301 N 200 E Suite 2C St. George, UT 84770
Phone (435) 218-7250 Fax (4350 218-7251

WELCOME

Thank you for choosing our practice for your chiropractic needs.

Please present your Drivers License and Insurance Cards (if applicable) to copy. If you have any questions or concerns, please ask us for assistance. We will be happy to help.

Please complete this form in ink.

PATIENT INFORMATION

PLEASE PRINT ALL INFORMATION

Last Name: SS#

First Name: MI:

Address:

City:

State: Zip:

Home Phone: Ext'n:

Cell Phone:

Birth Date: Age:

Gender:
☐ Male
☐ Female

Marital Status
☐ Minor ☐ Widowed
☐ Married ☐ Single
☐ Divorced ☐ Separated

Do you prefer to receive calls ☐ Home ☐ Cell ☐ Either

Email Address:

Your Employer: Occupation:

Employer's Address: City: State: Zip:

Spouse or Parent's name: Work phone:

Person to contact in case of an emergency: Phone:

RESPONSIBLE PARTY

Name of person responsible for this account:

Relationship to patient: Phone:

Address: City: State: Zip:

Name of Employer: Work phone:

INSURANCE INFORMATION

Name of insured: Relationship to Patient:

Birth Date: SS# of insured:

Insurance Co: Group #

Address: City: State: Zip:

DO YOU HAVE ADDITIONAL INSURANCE? IF SO, PLEASE COMPLETE THE FOLLOWING:

Name of insured: SS# of insured:

Insurance Co: Group #

Address: City: State: Zip:

AUTO INSURANCE **YOUR** VEHICLE

AUTO INSURANCE **OTHER** VEHICLE

Insurance Co:

Telephone No.

Agents Name:

Owner of Vehicle:

Year and Make:

Were You ? ☐ DRIVER ☐ PASSENGER

Policy #:

Claim #:

Date of Accident:

Date you reported Accident to Agent:

Estimated amount of damage to your vehicle $

Citation issued to: ☐ YOU ☐ OTHER DRIVER

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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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present and future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as a needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation. Also, Research, Criminal Activity, Military Activity, National Security, Workers' Compensation and Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent. Authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to see another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternate means or at an alternate location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to receive an accounting of certain disclosures we have made, of any of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our private contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and private practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at the main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Policies:

Print Name: _____

Signature: _____

Date: _____

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MOTOR VEHICLE ACCIDENT

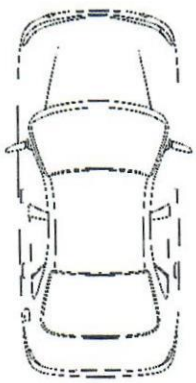
Date of Injury: Today's Date:

Name: Birth Date: Age: ☐ Male ☐ Female

Describe how the injury happened:

AUTOMOBILE ACCIDENT: Damage $

FRONT



REAR

O=Where patient sat

X= Where impact occurred

Were you the: ☐ Driver ☐ Passenger ☐ Front ☐ Rear

Seat Belt: ☐ Yes ☐ No ☐ Lap ☐ Shoulder

Vehicle was: ☐ Moving ☐ Stopped

Vehicle Struck: ☐ Head-on ☐ Rear ended ☐ Driver side ☐ Passenger side

During Impact: ☐ Brace w/arms ☐ Brace w/legs ☐ Steering wheel ☐ Dash ☐ Seat ☐ Floor ☐ Brakes ☐ Don't remember

Head: ☐ Straight Turned ☐ Right ☐ Left ☐ Strike headrest

Strike any part of body? *(Against what):*

After collision: ☐ Lose consciousness? Minutes:

Did you feel: ☐ Nervous ☐ Stunned ☐ Scared ☐ Dizzy ☐ Disoriented ☐ Lightheaded ☐ Confused

Immediate symptoms:

Subsequent symptoms:

Evaluated by Paramedics? Taken to hospital? Via ambulance?

Any emergency treatment?

Initial treatment When? Where?

Doctor's Name & Specialty:

Type of treatment:

SUBSEQUENT TREATMENT: (including all Doctors and testing)

1

2

3

4

Was anyone in the vehicle with you?

