IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:
This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between___________________________ ("Patient") and Adam L. Wilding, D.C., P.C. d/b/a Commonwealth Family Chiropractic (the"Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the Patient. This Assignment is to be a complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Providers total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patients attorney-in-fact any officer of Health Care Provider, to prosecute said causes(s) of action either in Patients name or in the Health Care Providers name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health care Providers right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patients claim against the individual or entity whose negligence is alleged to have caused Patients injuries.
Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs at a rate of 18% APR starting 90 days after the end of treatment at this office and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary. Additionally, I understand I will be charged in Full for any massage not canceled 24 hours in advance.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.
Notice regarding the assignment of medical expense benefits is provided in a separate document. I have been presented with and had an opportunity to read the notice. Acknowledged: _________(patient initials)

Witness the following signatures and seal as of the indicated date:

Patients Signature________________________________ Health Care Provider

Printed Name___________________________________ Adam L. Wilding, DC PC

Date_____________ SS#______________________ By: it's Owner

Witness_____________________________ Date______________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

Name: ____ Date: __________________

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have had the opportunity to understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree
that you are bound to abide by such restrictions.

Signature: ____
Relationship to Patient: _______________________________
Patients 18 and over must complete the following:

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION
I hereby authorize Commonwealth Family Chiropractic, PC to use or disclose the following:

_____ All Protected Healthcare Information
_____ Other

My protected health information may be disclosed to: ____

This authorization shall be in force and effective until: (Check one of the following)
_____ No Expiration
_____ Other

I understand that, as set forth by Commonwealth Family Chiropractic, PC, I have the right to revoke this authorization, in writing, at any time by sending written notification to: Commonwealth Family Chiropractic, PC, and 140 Professional Circle, Williamsburg, VA 23185

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or Virginia Law).
- Refuse to sign this authorization

Signature: ____ Date: _______________________

OFFICE USE OFFICE
I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practice Acknowledgement, but was unable to do so as documented below.
_______ ________ ____
Date Initials Reason
Name: ____________________________ Date: _______________________

Patient Information

Date: ________________________________

Patient Name: ____ Name you go by: _____________________________

Street Address: ____

Mailing Address (if different): ____

City, State, Zip code: ____

Date of Birth: _________________________________ Sex: **M / F** Marital Status: **Single / Married / Divorced / Widowed**

Home Phone: ________________________ Work Phone: ________________________ ext.______ Cell Phone: _____________________________

Social Security Number: ___________________________________ Email address: ____

Emergency Contact: ____ Phone Number: ____

Occupation: _____________________________________ Employer: ____

Employer's Address: ____

Student: **Full Time / Part Time / Not applicable**

Name of Spouse or Parent: ____ Social Security Number: ______________________________

DOB: _______________________________________Occupation: ____

Employer: ____

Parent Address if Student not living at home:____

Purpose of this appointment: ____

Is your condition due to an accident? **Yes / No** Illness? **Yes / No** Other: _________________________

Was the accident at work? **Yes / No** Were you in an auto accident? **Yes / No** Other type of accident? **Yes / No**

Describe any accidental injury or related illness: ____

____

Other health professionals seen for this condition: ____

List any health conditions you have received treatment for in the last year: ____

____

Who is your primary care physician? ____ Phone: ____

List any medications that you currently take: ____

List any surgeries you have had: ____

How did you hear about our office? **Dr. Referral / Patient Referral / Advertisement / Yellow Pages / Other:** ___________________

Name of person who referred you to our office: ____

Payment is expected at the time of visit. We offer a "Time of Service" discount to our short term visitors. We will happily generate a statement and give you the paperwork necessary to file our charges to your insurance company for reimbursement.

Person responsible for payment of this account____

Address if different from above: ____

Welcome to Commonwealth Family Chiropractic

PLEASE READ CAREFULLY

Welcome to Commonwealth Family Chiropractic! We are committed to providing you with the best chiropractic care possible, and look forward to a long and healthy relationship.

We will file your insurance claims automatically for you. It is imperative that you give us correct, updated and accurate insurance information. Your understanding of your specific insurance policy and of our payment policy will be of great benefit to our relationship. We will make every effort to answer any questions you might have. The following statements are areas that are most frequently misunderstood by the patent. Please review and initial.

