

RESTORATION

C H I R O P R A C T I C

AUTO ACCIDENT

**WELCOME! WE ARE HONORED TO SERVE
YOU!**

Please bring all your completed paperwork along with
the following items to your first appointment:

VAILD DRIVER'S LICENSE
PHOTOS OF INJURY/VEHICLE
POLICE REPORT
YOUR HEALTH INSURANCE CARD
YOUR AUTO INSURANCE CARD

QUESTIONS?

CALL US
972-818-5820

EMAIL US
team@gorestorationtx.com



Restoration Chiropractic
1061 N Coleman St Ste 130
Prosper, TX 75078

ACCIDENT QUESTIONNAIRE

AUTO INSURANCE INFORMATION

****Your car insurance will only release information to you, the policy holder. Please call your car insurance provider to obtain this information.**

Do you have med pay? Yes No

If so, how much? _____

Do you have uninsured motorists insurance?

Yes No

If so, what's the limit? _____

Patient Name: _____

YOUR Insurance Company: _____

YOUR Claim #: _____

Adjuster: _____

His/Her Phone #: _____

ATTORNEY INFORMATION

FIRM: _____

DATE OF INJURY: _____

ATTORNEY: _____

PHONE #: _____

CASE MANAGER: _____

PHONE #: _____

OTHER INSURANCE INFORMATION (TYPICALLY THIS IS THE AT FAULT DRIVER INFORMATION)

INSURANCE COMPANY: _____

CLAIM NUMBER: _____

ADJUSTER: _____

CONTACT NUMBER: _____

COMMENTS: _____

YOUR VEHICLE DAMAGE

On a scale of 1-10, rate the damage to your vehicle:

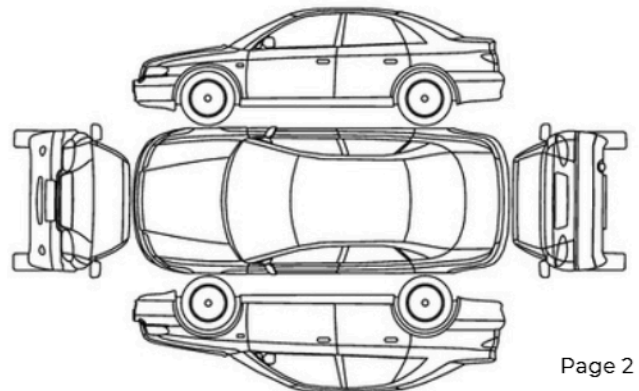
1 2 3 4 5 6 7 8 9 10

Total Cost of Damage: \$ _____

Was the vehicle drivable after the accident?

Yes No

Circle Areas of Damage:



AUTOMOBILE ACCIDENT FORM

PATIENT DEMOGRAPHICS

Last: _____ First: _____ M.I. _____ MALE / FEMALE Date of Birth: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Email: _____ Social Security #: _____

WORK STATUS: FULL TIME PART TIME DISABLED RETIRED UNEMPLOYED

Occupation: _____ Employer: _____

ACCIDENT DETAILS

Please describe the accident in detail: _____

Was anyone else in the car with you? _____ Date of Accident: _____

Time of Accident: _____ am / pm Road conditions at the time of the accident: _____ WET / DRY / OTHER: _____

Were you in a company vehicle? YES / NO Was the accident on the job? YES / NO

Location of the Accident: _____

Were you aware of the approaching collision prior to the impact, or did it catch you by surprise?

AWARE / SURPRISED Did you hit the head rest during the accident? YES / NO

Did you lose consciousness upon impact? YES / NO

Which way was your head pointing at the time of impact? STRAIGHT / LEFT / RIGHT

Which way was your body pointing at the time of impact? STRAIGHT / LEFT / RIGHT

Were you wearing a hat or glasses at the time of impact? NO / HAT / GLASSES / BOTH

If so, were they still on after the accident? YES / NO Other: _____

AFTER ACCIDENT TREATMENT

Did you go to the hospital? YES / NO Which hospital? _____

Did you go to the hospital the same day? YES / NO If no, when? _____

How did you get to the hospital? AMBULANCE / DROVE / OTHER: _____

Did the hospital take imaging? XRAYs / CT SCAN / MRI / NONE

What areas? HEAD / NECK / MID BACK / LOW BACK / OTHER: _____

What did they recommend for follow-up care? _____

Please list any other doctors/treatments you have had for this injury: _____

Please list any previous injuries or trauma: _____

ACCIDENT COMPLAINTS

Rate the symptoms that have started since the accident/injury from 1-10 (1=mild, 10=extreme)

____ Neck pain	____ Arm Pain	L or R	____ Numbness in arms	____ Loss of smell
____ Mid back pain	____ Shoulder pain	L or R	____ Numbness in legs	____ Loss of taste
____ Low back pain	____ Leg pain	L or R	____ Numbness in hands	____ Loss of hearing
____ Chest pain	____ Knee pain	L or R	____ Numbness in feet	____ Loss of vision
____ Abdominal pain	____ Hip pain	L or R	____ Irritability	____ Fatigue
____ Headaches/ Migraines	____ Wrist pain	L or R	____ Depression	____ Trouble sleeping
____ Fainting	____ Ankle pain	L or R	____ Anxiety	____ Shortness of breath
	____ Elbow pain	L or R		

1st COMPLAINT DESCRIBE THIS ONE COMPLAINT ONLY

Body Part: _____ Date symptom first appeared: _____

How often do you experience this symptom? CONSTANT / FREQUENT / INTERMITTENT / OCCASIONAL

What makes the symptom feel worse? _____

What makes the symptom feel better? _____

Type of pain? ACHING / THROBBING / STABBING / BURNING / NUMBING / DULL / SHARP

On a scale of 1-10, rate the intensity of this symptom (1=mild, 10=extreme):

1 2 3 4 5 6 7 8 9 10

Where does the pain radiate to? _____

BEFORE THE ACCIDENT

Have you ever had this complaint before? YES / NO If yes, when? _____

On a scale of 1-10, rate the intensity of this symptom before the accident (1=mild, 10=extreme):

1 2 3 4 5 6 7 8 9 10

Where did the pain radiate to? _____

What was the condition affecting you from doing? (Work, sports, home, etc.) _____

2nd COMPLAINT DESCRIBE THIS ONE COMPLAINT ONLY

Body Part: _____ Date symptom first appeared: _____

How often do you experience this symptom? CONSTANT / FREQUENT / INTERMITTENT / OCCASIONAL

What makes the symptom feel worse? _____

What makes the symptom feel better? _____

Type of pain? ACHING / THROBBING / STABBING / BURNING / NUMBING / DULL / SHARP

On a scale of 1-10, rate the intensity of this symptom (1=mild, 10=extreme):

1 2 3 4 5 6 7 8 9 10

Where does the pain radiate to? _____

BEFORE THE ACCIDENT

Have you ever had this complaint before? YES / NO If yes, when? _____

On a scale of 1-10, rate the intensity of this symptom before the accident (1=mild, 10=extreme):

1 2 3 4 5 6 7 8 9 10

Where did the pain radiate to? _____

What was the condition affecting you from doing? (Work, sports, home, etc.) _____

3rd COMPLAINT DESCRIBE THIS ONE COMPLAINT ONLY

Body Part: _____ Date symptom first appeared: _____

How often do you experience this symptom? CONSTANT / FREQUENT / INTERMITTENT / OCCASIONAL

What makes the symptom feel worse? _____

What makes the symptom feel better? _____

Type of pain? ACHING / THROBBING / STABBING / BURNING / NUMBING / DULL / SHARP

On a scale of 1-10, rate the intensity of this symptom (1=mild, 10=extreme):

1 2 3 4 5 6 7 8 9 10

Where does the pain radiate to? _____

BEFORE THE ACCIDENT

Have you ever had this complaint before? YES / NO If yes, when? _____

On a scale of 1-10, rate the intensity of this symptom before the accident (1=mild, 10=extreme):

1 2 3 4 5 6 7 8 9 10

Where did the pain radiate to? _____

What was the condition affecting you from doing? (Work, sports, home, etc.) _____

4th COMPLAINT DESCRIBE THIS ONE COMPLAINT ONLY

Body Part: _____ Date symptom first appeared: _____

How often do you experience this symptom? CONSTANT / FREQUENT / INTERMITTENT / OCCASIONAL

What makes the symptom feel worse? _____

What makes the symptom feel better? _____

Type of pain? ACHING / THROBBING / STABBING / BURNING / NUMBING / DULL / SHARP

On a scale of 1-10, rate the intensity of this symptom (1=mild, 10=extreme):

1 2 3 4 5 6 7 8 9 10

Where does the pain radiate to? _____

BEFORE THE ACCIDENT

Have you ever had this complaint before? YES / NO If yes, when? _____

On a scale of 1-10, rate the intensity of this symptom before the accident (1=mild, 10=extreme):

1 2 3 4 5 6 7 8 9 10

Where did the pain radiate to? _____

What was the condition affecting you from doing? (Work, sports, home, etc.) _____

At the time of the accident, did you experience any of the following?:

- Confusion Disorientaion Lightheadedness Dizziness
 Nausea Blurred Vision Loss of Balance Ringing in Ears

Do you have any of those symptoms now? YES / NO If yes, which ones? _____

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT NAME: _____

Please list your allergies: NONE (please check if no known allergies)

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Please list any surgeries you have had: NONE (please check if no prior surgeries)

Date _____ Type _____

Date _____ Type _____

Date _____ Type _____

Date _____ Type _____

Please list any medical conditions you currently have: NONE (please check if none)

List any medication you are currently taking: _____

SOCIAL HISTORY

EXERCISE: DAILY WEEKLY MONTHLY RARELY NEVER

CHILDREN: YES / NO If so, how many? _____

DO YOU SMOKE? YES / NO If so, how many packs per day? _____ For how many years? _____

OTHER NICOTINE PRODUCTS? YES / NO If yes, which? _____

DRINK ALCOHOL? DAILY 1-2 WEEK 1-2 MONTH 1-2 YEAR NEVER

LIFESTYLE (Hobbies, recreational activities, etc.) _____

FAMILY HISTORY

If yes, please specify which family member on the line provided)

ARTHRITIS? YES / NO _____

BLOOD CLOTS? / EXCESSIVE BLEEDING? YES / NO _____

HYPERTENSION? YES / NO _____

DIABETES? YES / NO _____

CANCER? YES / NO _____

MENTAL HEALTH DISORDERS? YES / NO _____

CARDIAC DISORDERS? YES / NO _____

PATIENT SIGNATURE: _____ DATE: _____

ACTIVITIES OF LIFE

Please rate how each activity affects you. Write "N/A" for any activity not applicable to you.

PERSONAL HYGIENE & DAILY CARE					
ACTIVITY	No effect	Painful (can do)	Painful (limits)	Unable to perform	ADDITIONAL NOTES
Bathing/Showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grooming Hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brushing Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Using the Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing Upper Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing Lower Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DAILY PHYSICAL ACTIVITIES					
ACTIVITY	No effect	Painful (can do)	Painful (limits)	Unable to perform	ADDITIONAL NOTES
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reaching Overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Turning Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Turning Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lying to Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting to Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Standing to Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FUNCTIONAL ACTIVITIES					
ACTIVITY	No effect	Painful (can do)	Painful (limits)	Unable to perform	ADDITIONAL NOTES
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Up & Down Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
In & Out of Car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Focusing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Preparing Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Household Chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SOCIAL, RECREATIONAL, & OTHER ACTIVITIES					
ACTIVITY	No effect	Painful (can do)	Painful (limits)	Unable to perform	ADDITIONAL NOTES
Competitive Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Running / Jogging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hiking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other Rec. Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hobbies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PATIENT SIGNATURE: _____ DATE: _____

QUADRUPLE VISUAL ANALOGUE SCALE

PLEASE READ CAREFULLY

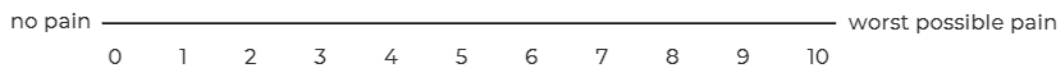
Instructions: Please check the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

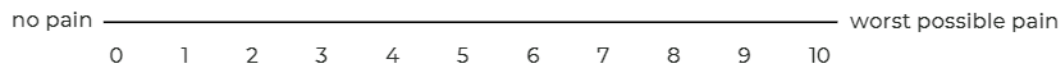
EXAMPLE:



HOW WOULD YOU DESCRIBE YOUR PAIN RIGHT NOW?

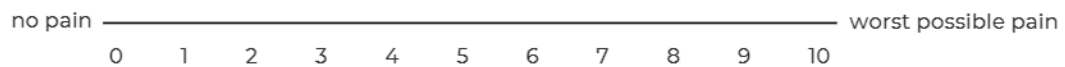


WHAT IS YOUR AVERAGE OR TYPICAL PAIN?



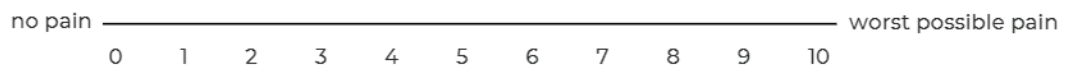
WHAT IS YOUR PAIN LEVEL AT ITS BEST?

(HOW CLOSE TO 0 DOES YOUR PAIN GET AT YOUR BEST?)



WHAT IS YOUR PAIN LEVEL AT ITS WORST?

(HOW CLOSE TO 10 DOES YOUR PAIN GET AT YOUR WORST?)



PATIENT SIGNATURE: _____ DATE: _____

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Jacob Schumann, D.C. and Daniel Noble, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print Name: _____

Signature: _____ Date: _____

If This Health Profile Is For A Minor/Child, Please Fill Out And Sign Below Written Consent For A Child

Name of practice member who is a minor/child: _____

I authorize Dr. Jacob Schumann, Dr. Daniel Noble, and all Restoration Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Restoration Chiropractic.

Guardian Signature _____

Relationship to Minor/Child _____ Date: _____

Terms of Acceptance

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.

C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by Doctors of Chiropractic in the United States alone.

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.

E. Chiropractic does not seek to replace or compete with your medical, dental, or other types of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic care.

G. We invite you to speak frankly to the doctor on any matter related to your health care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Signature: _____

Date: _____

Notice of Privacy Practices Acknowledgement

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

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

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: _____

Date: _____

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information:

I authorize the release of information including the diagnosis, records; examination rendered to me, appointment times, and claims information. This information may be released to:

- Spouse
- Child(ren)
- Other _____
- Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages:

Please call my home my work my mobile number:

If unable to reach me(please select all that apply):

- you may leave a detailed message
- you may leave a message asking me to return your call
- you may send information regarding my treatment via text message
- Other: _____

The best time to reach me is (day)_____ between (time) _____

Signature: _____

Date: _____

Witness: _____

Date: _____

RESTORATION

C H I R O P R A C T I C

NOTICE OF DOCTORS LIEN

Dr. Jacob Schumann & Dr. Daniel Noble

1061 North Coleman St Ste 130

Prosper, TX 75078

972-818-5820

Patient: _____ Date of Accident: _____

I do hereby authorize Dr. Jacob Schumann and Dr. Daniel Noble to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my 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 doctors for all medical bills submitted by him for service 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 eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

I acknowledge that Restoration Chiropractic LLC is not required to permit me the option to postpone or make payments toward of services rendered, and that it is being done solely as a courtesy. As such, Restoration Chiropractic may, at any time, seek payment for any and all amounts owed by me while this lien is in force. Additionally, if my attorney fails to acknowledge this lien in favor of Restoration Chiropractic LLC, the entire balance related to this personal injury treatment is my sole responsibility, and Restoration Chiropractic LLC may demand payment immediately.

Please acknowledge this letter by signing below and returning to the doctor's office. 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 and may declare the entire balance due and payable.

Patient Signature: _____

Date: _____

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 and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

Attorney Signature _____

Date: _____

Assignment of Benefits Form
DIRECTION TO PAY: Restoration Chiropractic LLC

MAIL PAYMENT TO:

RESTORATION CHIROPRACTIC LLC
1061 North Coleman St Ste 130
Prosper, TX 75078

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICE RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Known by all these present that: the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint RESTORATION CHIROPRACTIC LLC and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and RESTORATION CHIROPRACTIC LLC which checks, drafts or money orders are made payable for services which have been made RESTORATION CHIROPRACTIC LLC at the request of with the knowledge and approval of the undersigned and/or maker of the check, draft or money order.

This assignment includes but is not limited to, all rights to collect benefits directly from my insurance company for services that I have received and all rights to proceed against my insurance company in any action including legal suit if for any reason my insurance company fails to make payments of benefits due to my assignee or me. This assignment also includes any rights to recover attorney's fees and costs for such action brought by the provider as my assignee.

The undersigned by these presents does give and grant RESTORATION CHIROPRACTIC LLC as attorney the full power and authority to do and perform all and every act 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 check and concerned as well as any other document.

A photocopy of this document shall be as binding as an original signature page. The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do cause to be done by virtue of these

Assignment of Benefits

I, _____, hereby authorize _____
(name of insured) (name of insurance company)
to pay to and mail directly RESTORATION CHIROPRACTIC LLC the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby irrevocably assign to RESTORATION CHIROPRACTIC LLC and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Texas Statutes for any services and charges provided by RESTORATION CHIROPRACTIC LLC.

PATIENT'S SIGNATURE

PATIENT'S NAME

DATE

RESTORATION

C H I R O P R A C T I C

Dr. Jacob Schumann & Dr. Daniel Noble

1061 North Coleman St Ste 130

Prosper, TX 75078

972-818-5820

To: _____

Date: _____

From: Restoration Chiropractic LLC

Please forward to the address above:

X-rays and Reports

Medical Reports

I, _____, authorize any doctor, hospital, employer, or other person whom a signed copy or a photocopy of this authorization is delivered, to furnish any information, reports or copies of records which may be requested by Restoration Chiropractic.

Date of Birth: _____

Patient Signature: _____

Date: _____

This form is to remain in effect until terminated by me in writing.

Restoration Rep.: _____

Date: _____

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide digital copies of your x-rays via email to the email address on file. Digital x-rays will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctors of Restoration Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

FEMALES ONLY: To the best of my knowledge, I **BELIEVE I AM NOT PREGNANT** at the time the x-rays are taken at Restoration Chiropractic.

Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE ● DO NOT WRITE BELOW THIS LINE ● DO NOT WRITE BELOW THIS LINE

Cervicals (cm)	Thoracics (cm)	Lumbar (cm)
Lateral Cervical:	Lateral Thoracic:	Lateral Lumbar:
AP Cervical:	AP Thoracic:	AP Lumbar:
APOM:		
Flexion / Extension:		
Obliques:		