9000 Southwest Frwy. Ste. 204
Houston Texas 77074
Phone: 832.831.6639
Fax: 832.962-7991

Steven InBody M.D.
Thomas Superville D.C.
Laura Ariyo D.C.

Claim # _____

Insurance Co. _____

Patient Demographic Form

Date _____

Name _____ D.O.B _____

Tel ephone _____ ALT# _____

Address: _____

SS# _____

EMPLOYER: _____ YEARS: _____

FEDERAL COMP: ☐ CA-1 ☐ CA-2 D.O.I. _____

INJURED BODY AREA: _____

CRAFT/JOB DUTIES: _____

HAVE YOU FILED A REPORT WITH EMPLOYEE? ☐ YES ☐ NO

HAVE YOU BEEN SEEN BY ANOTHER FACILITY FOR THIS INJURY? ☐ YES ☐ NO

HOW MANY TIMES? _____ WHERE? _____

ADDITIONAL INFORMATION:

_____

_____

REFERED BY: _____

APPT.DATE/TIME: _____

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DOL PATIENT INTAKE FORM

Name:			Date:
Home Address:	City:	State:	Zip:
Phone:	Birthdate:		
Social Security#	Age:		
Driver's License			
Emergency Contact Name & Phone Number:			
Relation to Emergency Contact:			

Insurance Information

Date of Injury:	Time:	AM/PM
Employer:	Occupation:	
Work Address:	Phone:	
Insurance Company:		
Adjuster Name:		
Adjuster Phone:	Claim #	
Billing Address:		
Attorney:	Attorney Phone:	

PATIENT STATEMENT: _____

_____

_____

_____

_____

_____

If a minor, Name, Address & Phone of person responsible for care:

_____

_____

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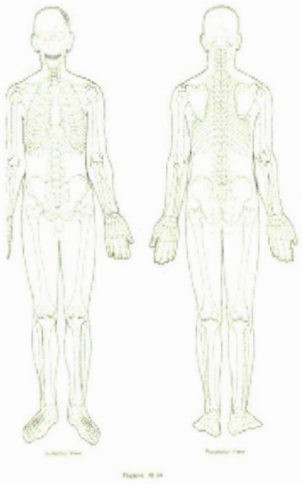
Symptoms:

Shade in areas of pain abnormal sensation (Check all that applied)



- ☐ Neck
- ☐ Low Back
- ☐ Stomach
- ☐ Shoulder
- ☐ Arm
- ☐ Elbow
- ☐ Wrist
- ☐ Hand
- ☐ Finger
- ☐ Hip
- ☐ Leg
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Toes

- ☐ Between Shoulders
- ☐ Headaches
- ☐ Chest
- ☐ R ☐ L
- ☐ R ☐ L
- ☐ R ☐ L
- ☐ R ☐ L
- ☐ R ☐ L
- ☐ R ☐ L
- ☐ R ☐ L
- ☐ R ☐ L
- ☐ R ☐ L
- ☐ R ☐ L
- ☐ R ☐ L

- ☐ Weakness
- ☐ Insomnia
- ☐ Depression
- ☐ Coldness
- ☐ Hearing problems
- ☐ Difficulty swallowing
- ☐ Increased sweating
- ☐ poor balance
- ☐ dizziness
- ☐ poor appetite
- ☐ visual difficulty
- ☐ paralysis
- ☐ nausea
- ☐ bowel problems
- ☐ shortness of breath
- ☐ ringing in ears
- ☐ urinary problems
- ☐ other
- ☐ colds
- ☐ vomiting

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WORK RELATED INCIDENT

1. Are you currently working? ◉YES ○NO
   ○Part-time ○Full-time ○Unemployed ○Unemployed due to injuries
2. Did you get a note for light duty or to stay off work? ○YES○NO
3. How many days/hours did you lose from work due to injuries? _____
4. Please describe type of work

   ○Office/Clerical ○Light Labor ○Medium Labor ○Heavy Labor ○Other_____
5. Does your job involve strenuous activities that increase your pain? ○YES○NO
   If "YES", check all strenuous activities that apply:
   ☐Lifting ☐Pushing ☐Walking ☐Bending ☐Twisting ☐Kneeling ☐Reaching
   ☐Other _____

SOCIAL HISTORY

1. Do you drink? ○YES○NO If "YES" How many glasses a week? _____
2. Do you smoke? ○YES○NO If "YES" How many packs a day? _____

GYNECOLOGICAL HISTORY

***For Female Patients Only**

Date of last menstrual Period ____/____/____ Difficulties with cycle? ○YES○NO
Number of pregnancies ____ Number of children ____

PREVIOUS HEALTH HISTORY

1. Have you gone to a chiropractor before? ○YES○NO
   When was your last adjustment? ____/____/____
2. Please list all medications you are currently taking – *include over the counter medicine.*
   *List Medications
   Name_____ Doses_____ How often_____

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3. Have you ever had the following?