CURRENT COMPLAINTS

1

2

3

4

PAST MEDICAL HISTORY

(Prior injuries) Motor Vehicle:

Work:

Sports:

Other:

Major surgeries:

Hospitilizations:

Major illnesses: ☐ Diabetes ☐ Hypertension ☐ Ulcers ☐ Cancer ☐ Heart Disease

☐ Hernia ☐ Tuberculosis ☐ Kidney ☐ Lung

☐ Other *(please list)*

Family history of any of the above conditions: *(Relationship)*

Is there any chance that you are pregnant at this time? ☐ YES ☐ NO

Allergies:

Current Medications:

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Events of Accident in Patients Own Words

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NAME: **DATE:**

1. What is the **MAIN** problem/symptom you are having?

Place a mark through the line to rate your pain/symptoms today.

No pain *Worst pain*

Check the **ONE** that **BEST** describes how often you experience this pain.

☐ All the time
☐ Most of the time
☐ Some of the time
☐ Hardley any of the time
☐ None of the time

Hx for HA:
Location: R L B Occipital / Frontal / Temporal
Freq: C 1 2 3 4 5 6 7 / W / M
Intensity: Forgot / Not Forgot / Stops Act / Cries-pain
Lasts: _____/ M / H / ALL D

What have you notice that makes this condition **WORSE?**

What have you notice that makes this condition **BETTER?**

Please check the word(s) that best describe this symptom.

☐ sharp ☐ shooting ☐ stabbing ☐ dull
☐ achy ☐ numb ☐ tingly ☐ burning

2. What is the **NEXT** most bothersome problem you are having?

Place a mark through the line to rate your pain/symptoms today.

No pain *Worst pain*

Check the **ONE** that **BEST** describes how often you experience this pain.

☐ All the time
☐ Most of the time
☐ Some of the time
☐ Hardley any of the time
☐ None of the time

What have you notice that makes this condition **WORSE?**

What have you notice that makes this condition **BETTER?**

Please check the word(s) that best describe this symptom.

☐ sharp ☐ shooting ☐ stabbing ☐ dull
☐ achy ☐ numb ☐ tingly ☐ burning

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3. What is the **NEXT** most bothersome problem you are having?

Place a mark through the line to rate your pain/symptoms today.

No pain *Worst pain*

Check the **ONE** that **BEST** describes how often you experience this pain.

☐ All the time
☐ Most of the time
☐ Some of the time
☐ Hardley any of the time
☐ None of the time

What have you notice that makes this condition **WORSE?**

What have you notice that makes this condition **BETTER?**

Please check the word(s) that best describe this symptom.

☐ sharp ☐ shooting ☐ stabbing ☐ dull
☐ achy ☐ numb ☐ tingly ☐ burning

4. What is the **NEXT** most bothersome problem you are having?

Place a mark through the line to rate your pain/symptoms today.

No pain *Worst pain*

Check the **ONE** that **BEST** describes how often you experience this pain.

☐ All the time
☐ Most of the time
☐ Some of the time
☐ Hardley any of the time
☐ None of the time

What have you notice that makes this condition **WORSE?**

What have you notice that makes this condition **BETTER?**

Please check the word(s) that best describe this symptom.

