damage to vehicle: _____

Please use either the car or truck diagram to mark the point of impact and any areas damage occurred:



Please provide a brief description of the accident and the motions of the vehicles involved: _____

_____

_____

_____

OTHER VEHICLE

Make: _____ Model: _____ Year: _____ Airbags Deployed: □Yes □No

Estimated speed at time of impact: _____ Estimated damage to vehicle: _____

ACCIDENT DETAILS

Date of Accident: _____ Time of Accident: _____

Weather conditions: _____

Where was the patient seated at the time of the accident? □Driver □Passenger □Rear-Seat □Other: _____

Did the patient impact the interior of the vehicle? □Yes □No

If yes, where and list details: _____

Did the patient suffer an injury to the head and/or neck? □Yes □No

Did the patient lose consciousness? □Yes □No

EMERGENCY ASSISTANCE

Were emergency vehicles at the scene? □No □Police □Ambulance □Fire Engine □Other: _____

Is there a police report? □Yes □No

Describe pain at time of accident: _____

Were you treated at the scene? □Yes □No

Were you taken to the hospital in an ambulance? □Yes □No

Did you see your primary care doctor/urgent care doctor following the accident?

If yes, who did you see and when? _____

Was your vehicle towed? □Yes □No

_____

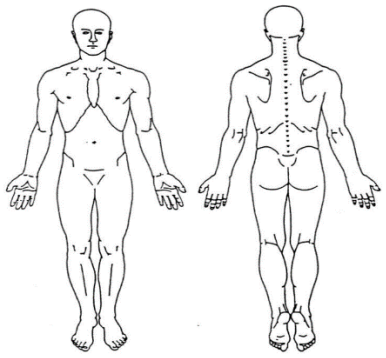
MVA INTAKE FORMS - PATIENT HISTORY

CURRENT CONDITION

Describe Major Complaint: _____
Describe Secondary Complaint: _____
When did this complaint begin? _____
How long has this complaint persisted? _____
Does this complaint radiate/shoot to any areas of your body? No / Yes (*Describe*): _____
Does anything make this better? Ice / Heat / Movement / Rest / Medication / Other: _____
Does anything make this worse? Sit / Stand / Walk / Laying / Overuse / Other: _____
Which activities are being affected by this complaint?: _____
Have you received any treatment for this pain? None / DC / MD / PT / Massage / Other: _____
Had any diagnostic testing? X-rays / MRI / CT / Other: _____ When/Where: _____

Please mark an X at any areas of pain

Severity (**0** = *no pain* and **10** = *severe*): **0 1 2 3 4 5 6 7 8 9 10**



Frequency: Constant / Intermittent / Off & On / Other
Quality of Pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff / Sore / Numbness / Tingling / Other: _____
_____

HEALTH HISTORY

Surgeries: None / Yes (*describe*): _____
Family History (*Major health problems*): _____
Allergies to Medications: _____
Current Medications & Supplements: _____
_____

REVIEW OF SYSTEMS

General: (constitutional)
- ☐ Recent weight change
- ☐ Fever
- ☐ Fatigue
- ☐ None in this category

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Painful Joints
- ☐ Stiff/Swollen/Joints
- ☐ Sore/Weak Muscles
- ☐ Muscle Cramps/Spasms
- ☐ Broken Bones
- ☐ None in this category

Respiratory:
- ☐ Difficulty breathing
- ☐ Persistent coughing
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ None in this category

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Constipation
- ☐ Frequent Diarrhea
- ☐ None in this category

Cardiovascular:
- ☐ Chest Pains
- ☐ Rapid Heartbeat
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands
- ☐ Heart Problems
- ☐ None in this category

Skin and Nails:
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Non-healing issues
- ☐ Change in hair or nails
- ☐ Change in mole appearance
- ☐ None in this category