◯ Allergies	◯ Arthritis	◯ Hypertension
◯ Diabetes	◯ TB	◯ Asthma
◯ Headaches	◯ Cancer	◯ Fainting
◯ Kidney disease	◯ Heart disease	◯ Bladder problems
◯ Thyroid	◯ Other_____	

FAMILY HEALTH HISTORY

Age of: Mother _____ Father _____

Has anyone in the family ever had any of the following?

◯ Diabetes	◯ Hypertension
◯ Ulcers	◯ TB
◯ Arthritis	◯ Kidney disease
◯ Seizures	◯ Asthma
◯ Allergies	◯ Cancer

SURGICAL HISTORY

Describe all surgeries you had had:

Type of Surgery

_____ Date ____/____/____

_____ Date ____/____/____

_____ Date ____/____/____

TRAUMA

1. Describe trauma you had in the past (auto accident, falls, sports injuries, etc, & care your received: _____

_____

_____

2. Have you ever broken a bone? ◯ YES ◯ NO IF "YES" what area?

_____

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3. At what time of the day do you feel your best? _____

4. At what time of the day do you feel your worst? _____

5. Are you involved in any kind of counseling or self-improvement program? ◯ YES ◯ NO

6. Do you suffer from any unexplained attacks of anxiety, fatigue or depression?

   ◯ YES ◯ NO

7. Are you under any unusual stress right now? (Friends, work, home, changes in life?

   ◯ YES ◯ NO (IF "YES" explain)

_____

_____

I hereby certify that my statements are true and complete to the best of my knowledge.

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_____ ____/____/____

Patient's Signature (Parent or Guardian if Patient is a minor) Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date of 1st request _____ Date of 2nd request_____

TO: _____

(Name of Doctor, Clinic, Hospital or Medical Center)

Address: _____ Phone/Fax: _____

I, _____ request the following information:

X-Rays/Reports ☐ Films ☐

Medical Records ☐ Other ☐

Medical Reports ☐

To be release to: Frontline Recovery & Consulting
8700 Commerce Park Dr. Ste. 245
Houston, TX 77036
Ph. 832.831.6639 Fax 832.831.6643

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Patient Information:

Name: _____

Date of Birth: ____/____/____

Date of Injury: ____/____/____

Social Security Number: ____-____-____

Signature: _____ Date: ____/____/____

Patient ◯, Spouse ◯ Parent ◯ Guardian ◯

*According to section; 1795/CA Health and Safety Code. The information must be release within 15 business days of receipt of this notice.

Form Revised November 29, 2017

FRONTLINE RECOVERY& CONSULTING
AUTHORIZATION & CONSENT FOR CARE

I, the undersigned, hereby authorize FRONTLINE RECOVERY to administer treatments ordered by my physician, the doctor of chiropractic and/or other license doctors at the facility who now, or in the future, render treatment including chiropractic adjustments and other chiropractic procedures, examination testing, diagnostic testing, X-Rays and other advanced imaging studies as medically necessary and physical therapy techniques to include cardiovascular exercise, stretching, proprioceptive and any other physical rehabilitation techniques to me or the patient named below for whom I am legally responsible.

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FRONTLINE RECOVERY, Inc. is authorized to release medical records the provider deems apt. regarding my physical state to any insurance group, attorney or adjuster to aid in compensation of fees incurred. I permit direct payment be made to FRONTLINE RECOVERY, for any & all services rendered.

I understand I am responsible for charges if services are not covered by the insurance, or if FRONTLINE RECOVERY is unable to verify my eligibility. I realize if a check is dishonored or if I refuse to pay, I am liable for collection cost including but not limited to returned check and attorney fees.