1. Not all services are a covered benefit. Some insurance companies arbitrarily select certain services they will not cover. It is up to you, the patient, to know what these services are. We will do our very best to assist you in this area; however, this ultimately is your responsibility**.**

_____ *Initial*

2. It is your responsibility to know when a referral is needed, and to obtain the referral before your appointment. If your primary care physician has any questions regarding the necessity, we will gladly answer them.

_____ *Initial*

3. Some insurance policies have a higher co-payment due the specialist physician than to the primary care physician. Please refer to your card or contract for that amount**.**

_____ *Initial*

4. All co-payments, any deductible that has not been met, and services that are not covered by your contract, are due at the time of your visit. If we do not participate with your insurance company, payment in full is expected at the time of service. We will file with your insurance company as a courtesy to you.

_____ *Initial*

If you do not have health insurance, financial arrangements must be made in advance with our billing receptionist. We accept cash, check, MasterCard or Visa. There is a $25.00 charge for any returned check. We reserve the right to require subsequent payments on such accounts in cash or by money order. I understand any balances over 120 days are subject to accrued interest of 1.5 percent per month.

Your signature below is your acknowledgement of this information. This serves as your authorization to release any necessary medical information to your insurance carrier, to process claims for services rendered. This also serves as your authorization of payment of all medical insurance benefits, which are payable under the terms of your insurance policy, to be paid directly to Commonwealth Family Chiropractic, for services rendered. A copy of this authorization may be used in place of the original.

Signature ______________________________________ Date ____________________

Commonwealth Family Chiropractic

Policy on No Shows, Cancellations, and Rescheduling

One of the very unique aspects of our office is the flexibility of our scheduling and efficiency in which we see you (i.e., minimal wait times.) Unfortunately, we must have certain guidelines to ensure that all our patients are able to benefit from minimal to no wait times. Therefore, the following policy has been instituted:

NO SHOWS:

Any patients not appearing for a scheduled appointment will be charged $25.00 PER missed visit.

Cancellations:

Any patients canceling without a 24-hour notice prior to their scheduled appointment will be charged a late cancellation fee of $25.00 per visit.

Rescheduling:

Any patients needing to reschedule an appointment, 24-hour notice is required prior to their scheduled appointment or a charge of $25.00 will apply.

Massage Appointment:

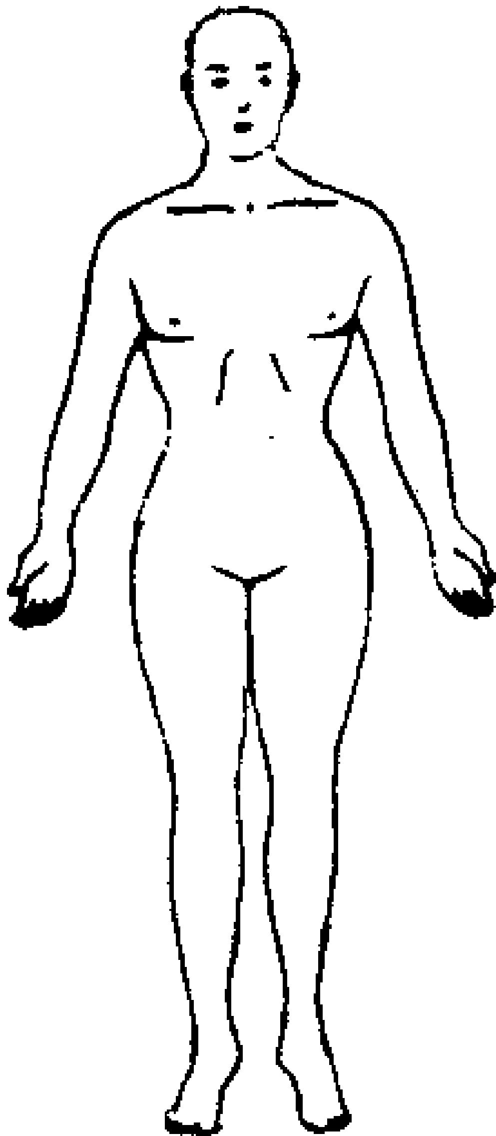
Please be aware that ALL same day cancellations/NO Shows will be CHARGED the full price of the massage that was reserved for you.