Endocrine, Hematologic, & Lymphatic:
- ☐Thyroid Problems
- ☐ Diabetes
- ☐ Excessive Urination
- ☐ Cold Extremities
- ☐ Heat or Cold Intolerance
- ☐ Swollen Glands
- ☐ Glandular/hormone issues
- ☐ Dry Skin
- ☐ Easily Bruise or Bleed
- ☐ Anemia
- ☐ None in this category

Ears, Nose and Throat:
- ☐ Bad Breath or bad taste
- ☐ Bleeding gums/sores
- ☐ Swollen throat
- ☐ Swollen glands in neck
- ☐ Ear Ache/Ringing/Drainage
- ☐ Sinus/Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ None in this category

Neurological:
- ☐ Numbness or tingling
- ☐ Loss of feeling
- ☐ Dizziness
- ☐ Frequent Headaches
- ☐ Convulsions/seizures
- ☐ Tremors
- ☐ Stroke
- ☐ None in this category

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force of urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting

Women Only:
- ☐ Painful or Irregular periods

Are you pregnant? ☐No
- ☐ Yes, Due Date: _____
- ☐ Previous Pregnancies _____
- ☐ Infertility

Patient Signature _____ Date _____

COBB WELLNESS CLINIC

Consent for Chiropractic Service

Patient Name: _____

D.O.B.:_____

Date: _____

By signing below, you authorize the office and provider to complete a consultation and examination of the patient listed above. Before this office begins any health care operations, we require that you read and sign this form stating that you understand the items below. I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examination and supportive therapies and procedures. If you decline to sign this form, the doctor reserves the right to refuse care.

By reading below, I have been made aware:

1. The process of delivering a **'Chiropractic Adjustment (manipulation)'** may be performed manually, with a table mechanism, or with an instrument to the vertebra of the spine and/or associated structures (legs, arms, etc.), often resulting in an audible pop or click sound.
2. As an addition to the Chiropractic Adjustment, **'Supportive Therapies and/or Procedures'** may be applied by the chiropractor, or by a staff member under the chiropractor's direction or supervision, incorporating the use of light, electricity, traction, motion, heat/cold therapies, or nutritional advice.
3. That on occasion, some temporary soreness and/or stiffness may occur; less frequently aggravation of the presenting symptoms or initiation of new symptoms; rarely bruising, swelling; even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a chiropractic adjustment.
4. That the chiropractor has made no guarantee of a positive outcome from treatment.
5. I have been afforded ample opportunity for questions and answers.

Therefore, by signing below:

I **consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and/or the staff member under the direction and supervision of the office chiropractor involved in my case.

I **consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and/or staff, under the direction and supervision of the office chiropractor involved in my case.

Patient Signature: _____

905 S Adams Street
Fredericksburg, TX 78624
Phone: 830-992-3221 • Fax: 830-992-3212

COBB WELLNESS CLINIC

Practice & Payment Policies

Patient Name: _____

D.O.B.:_____

Date: _____

1. INSURANCE We are participating providers with Medicare only. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

Medicare does not cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

We are not in network with other insurance companies and do not accept payments from them. If you are insured by a plan with which we have no prior arrangement, we will prepare your Superbill for you to submit to your insurance. This means the insurer will send any applicable reimbursement payment directly to you, and therefore, our charges for you are due at the time of service. Every insurance is different and will not necessarily reimburse you for the total charge of the appointment. Please contact your provider for details on their covered services.

You understand and accept that you are financially responsible to Dr. Neal Cobb, D.C / Cobb Wellness Clinic for charges not covered by the assignment of insurance benefits.

2. PAYMENT is expected at the time of each visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, or non-covered charges from your insurance company. We will need to make a copy of a valid ID card or license during your first visit, as well as your insurance card.

Your account must be in good standing to receive treatments. Any balance due must be paid prior to services and treatments being rendered. Late charges of 12% annually will be applied to all patient balances 90 days old or greater.