I grant FRONTLINE RECOVERY exclusive and irrevocable rights to coordinate benefits with other insurance coverage and to collect from other parties for expense reimbursement of my injury or illness was caused by or is reimbursable by that party.

I understand FRONTLINE RECOVERY does not employ physicians, nor controls my physician's medical decisions. I acknowledge that no warranty or guarantee has been made as to result or cure.

If the patient is a minor, I authorize treatment and care to be administered as necessary to my child.

I certify that I understand this statement.

Patient Name: (Please Print) _____

Patient: (or guardian's) signature _____

If Patient is a minor: Guardian's name (Please Print) _____

Relationship to patient: (if not signed by patient) _____

Date: _____/_____/_____

Form Revised November 29, 2017

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Assignment of Benefits and Cause of Action to Protect Medical Expenses

I, individually or as a legal representative of the patient identified below in consideration for treatment rendered assign to FRONTLINE RECOVERY, the following rights, power and authority:

- In regard to the following assignment of benefits and cause of action to protect medical expenses with my signature below I certify that the injury claim I am pursuing was the result of the legitimate accident that occurred on _____.

- I hereby acknowledge that I have been informed that it is a violation of Federal and State Law to falsely claim I was injured or involved in an accident that was in anyway staged for the purpose of filing a fraudulent claim.

- By my signature below, I acknowledge no one came to my residence or otherwise contacted me to inform me that I should or must come to this clinic for therapy due to the accident in which I was injured.

Irrevocable Assignment of Rights and Causes of Action: FRONTLINE RECOVERY is hereby assigned the exclusive and irrevocable right to benefits, claims or causes of action that exist in my favor arising from any injury, disease or disability against any individual, entity, insurance policy or other agreement for payment of monies to me to the extent of total bills for services. I assign exclusive and irrevocable rights for the clinic to receive payment under any such benefit, claim or cause of action. I appoint FRONTLINE RECOVERY, its successor and assigns as my attorney in fact to endorse or sign my name on any and all checks received as payment for services to make demand in my name to prosecute and receive penalties, interest, court cost, attorney fees and any other legally compensable amounts owed. I agree to assist and provide information and appear as needed where required to aid the prosecution of claims for benefit upon request.

Demand for Payment: I hereby instruct and make demand on any insurance company owing a duty of payment of any kind to me for treatment rendered by FRONTLINE RECOVERY, its successors and assigns within 60 days following receipt of such bill for services to the extent such bill is payable under the terms of an insurance policy of insuring agreement. This demand conforms to Article 21.55 of the Insurance Code providing for attorney fees, penalties, court cost and interests from judgment upon violation. I further instruct you to make such payment via draft or check to be sent to FRONTLINE RECOVERY 8700 COMMERCE PARK DR. STE. 245 HOUSTON, TX 77036.

Primary Liability: Notwithstanding above assignments, I understand if my charges are not paid by a third party who may be liable for them, I will be ultimately responsible for payment of charges incurred and costs of collection, including but not limited to attorney and court cost. I understand that you are not required to exhaust remedies against a third party before requiring me to pay.

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Waiver of Statute of Limitations: I waive my rights to assert any statue of limitations defense against claims for goods or services rendered by the physician or facility named above, in addition to reasonable costs of collection including attorney fees and court cost if incurred.

A photocopy of this document shall serve as the original.

_____ Date _____/_____/_____
Signature of Patient or Responsible Party

_____
Relationship of Signatory to Patient

FRONTLINE RECOVERY

IRREVOCABLE ASSIGNMENT OF PROCEEDS AND CONVEYANCE LIEN INTEREST
(Not a Statutory Lien)

Re: Medical Reports and Lien for _____.

I hereby authorize _____, my doctor and FRONTLINE RECOVERY, (hereafter "the treating facility") to furnish my attorney and/or insurance carrier with reports of any examination, treatment, prognosis (including x-rays and other medical data as deemed necessary by my doctor) relating to treatment in regard to the automobile accident or other contributing incident giving rise to my need for such health care services.

ASSIGNMENT AND CONVEYANCE OF LIEN INTEREST

- I hereby execute and provide this Irrevocable Lien and Assignment of Proceeds in favor of the above name doctor and/or the doctor's designated treating facility. This Irrevocable Lien and Assignment of Proceeds shall apply to monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am entitled and from which I am paid in the form of a settlement(s), claim(s), judgment(s), or verdict(s) resulting from the above identified accident (collectively "insurance proceeds").