☐ sharp ☐ shooting ☐ stabbing ☐ dull
☐ achy ☐ numb ☐ tingly ☐ burning

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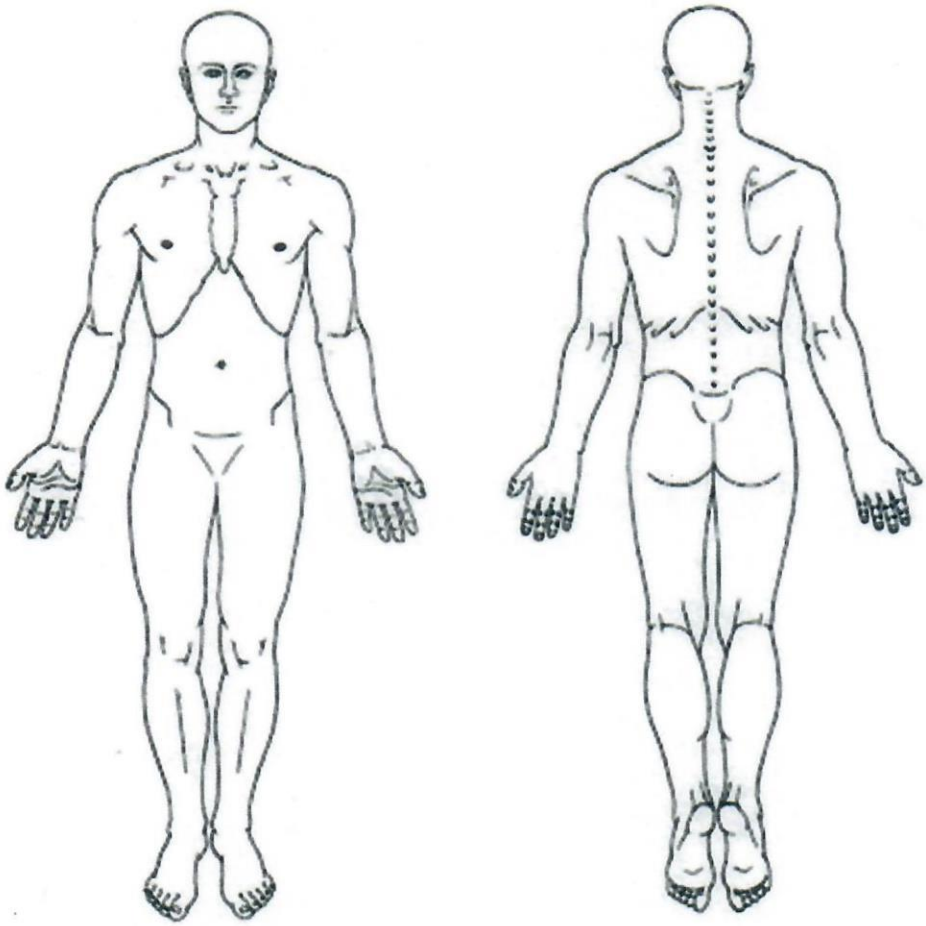
MARK AREAS ON THE BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS

NUMBNESS	ACHES	PINS & NEEDLES	BURNING	STABBING	OTHER
= = = =	AAAA	OOOO	XXXX	////	* * * *
= = = =	AAAA	OOOO	XXXX	////	* * * *
= = = =	AAAA	OOOO	XXXX	////	* * * *
= = = =	AAAA	OOOO	XXXX	////	* * * *
= = = =	AAAA	OOOO	XXXX	////	* * * *



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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physiotherapy and diagnostic x-rays on myself (or the patient named below for whom I am legally responsible) by the doctor or intern affiliated with HEALTHOLOGY EXPERTS.

I understand that, as in the practice of medicine, and the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, are in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern affiliated with HEALTHOLOGY EXPERTS to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature **Date**

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize HEALTHOLOGY EXPERTS, the Doctors and those designated as assistants, to administer treatment as is deemed necessary to my son/daughter or minor.

Patient Name

Legal Guardian Signature **Date**

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ACKNOWLEDGMENT OF LIABILITY AND ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, hereby acknowledge personal responsibility and liability for all medical services which are provided by HEALTHOLOGY EXPERTS, and all Doctors associated with it. This personal obligation is not affected by any obligation of insurance companies to pay health care costs. If an insurance company pays, the payments shall be credited to your account. If no insurance payment is received, you are completely responsible to pay for all medical treatments. In addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, the undersigned hereby assigns the physician or facility named above the following rights, power and authority.

RELEASE INFORMATION: You are authorized to release and to permit the examination or copying of any of my medical records, x-rays, laboratory reports and the results of all tests of any type or character to such person(s) as the physician and/or facility deems appropriate.

ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity to the extent of your bill for total services, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance company or other person or entity. I as the patient and/or responsible party, further agree to cooperate, provide information as needed and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and/or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claim.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above, following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we owe personally which are not payable under the terms of your policy.

THIRD PARTY LIABILITY: If patient(s) treatments for injuries are the result of the negligence of any third party, then patient(s) grant a secured interest (lien) against any recovery from such third part(s) to the extent of the bills for treatment in favor of the physician/facility named above.

STATUTE OF LIMITATIONS: Patient(s) waive the right to claim any Statute of Limitations regarding claims for services rendered or to be rendered by the physician/facility named above.