3. RETURNED CHECKS will incur a $30 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action.

4. COLLECTION FEES I understand that in the event my account is placed in collection status, any additional fees incurred will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand the additional fees will be my personal responsibility to pay in full.

905 S Adams Street
Fredericksburg, TX 78624
Phone: 830-992-3221 • Fax: 830-992-3212

COBB WELLNESS CLINIC

5. CANCELLATIONS OR MISSED APPOINTMENTS If you are unable to make your appointment, please call the office to reschedule as soon as possible. Missed appointments or cancellations made within 24-hours of your appointment will be subject to a $25 cancellation fee, due before your next treatment.

6. TARDINESS Please be on time for your appointments. Patients who have arrived late may be seen after patients who have arrived for their appointment on time. New patients that are more than 15 minutes late to their scheduled time will be rescheduled.

7. RELEASE OF PERSONAL INFORMATION I hereby authorize the and direct Dr. Neal Cobb, D.C / Cobb Wellness Clinic to release to governmental agencies, insurance carriers, or other healthcare facilities and associates who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

We are very concerned with protecting your personal and health information. By signing below, you have authorized this office to contact you for office related health matters. Messages may be left on an answering machine/voicemail, or with the person answering your phone. Your cell phone number may be used for text (SMS) messages with upcoming appointment reminders. Emails may be sent to you regarding your current health and wellness program, billing reminders or office updates and marketing. Mailings from the office will be sent to the address on file and may include billing statements and marketing materials.

8. PARENTS/GUARDIANS OF MINOR PATIENTS By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent/guardian who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

9. MOTOR VEHICLE ACCIDENTS In the event that you have been in a motor vehicle accident, you can use your PIP, or we can refer you to an attorney. We do not bill out to third-party insurances.

The office will supply you with a copy of this office privacy policies and procedures upon your request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below, you gave acknowledged that you have been offered a copy of this document. Cobb Wellness Clinic reserves the right to make changes to the practice and payment policies at any time.

By signing below, I understand and agree with the policies and procedures outlined in this form. I acknowledge and certify that all the information given to the office and provider in the Patient Intake Forms are true and accurate to the best of my knowledge. Any changes to my personal information or insurance or contact information will be given to the office in writing as soon as possible.

Patient Signature: _____

905 S Adams Street
Fredericksburg, TX 78624
Phone: 830-992-3221 • Fax: 830-992-3212

COBB WELLNESS CLINIC

Notice of Doctor's Lien

Patient Name: _____

D.O.B.:_____

Date: _____

I do hereby authorize Dr. Neal Cobb, D.C. to furnish to you, my attorney, a full report of my examination, diagnosis, treatment, prognosis, and any other medical information as it pertains to the accident I was recently involved in.

I authorize and direct you, my attorney, to pay Dr. Neal Cobb, D.C./Cobb Wellness Clinic any such sums that may be due and owed for the medical services rendered to me both my reason of this accident and by the reason of any other bills that are due to the office, and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect the amounts due to Cobb Wellness Clinic.

I agree not to rescind this document for any reason and that a rescission will not be honored by my attorney. I instruct that in the event a new attorney is substituted in this matter, the new attorney must honor this lien as inherent to the settlement and is enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to Dr. Neal Cobb, D.C./Cobb Wellness Clinic for all medical bulls submitted for services rendered, and that this agreement is made solely for his protection. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fees.

Please acknowledge this letter by signing below and returning it to Cobb Wellness Clinic. I have been advised that if my attorney does not wish to sign in agreement, Dr. Neal Cobb, D.C. may declare the entire balance due and payable.

Patient/Guardian Signature:_____

The undersigned being the attorney of record for the above patient does herby agree to observe all terms of the above statements and agrees to withhold the sums from any settlement, judgement or verdict.

Date: _____

Attorney's Name: _____

Attorney's Signature: _____

905 S Adams Street
Fredericksburg, TX 78624
Phone: 830-992-3221 • Fax: 830-992-3212

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.