WELLISTICS CONDITIONING CENTER

PATIENT APPLICATION - INJURY

Name/Nombre:	**Date**/Fecha:		
Home Address/Dirección de casa:	City/Ciudad	St/Est	Zip
Birthdate/Fecha de Nacimiento:	**Phone#**/Teléfono:		
Social Security/ # del seguro social:	**Age**/Edad:		
Driver's License/Licencia:			
Emergency Contact Name & Phone Number:			
Relation to Emergency Contact:			

AUTO ACCIDENT/ACCIDENTE DEL AUTOMÓVIL

Date of Accident/Fecha del Accidente	**Time**/Tiempo	am/pm
Insurance Co./Seguro del Compañía		
Adjuster Name/Nombre del Ajustador	**Phone#**/Telefono	
Policy #/Póliza de Seguro:	**Claim#**/ # del Reclamo	
Attorney/Abogado	**Attorney Ph#**/Telefono De Abogado	

WORK INJURY/TRABAJO (**WORKER'S COMP**/ PARA COMPENSACION DE TRABAJADORES)

Date of Injury/Fecha del Accidente:	**Time**/Tiempo:	am/pm:
Employer/Empleador:	**Occupation**/Ocupación:	
Work Address/Dirección de trabajo:	**Phone#**/Telefono	
Insurance Co./Seguro del Compañía:		
Adjuster Name/Nombre del Ajustador :		
Adjuster Phone#/Telefono De Ajustador:	**Claim#**/ # del Reclamo:	
Billing Address:		
Attorney/Abogado:	**Attorney Ph#**/Telefono De Abogado:	

HEALTH INSURANCE /INFORMACION DEL SEGURO

Insurance Co./Seguro del Compañía:	**Phone#**/Telefono
Insurance Address/Dirección de Seguro:	
Billing Address:	
Policy #/Póliza de Seguro:	**Group #**/ # de Grupo:
Insured Name/Nombre del Suscriptor:	**Insured DOB**/Fecha de Nacimiento:
Social Security/# del seguro social:	**Relation to Patient**/Relación al Paciente

If a minor, name and address of person responsible for care/**Si un menor**, el nombre y la dirección de persona responsable del cuidado:

_____

I give permission for this minor to be seen at this office/Doy el permiso para este menor a ser visto en esta oficina.

Signature/Firma:_____ Date: _____

WELLISTICS CONDITIONING CENTER .

PATIENT HISTORY

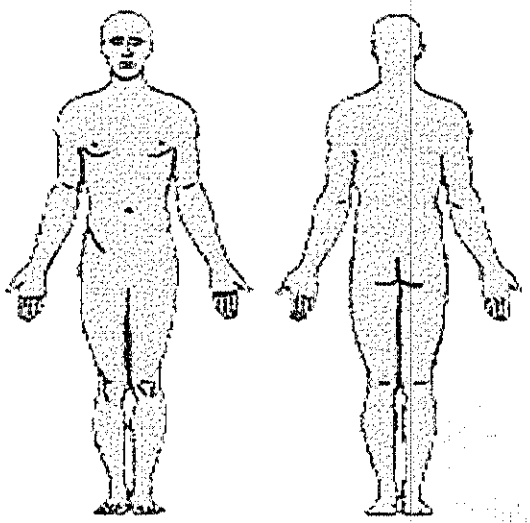
A. REASON FOR THIS VISIT / MOTIVO DE SU VISITA:

☐ Workers Comp/Compensación deTrabajadores ☐ Auto Accident/Accidente del Auto ☐ Other/Otro

B. SYMPTOMS/SINTOMAS:

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

Sombree las areas donde siente dolor o sensación anormal (Marque todas las que apliquen)



____ Neck/Cuello	____Between Shoulders/Entre hombros	
____ Low Back/Espalda Bajo	____Headaches/ Dolor de Cabeza	
____ Stomach/Estomago	____Chest/Pecho	
____ Shoulder/Hombro ⇨	____R/Derecho	____ L/Izquierda
____ Arm/Brazo ⇨	____R/Derecho	____ L/Izquierda
____ Elbow/Codo ⇨	____R/Derecho	____ L/Izquierda
____ Wrist/Muñeca ⇨	____R/Derecho	____ L/Izquierda
____ Hand/Mano ⇨	____R/Derecho	____ L/Izquierda
____ Finger/Dedos de Mano ⇨	____R/Derecho	____ L/Izquierda
____ Hip/Cadera ⇨	____R/Derecho	____ L/Izquierda
____ Leg/Pierna ⇨	____R/Derecho	____ L/Izquierda
____ Knee/Rodilla ⇨	____R/Derecho	____ L/Izquierda
____ Ankle/Tobillo ⇨	____R/Derecho	____ L/Izquierda
____ Foot/Pie ⇨	____R/Derecho	____ L/Izquierda
____ Toes/Dedos de Pie ⇨	____R/Derecho	____ L/Izquierda

____ weakness/debilidad	____ poor balance/equilibrio pobre	____ parlysis/paralisis	____ colds/gripa
____ insomnia/insomnio	____ dizziness/mareo	____ nausea/náusea	____ vomiting/vomito
____ Depression/Depresión	____ poor appetite/apetito pobre	____ bowel problems/problemas de intestino	
____ Coldness/Tienes Frio	____ visual difficulty/dificultad visual	____ shortness of breath/falta de aliento	
____ hearing problems/ problemas auditivos		____ ringing in ears/zumbido en oidos	
____ Difficulty swallowing/dificultad al digerir		____ urinary problems/problemas urinarios	
____ increased sweating/Sudor excesivo		Other/Otro: _____	

C. AUTO INJURY / LESIONES DEL ACCIDENTE DE AUTO:

Fill out this section if the injury occurred from an auto accident. **IF NOT,** skip to section D.

Llene la siguiente sección si su lesion ocurrió por un accidente de auto. **SI NO**, salte a la sección D.

1. **DRIVER, were your hands on the steering wheel?** / ***CONDUCTOR***, Tenia las manos en el volante?
   ☐ Left / *Izquierda* ☐ Right / *Derecha* ☐ Both / *Ambas*
2. **Where were you seated in the vehicle?** / Dónde estuvo sentado en el vehículo?
   Driver/Chofer [ ] Front passenger/Pasajero anterior [ ] Pedestrian/Peatón [ ]
   Rear Passenger/ Sentado atras ⇨ R/Derecho [ ] L/Izquierda [ ] Middle/Centro [ ]

IF YOU WERE A PEDESTRIAN SKIP TO #17 / SI USTED ERA UN PEATÓN VAYA A LA PREGUNTA #17

3. **What types of other vehicles were involved?** /¿Qué otro tipos de vehículos estuvieron implicados?
   _____
4. **What kind of vehicle were you in?**¿En qué tipo de vehículo estaba usted? _____

5. **Did you have your seatbelt on?** ¿Tenia puesto el cinturón de seguridad? ☐ YES / *SI* ☐ NO

6. **What side was your vehicle struck from?** ¿De qué lado se golpeó su automóvil?
   Behind/Atrás [ ] Front/Frente [ ]
   Passenger side/Lado Del pasajero [ ] Driver side/Lado Del chofer [ ]
7. **Did your auto strike the other auto?** ¿Su auto golpeó el otro auto? ☐ YES / *SI* ☐ NO
8. **Did the other auto strike your auto?** ¿El otro auto golpeó su auto? ☐ YES / *SI* ☐ NO
9. **Did you have your head turned during the time of the collision?** ☐ YES / *SI* ☐ NO
   ¿Tenia la cabeza volteada en el momento del choque?
10. **Did you brace for impact?** ¿Se reforzo para el impacto? ☐ YES / *SI* ☐ NO
11. **Did you head hit or go over the headrest?** /¿Se golpeó la cabeza o fue por encima el cabezal?
    On Headrest/Cabezal Directo [ ] Over Headrest/Por Encima el Cabezal [ ] No/No [ ]
12. **How did your body move around in the vehicle?** ¿Cómo circuló su cuerpo en el automóvil?
    left side/lado izquierda [ ] right side/lado derecho [ ] forward/adelante [ ]
    Backwards/atrás [ ] unsure, it happened so fast/No estoy seguro, fue muy rápido [ ]
13. **Did you hit your head or other part of your body against anything inside the vehicle?**
    ¿Golpeó la cabeza o cualquier otra parte de su cuerpo contra algo dentro de su vehículo?
    ☐ YES / *SI* ☐ NO Where? ¿Donde? _____
14. **Did your airbag deploy?**¿Se abrio la bolsa de aire? ☐ YES / *SI* ☐ NO
15. **Was your vehicle drivable after the accident?** ☐ YES / *SI* ☐ NO
    ¿El auto estaba en condicion de ser manejado después del accidente?
16. **Did you lose consciousness?**¿Perdió el conocimiento? ☐ YES / *SI* ☐ NO
    For how long?¿Por cuanto tiempo? _____
17. **Did you have immediate pain?**¿Tuvo usted dolor inmediato? ☐ YES / *SI* ☐ NO
18. **Injuries from accident (cuts, bruises, etc.)**/Liste lesiones ocurridas en el accidente (cortes, fracturas, etc):
    _____
19. **Did the police come to the scene?**/¿La policía llego a la escena? ☐ YES / *SI* ☐ NO
20. **Did an ambulance come to the scene?**/¿Llego una ambulancia? ☐ YES / *SI* ☐ NO
    Did they take you to an Emergency Room? ¿Lo llevaron a Emergencia? ☐ YES / *SI* ☐ NO
21. **Did you go to the emergency room?**¿Fue a Emergencia por si mismo? ☐ YES / *SI* ☐ NO
    Name of Hospital/Nombre del Hospital: _____
22. **Did you go the same day of the accident?**¿Fue el mismo día del accidente? ☐ YES / *SI* ☐ NO
    If not, what day?/¿Si no, qué día? ___/___/___
23. **Was this car accident a work related injury?** ☐ YES / *SI* ☐ NO
    ¿Este accidente de auto esta relacionado con su trabajo? _____
24. **Did you go to any doctor for this injury before coming to this clinic?** ☐ YES / *SI* ☐ NO
    ¿Fue usted a otro doctor para examinar su lesion antes de visitar esta clinica?