- As consideration for my execution of this Irrevocable Lien and Assignment of Proceeds, I represent that said doctor and/or treating facility provided me professional services upon my request, I am aware of the nature and expense of such services provided and that as

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consideration for forbearance of his legal right to require payment by me at the time services were rendered, said doctor and treating facility relied upon my express declaration and intention to execute and instruct that this Irrevocable Lien and Assignment of Proceeds shall apply to all proceeds to which I am entitled and direct that the amount of such proceeds required to satisfy my balance with said doctor and/or facility be remitted directly to the doctor and/or treating facility, at such time I receive an insurance settlement or other monetary settlement/award.

- In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts determined to be owed, due and payable for my account to named doctor and facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt my settlement award(s).
- I fully understand and stipulate that I am ultimately and directly responsible to the doctor and/or treating facility for all medical bills incurred by me for services rendered to me or on my behalf or request and this agreement is made solely for the benefit of the doctor and treating facility as additional protection and in consideration of the treating facility's agreement to forgo immediate collection of payment for such services rendered.

SIGNED _____ Date _____/_____/_____

Printed Name of Patient: _____

For or On Behalf of the Minor Child: _____. I do hereby assume full financial responsibility.

SIGNED: _____ Date _____/_____/_____

FRONTLINE RECOVERY

Patient Consent to the use and disclosure of health
Information for treatment, payment and healthcare Operations

I, _____, understand that as part of my health care FRONTLINE RECOVERY, originates and maintains paper and/or electronic records regarding my health history, exam and test results, treatment and plans for future management. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were provided.
- A tool for clinic operations, i.e. assessing quality & competence of medical professionals.

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I understand and have been provided with a *Notice of Information Practices* that provides a more complete account of information uses and disclosures. I understand I have the following rights:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes
- The right to restrict how my records are used or disclosed to carry out treatment, payment or health care operations.

I understand FRONTLINE RECOVERY is not required to agree to restrictions requested. I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, this clinic may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand FRONTLINE RECOVERY reserves the right to alter notice and practices prior to completion in accord with Section 164.520 of the Code of Federal Regulations. If FRONTLINE RECOVERY alters notice, if requested, a copy will be sent to the address I supply (U.S. mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand for this organization's treatment, payment or care operations, it may be necessary to release my health records to another entity; I consent to disclosure for these uses, including via fax.

I fully understand and accept/decline the terms of this consent.

_____ _____/_____/_____

Patient Signature (authorized representative signing for the patient) Date

For Office Use Only

☐ Consent received by _____ on _____/_____/_____.

☐ Consent refused by patient, and treatment refused as permitted.

FORM REVISED November 29, 2017

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DISCLOSURE OF PROTECTED HEALTH INFORMATION LOG

Date & Time Information was Requested	Date & Time Information was sent	Name & Company of Requestor	Information Requested	Reason for Request	Sent to: Fax# or Address	Approved? Date of Approval or disapproval	Name of Sender
						YES ◯ NO ◯	
						YES ◯ NO ◯	
						YES ◯ NO ◯	
						YES ◯ NO ◯	
						YES NO	

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Notice of Information Practices

This notice describes how use/disclose health information to aid treatment, collect payment and for operations and explains policies for uses permitted/required by law and your rights to access & control your data. "Protected Health Information" (PHI) is data about you, demographic data, your past, present or future health and care. We are required to abide by these terms. We may change terms at any time, new terms are effective for data we presently retain. You may get revisions by requesting a copy.

USE/DISCLOSURE OF HEALTH INFORMATION: By signing the consent form, you approve use & disclosure of OHI by your doctor, staff & others outside our office for the use of providing care to you. PHI is used to bill for care & support the practice.

Treatment: We may disclose PHI to provide, coordinate or manage your care. This includes coordination or management of your PHI. For example, we may disclose PHI, as necessary to another doctor who may treat you. PHI may be provided to a physician to whom you were referred to ensure they have necessary information to diagnose or treat you. We may disclose PHI to a provider (a specialist or lab) who at the request of your doctor, is involved in your care by assisting with your diagnoses or treatment.