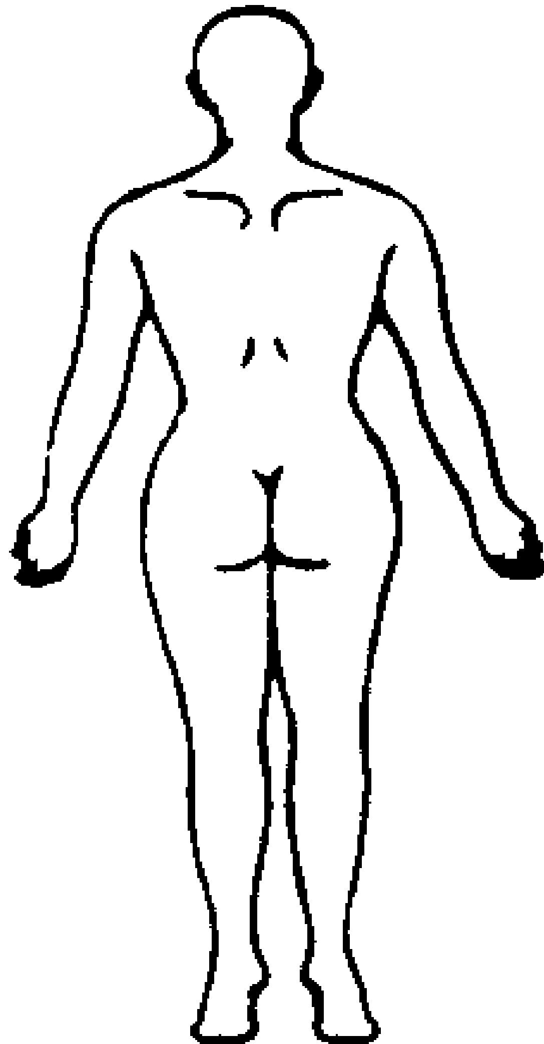
Signature: ____________________________________ **Date:** ______________

Name: ____ Date: ____________________

Using the appropriate symbols; mark the areas of pain. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - - - -	0 0 0 0 0 0 0 0 0	XXXXX	******	///////////
- - - - - - - - -	0 0 0 0 0 0 0 0 0	XXXXX	******	///////////
- - - - - - - - -	0 0 0 0 0 0 0 0 0	XXXXX	******	///////////





Right Left Left Right

Please rate your pain level with a vertical line:

Patient Name: ____ Date: ___________________________

Date of Birth: _______________________ Name of Family Doctor: _______________________________

Best number to contact you: **Home/Work/Cell**: _______________________ Text reminders? **Yes/No**

What is your race**? Native American, African American, Asian, Pacific Islander, White, Mixed Race**

Have you ever smoked? **Yes/No** Quit date: _________________________

How many days a week do you exercise? **0 1 2 3 4 5 6 7**

Do you drink alcohol? Yes or No
If you do drink alcohol, what do you drink and how much? Beer: ______ bottles per day week month Wine: ______ glasses per day week month Liquor: ______ oz per day week month

What are your active medications?

Name of Medication	**Mg**	**How often do you take this medication?**	
1.		1 2 3	Cap Tab Inhaler Cream
2.		1 2 3	Cap Tab Inhaler Cream
3.		1 2 3	Cap Tab Inhaler Cream
4.		1 2 3	Cap Tab Inhaler Cream
5.		1 2 3	Cap Tab Inhaler Cream
6.		1 2 3	Cap Tab Inhaler Cream
7.		1 2 3	Cap Tab Inhaler Cream

Please list current and past medical conditions:	**Please list surgeries:**

Please list all allergies and reactions

Signature: ____ Date: ________________________

Review of Systems

Name: ____ Date: ______________________

Please indicate whether you have had any of the following symptoms in the past year:

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headaches	Y	N

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Loss of Vision	Y	N

Allergic/Immunologic

Hay fever	Y	N
Drug Allergies	Y	N

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N
Paralysis	Y	N

Endocrine

Excessive Thirst	Y	N
Too hot/cold	Y	N
Tired/Sluggish	Y	N

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Diarrhea/Constipation	Y	N
Hemorrhoids	Y	N
Blood in Stool	Y	N

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N
Palpitations	Y	N

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of breath	Y	N

Hematological/Lymphatic

Swollen Glands	Y	N
Blood Clotting Problems	Y	N

Psychological

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N

Other: