Date: _____

CONFIDENTIAL PATIENT INFORMATION

Full Name _____ Nick Name _____

Home Phone _____ Cellular Phone_____

Mailing Address _____

Street Address _____

City _____ State _____ Zip Code _____

Social Security Number _____ Date of Birth _____

Age _____ Marital Status **S M D W** How Many Children? _____

Occupation _____ Employer _____

Business Address _____ Business Phone _____

Nearest Relative (in case of emergency) _____

Address _____ Phone _____

Referred By _____

Primary Care Physician _____

Spouse Information

Name _____ Phone _____

Date of Birth _____ Occupation _____ Employer _____

INSURANCE INFORMATION

Insurance Company _____

Policy Number _____ Group Number _____

Insurance Address _____

Insurance Phone Number _____

Policy Holder's Name _____

Policy Holder's Social Security Number _____

HISTORY AND HEALTH INFORMATION

Have you ever suffered from: (please circle all that apply)

Anemia	*Cancer*	*Headaches*	*Sinus Trouble*	
Arthritis	*Diabetes*	*Heart Trouble*		*Tuberculosis*
Asthma	*Digestive Disorders*	*Nervousness*		
Backaches Dizziness		*Neuritis*		

Purpose of this Appointment _____

Other Doctors seen for this/these condition(s) _____

Have you been treated for any other health condition by a physician in the last year? _____

Describe _____

Medications _____

Remarks and Additional Information _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE!

Name of Person Responsible for Payment _____

Patient's Signature _____ Date: _____

Guardian's Signature _____ Date:_____

Information Taken By _____ Date: _____

PARTIAL ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AND TREATMENT AGREEMENT

Consideration. In order to facilitate the ability of the Office to collect in Charges directly from various Payers and thereby to enhance the patient provider relationship, I the undersigned, as consideration for the Office's services, agree to the following and direct all Payers as follows.

Partial Assignment of the Cause of Action, Assignment of Proceeds, and Contractual Lien. I hereby assign, in so far as permitted by law, all of my rights, remedies, benefits to the office as well as any and all causes of action that I might have now or in the future against any Payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the office's name, and the right to settle or otherwise resolve such causes of action as the office sees fit. I further assign my right to receive any proceeds from any payer to the office and further grant a contractual lien to the office with respect to my charges. I further assign my right to receive any proceeds from any payer to the office and further grant a contractual lien to the office with respect to my charges. I understand that these assignments of rights and contractual lien may effectuate, automatically or otherwise, a secured interest under the applicable uniform commercial code. I intend for this agreement to effectuate such a lien and hereby authorize the office to file the form(s) normally filed with the secretary of state and other governmental agency in order to perfect such lien. Except as provided herein, nothing in this agreement shall be construed as an election or waiver by the office to a secured interest under any other statutory lien law. Consistent with these rights, I hereby direct any and all payers, to pay to proceeds directly and immediately to, and exclusively in the name of, deBarros Chiropractic clinic in the amount of my charges.

Other terms, I understand that I remain personally responsible for my charges. Consistent with law or contract, I agree to pay the full amount of my charges of the office upon its demand. Unless mutually agreed to in writing, the receipt ad processing of partial payments by the Office shall not constitute a waiver of the Office's right to receive payment in full upon demand and shall not constitute an accord and satisfaction of my charges, irrespective of any restrictions indicated on any payments. I understand that at anytime, I can request a copy of my total Charges. I hereby waive any statute of limitations which may apply to the collection of my Charges.

In the event that I retain one or more attorneys to assist me in collecting any proceeds, I direct each attorney to issue an irrevocable letter of protection to the office regarding my charges. I further direct (and deBarros Chiropractic Clinic hereby requests) each attorney to provide immediate notice to the Office regarding any proceeds received by the attorney, to promptly pay the office in full out of such proceeds, and to provide a full accounting of such proceeds to the office.

I authorize and direct the office to submit my charges to any and all payers including, without limit, my health benefit plan. I understand, however, that in the event that my charges are submitted to more than one payer, I hereby authorize and direct the office to apply any proceeds received from one payer to any reductions, write-offs, or discounts, issued by another.

I authorize the office to endorse or sign my name on any and all check listing me as a payee which are received by the office for payment of charges incurred by me, my spouse or my dependents. I further authorize the office to apply any credit balances on my charges to any other outstanding charges still owed by me, my spouse or my dependents, regardless of whether these other charges are related to my condition.

This agreement shall not be modified or revoked without the mutual consent of the office and myself. I hereby revoke the terms of any previously signed documents to the extent those terms of the agreement. This agreement shall be governed under the laws of the state where the office is located, and performable in the county where the office is located. I hereby consent to personal jurisdiction and venue of any court in said county and waive all objection based on improper jurisdiction, venue, or forum non-conveniens.

I agree that each and every provision of the agreement is reasonable necessary for the protection of the rights and interest of the office and myself. However, should any provision of this agreement be found to-be "invalid, illegal and unenforceable, or for any reason cease to be binding on any party hereby, all other portions and provisions of this agreement shall, nevertheless, remain in full force and effect.

Definitions. For the purposes of this Agreement, the following terms shall have the following meaning: "Office shall refer to: deBarros Chiropractic Clinic located at 7020 Cold Harbor Road, Mechanicsville, VA 23111. "Payer" shall refer to, without limit, any insurance carrier, health benefit plan administrator, and fiduciary, health maintenance organization, preferred and independent provider organization, attorney at fault, party, tortsfeasor, individual, and any other entity, which may elect or be obligated to payer disburse Proceeds to me, either now or in the future, for any reason; "proceeds" shall include, without limit the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to payer reimburse, in the proceeds relating to the following benefits, plans, or overages: individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage and malpractice; "Charges" shall include, without limit, the full fees for the offices services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, depositions, and testimony) any collection costs incurred by the office, 18% interest on outstanding charges, and any other charges incurred by me at the office; "collection costs" shall include without limit, any pre and post judgment court costs, filing fees, service or process charges, attorneys fees, and any other costs of collection incurred by the office in any effort or action to collect my charges either from me or any payer.

Patient Name (please print) _____

Patient Signature _____ Date _____
Name of Custodial Parent or Legal Guardian,
On Behalf of the Patient (please print)

Parent/Guardian Signature _____ Date _____

HIPAA Notice of Privacy Practices
deBarros Chiropractic Clinic
7020 Cold Harbor Road
Mechanicsville, VA 23111
804-730-2609

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 or future physical or mental health or condition and related care services.

1. Uses and Disclosures of Protected Health Information

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. This includes the coordination or management of your health care with a third party. 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 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. The 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 at 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: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and 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 or 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 compiles 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 a 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 use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative 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 have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if 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 privacy contact of your complaint. **We will not retaliate against for 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 privacy 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 our Main Phone Number.

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

Print Name: _____
Signature: _____
Date: _____

Protection from Attorney

Certified Return Receipt Number: _____

Patient: _____
Claim Number: _____
Date of Accident: _____
Attorney's Name: _____
Firm: _____
Address: _____
Phone Number: _____
Fax Number: _____

deBarros Chiropractic Clinic, P.C.
7020 Cold Harbor Road
Mechanicsville, VA 23111
Ph: 804-730-2609 Fax: 804/730-6496

Please accept my signature below as authorization and direction to you, my attorney, to DIRECTLY pay then above-listed physician any unpaid balances due from any settlement, judgment, or verdict, for any and all services rendered to me in my care and treatment and efforts to collect remedies, for injuries sustained by me on Date(s): _____

Professional; treatments and services, including those for treatments heretofore and thereafter rendered, as well as for any reports; copying fees; (and any monies /balances due from prepaid depositions, court appearances or standby for court appearance fees) are to be paid DIRECTLY to the physician within three (3) days of receipt by you of settlement or recovery. Bills for services rendered automatically take precedence over any settlement for wages. All monies in dispute will be held in escrow. Any collection attempts, fees and/or costs incurred by the physician will also be covered by this letter of protection.

I agree to promptly notify the above mentioned physician of any change of attorney(s) used by me with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such subtitled or added attorney(s).

I understand that this does not relieve me, the undersigned patient, of my personal responsibility for all such charges in the even of failure to recover.

Upon signature, the undersigned patient and attorney do hereby agree to observe all the above terms and covenants. Furthermore, the attorney agrees to withhold such sums from ay settlements, judgments, verdicts or other sources that may become available to protect the physician's outstanding bill.

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due payable.

I have read and understand the above.
Patient Signature: _____ Date: _____

Attorney Instructions: Please sign, date, notarize and return one copy to this office within five (5) business days of Date: _____
Reply envelope enclosed. Thank you.

Attorney Name (Print): _____ Date: _____
Attorney Signature: _____

Notary Signature: _____ Date: _____
My Commission expires: _____

POWER OF ATTORNEY TO ENDORSE CHECKS

KNOW ALL MEN BY THSES PRESENT: That the undersigned has made, constituted an appointed, and by these presents does hereby make, constitute and appoint the *deBarros Chiropractic Clinic* and any of its duly authorized agents and employees as and to be the undersigned's true and lawful Attorney in Fact for and in the undersigned's name place and stead to **endorse any all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said deBarros Chiropractic Clinic** which checks, drafts or money orders are to pay for chiropractic services or the like which have been made by deBarros Chiropractic Clinic at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

The undersigned by these presents does thus give and grant unto the said *deBarros Chiropractic Clinic* the full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the **endorsing** and **cashing** of said checks are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by *deBarros Chiropractic Clinic* as Attorney In Fact, in accordance with this special power of attorney and shall do or cause to be done by virtue of these presents.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____, 20____.

Insurance Information-Personal Injury Cases

Patient Health Insurance

Do you have health insurance? _____
If yes, name of the company: _____
Mailing Address: _____
Insurance Identification Number: _____
Group Number: _____
Name of the Insured: _____
Insured Social Security Number: _____
Relationship to the Policyholder: _____

Patient Auto Insurance

Do you have Auto Insurance? _____
If yes, Name of the Company: _____
Mailing Address: _____
Policy Number: _____
Claim Number: _____
Have you reported this accident to your auto insurance company? _____
If no, **PLEASE DO SO IMMEDIATLEY**.
If you have turned this accident in, did they assign an adjustor to you? _____
Adjustors Name: _____
Adjustors Phone Number: _____
Is this auto policy in your name? _____
If no, whose name is the policy in? _____
Do you have **MEDPAY** on your policy? _____
If yes, what is the amount? _____

Attorney Information

Is there an attorney representing you in this case? _____
If yes, Name of Attorney: _____
Attorney Phone Number: _____
Attorney Mailing Address:
PLEASE NOTIFY YOUR ATTORNEY THAT YOU ARE BEING TREATED IN THIS OFFICE.

At Fault Auto Insurance

Did the person at fault have auto insurance? _____
Name of Insurance Company: _____
Mailing Address: _____
Policy Number: _____
Claim Number: _____
Adjustors Name: _____
Adjustors Phone Number: _____
Patient Signature: _____ Date: _____

Medical Lien

Patient: _____
Date of Injury: _____
Claim Number: _____

I hereby authorize and direct _____ Insurance Company, to pay David deBarros, D.C. such sums as may be due and owing him for medical/chiropractic services rendered me by reason of this accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor which would otherwise be paid to myself, as the result of the treatment charges incurred for injuries in connection therewith.

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

Please acknowledge your agreement to this request by signing below and return to the doctor's office. I have been advised that if you do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable by me.

Patient Signature: _____ Date: _____

The undersigned insurance company does herby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said doctor above named and make payment payable directly to said doctor.

Insurance Company Representative Signature: _____
Print First and Last Name: _____
Insurance Company Name: _____

Please date, sign and return or fax this copy to doctor's office. Also keep a copy for your records.

deBarros Chiropractic Clinic, P.C.
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