Payment: Your PHI will be used as needed to gain payment for treatment; your insurance may review it before it approves/pays for services, i.e. determining eligibility for benefits, reviewing medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use PHI for clinic activities, including but not limited to quality and employee reviews & training chiropractic students. We may disclose PHI to interns that see patients at our clinic. We may use a sign-in sheet where you sign your name. Communication between you & the doctor may be recorded to aid in capturing your response. We may call you by name in the waiting room & may use PHI to call & remind you of an appointment. We may share PHI with third party associates that perform activities (e.g. billing, transcriptions services) for us. When an arrangement between our office & an associate involves disclosure of PHI, we have a written contract with the associate containing terms protecting privacy of your PHI. We may use PHI for internal marketing for example, your name & address may be used t send a newsletter about our clinic & services we offer or send information about products or services that may be beneficial to you. You may request materials not be sent to you.

Consent or Chance to Object: You may agree or object to use/disclose of all or part of PHI; if you aren't present. The doctor may deem if disclosure is in your best interest. If so only OHI relevant to your care will be disclosed.

Others involved in your care: Unless you object, we may use/disclose PHI to notify family, friends or other people about your care or death and my disclose PHI to public/private units to aid in disaster relief to notify family or others involved in your care.

Use & Disclosure Made Without Consent, Approval Or Objection:

Law Requirement: We may disclose PHI to the extent, in compliance with laws limited to relevant provisions. You'll be notified.

Public Health: We may release PHI to a public entity allowed by law to collect data for controlling disease, injury or disability.

Communicable Disease: We disclose if approved by law to a person who was exposed to a disease or be at risk spreading it.

Health Oversight: We may disclose PHI to a health oversight agency authorized by law i.e. audits, investigations and inspections. Agencies seeking information include those that direct healthcare systems, government benefit programs & other programs.

Abuse/Neglect: We may disclose PHI to a public authority authorized by law to receive reports of abuse or neglect, or if we believe you were a victim of neglect or violence. The disclosure will be consistent with the requirement of federal and state law.

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Legal Action: We disclose PHI for judicial trials, court orders in response to a subpoena, discovery appeal or other lawful process.
Law Enforcement: We disclose PHI for legal purposes which include (1) legal process required by law (2) information request for identification & location (3) pertaining to crime victims (4) suspicion death occurred as a result of a crime (5) in the event crime occurs on the premises of the practice and (6) medical emergency (not on practices premises) and it is likely that a crime occurred.
Workers Compensation: We may disclose PHI to comply with workers compensation laws and similar programs.
Required disclosure: When obliged by law to verify compliance to the Secretary of Health & Human Services: Sect. 164.500 et.seq.
YOUR RIGHTS The following is a statement with respect to PHI and a description of how to exercise these rights.
To inspect & copy your PHI: You may inspect & obtain a copy of your PHI contained in a record as long as we maintain it. A "designated record set" contains records your doctor & the practice use. Under federal law, you may not inspect the following records; psychotherapy notes, data compiled in anticipation of or use in a civil, criminal or administrative proceeding & PHI subject to law prohibiting access to PHI. Depending on condition, decisions to deny access may be reviewable.
To request restrictions: You may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare. You may request PHI not to be disclosed to those involved in your care. Request must be written, signed, dated & state restrictions requested and to whom you want restrictions to apply. We are not required to agree to all request. If the doctor believes it is in your best interest, PHI will not be restricted. If your doctor does agree, we may not disclose PHI unless needed to provide emergency treatment. Discuss any restriction you wish to request with your doctor. Ask staff for a copy it will serve as your receipt.
To request confidential communications: We may honor realistic requests. We may request payment and alternative address or other contact method. We will not request explanation. Please make written requests to our office manager.
To ask to amend PHI: You may request a change in a record set while we maintain the data. We may deny request; if so, you may file a disagreement and we may make a denial. We will provide you a copy of the rebuttal.
To receive disclosures we made: For purposes other than treatment, payment or care as described in this Notice, excluding those we made to you, or others involved in your care, pursuant to a duly executed authorization for notification. You may receive data that occurred after April 14, 2003, or may request a shorter timeframe. This is subject to restrictions and limitations.
To obtain a copy of this notice: Upon request even if you agree to accept this notice electronically.
Complaints: You may file a complaint by notifying our Privacy Officer at (832)-831-6639 or you may choose to file your complaint with the Secretary of Health and Human Services if you believe your rights have been violated. We will not retaliate for filing a complaint.

FORM REVISED November 29, 2017