TERMS AND ATTORNEY FEES: Net 30 days from date of invoice unless otherwise indicated. A finance charge of 1.5% per month (annual percentage rate of 18%) of the unpaid balance may be added monthly, both pre-judgment and post-judgment. Should collection become necessary, the patient(s) agrees to pay an additional 50% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs for services rendered by the physician/facility named above.

RETURNED CHECK DISCLAIMER: I/we agree to pay $25.00 retuned check fee, attorney's fees of $150, all court, filing fees and charges or commissions of 50% that may be assessed to us by any collection agency retained to pursue this matter. I/we further agree to pay interest at the rate of 1.50% per month (18% per year).

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power of attorney to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company, representing payment for treatment and healthcare rendered by physician/facility. Additionally I grant the physician/facility the power of attorney to complete and sign any paperwork required to facilitate payment for care relative to injuries from a motor vehicle collision, i.e.: P.I.P. (Personal Injury Protection) application or other paperwork which may be required. 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. In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of this Agreement shall remain enforceable.

A PHOTOCO[Y OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL
Signatures of Patients and Responsible party:

Signature _____ Date _____ SS# _____

Print Name _____ Address _____

healthology experts

Name _____

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PERSONAL INJURY FINANCIAL INFORMATION

Thank you for choosing HEALTHOLOGY EXPERTS to provide your care following your motor vehicle collision. promise to provide you with the finest care available. The following is information that will be helpful to you in unc how our office interacts with your automobile insurance as well as our billing procedures.

Utah-A No Fault State
Even though you may not have been the at-fault party in your collision, Utah is considered a No-Fault State. That m that you must file a claim with your automobile insurance company and receive a claim number. Your insurance co will pay your medical bills up to your individual personal injury protection limit (PIP) and then seek reimbursement at-fault insurance company. The minimum PIP limit is $3,000.00. However, there are highter limits. You will want your individual policy to find out what your PIP limit is.

Personal Injury Protection (PIP) Application
Shortly after you have filed a claim with your automobile insurance, you will receive a PIP application from your in compay. Please complete that paperwork promptly and return it to your insurance company. That signed application your insurance company to pay your claims. Without that application, your insurance company will deny your claim have any questions regarding that paperwork, we will be happy to assist you.

PI Fee Schedule
Our fees for personal injury claims differ from regular health insurance fees. The fees are established by the Insuran commission of the State of Utah. They are different than regular health insurance fees.

Attorney
If your case requires an attorney, we can provide you with the names of attorneys that we have had positive experier with. Please contact the billing department with any questions.

Lien
You will be asked to sign a patient lien as part of your new patient paperwork. This lien protects us and assures that be paid from your settlement should your case require the assistance of an attorney. The lien is sent to your attorney signature and a copy is placed in your file here as well as with the attorney.

Date _____ **Initials** _____

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PERSONAL INJURY FINANCIAL INFORMATION

If you have not already filed a claim with your automobile insurance company and received a claim number, you are encouraged to do so immediately. A claim number is an identification number for your insurance company to reference in order to pay your claims.

I have read and understand the above information. I understand that after my automobile insurance has paid according to their limits and after any insurance company settlements, I am ultimately responsible for payment of any unpaid balance for my chiropractic care resulting from this motor vehicle collision.

Patient Name	**Date**
(Minor) Parent/Guardian	**Date**
Witness	**Date**

JUSTIN TRAVELLER MS, DC TYLER WILLIAMS MS, DC DEVIN HATCH MS, DC
1224 S River Road B100 St. George, UT 84790
Phone (435)218-7250 Fax (435)218-7251

MEDICAL REPORT AND DOCTOR'S LIEN

I do hereby authorize Healthology Experts to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself regarding the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to Healthology Experts such sums as may be due and owing to said facility for medical services rendered me both by reason of this accident and by reason of any other bills that are due to the facility and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect the doctor listed above. I hereby further give a lien on my case to said doctor against all proceeds, of any settlement, judgement or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may recover said fees.

Dated: _____ Patient Name (print) _____

Patient Signature: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor above named.

Dated: _____ Attorney Name (print) _____

Attorney Signature: _____

Attorney: Please date, sign and return one copy to Healthology Experts at once. Keep one copy for your records.