Name of Clinic /Nombre	**Specialty**/Especialidad	**Date**/Fecha
_____	_____	___/___/___
_____	_____	___/___/___

25. **What type of exams did the doctor do?**/¿Qué tipo de exámenes realizo el doctor?
    [ ] X-rays/Radiografía *Area _____ [ ] MRI/Resonancia Magnetica *Area _____
    [ ]EMG/EMG *Area _____ [ ] CatScan/Tomografía *Area _____
    [ ]Other/Otro: _____
26. **What treatment did the doctor do?** ¿Qué tratamientos ha recibido para su dolor?
    Prescription/receta medica [ ] Stitches/puntadas [ ] Brace/Fajas, soportes [ ]
    Splint/tablilla [ ] Surgery/cirugia [ ] Crutches/muletas [ ]
    Psychotherapy/Psicoterapia [ ] Bedrest/descanso [ ] Chiropractic/Quiropráctica [ ]
    Other /otro: _____
27. **What treatment helped?** ¿Qué tratamiento lo ayudó? _____
28. **What was the diagnosis?** ¿Cual fue el diagnostico? _____
29. **What was recommended?** ¿Qué se le recomendó? _____

Did you go back?/¿Volvió a otra visita? ☐ YES / *SI* ☐ NO **How many times?**/¿Cuántas? _____

D. WORK RELATED INCIDENT / ACCIDENTE RELACIONADO AL TRABAJO

1. **Are you currently working?** ¿Estás trabajando actualmente? ☐ YES / *SI* ☐ NO
   ☐ Part-time / Medio tiempo ☐ Full-time / Tiempo completo
   ☐ Unemployed / Desempleado ☐ Unemployed due to injuries / Desempleado debido a lesions
2. **Did you get a note for light duty or to stay off work?** ☐ YES / *SI* ☐ NO
   ¿Obtuvo una nota para limitarse a trabajos ligeros o para no trabajar?
3. **How many days/hours did you lose from work due to injuries?**
   Cuantas horas/dias perdio debido a sus lesiones? _____
4. **Please describe type of work** / Por favor, describa su tipo de trabajo:
   ☐ Office, Clerical / Oficina ☐ Light Labor / Labor ligera ☐ Medium Labor /Labor moderada
   ☐ Heavy Labor / Labor pesada ☐ Other / *Otro*: _____
5. **Does your job involve strenuous activities that increase your pain?**
   ¿Su trabajo implica actividades arduas que puedan incrementen su dolor? ☐ YES / *SI* ☐ NO
   If "YES", check all strenuous activities that apply / Si respondio "SI", marque las que aplican.

Lifting/Levantar cosas pesadas	[ ]	Pushing/Empujar	[ ]	Walking/Caminar	[ ]
Bending /Agacharse	[ ]	Twisting/Torcer	[ ]	Kneeling/Arrodillarse	[ ]
Reaching /Estirarse	[ ]	Other/ Otro: _____			

E. SOCIAL HISTORY / HISTORIAL SOCIAL:

1. **Do you drink?** /¿Toma bebidas alcoholicas? ☐ YES / *SI* ☐ NO
   How many glasses a week?/¿Cuantas copas/vasos por semana? _____
2. **Do you Smoke?**/¿Fuma cigarros, cigarrillos? ☐ YES / *SI* ☐ NO
   How many packs a day?/¿Cuantos paquetes diarios? _____

F. GYNECOLOGICAL HISTORY / HISTORIA GINECOLOGICA

***For Female Patients Only / *Solo para pacientes mujeres*:**
Date of Last Menstrual Period / Dia de su ultimo periodo menstrual ___/___/____
Difficulties with Cycle / Problemas con su ciclo: _____
Number of pregnancies/Número de embarazos _____ # of children/# de niños _____
Problems / Problemas: _____

G. PREVIOUS HEALTH HISTORY/HISTORIAL PREVIO DE SALUD

1. **Have you gone to a chiropractor before?**/¿Ha ido a un quiropráctico antes? ☐ YES / *SI* ☐ NO
   When was your last adjustment?/¿Cuándo era su último ajuste? ___/___/____
2. **Please list all medications you are currently taking - *include over the counter medicine.***
   *Liste las medicinas que esta tomando actualmente. *Incluya las que no necesitan de receta medica.*

Name/Nombre	**Dose**/Dosis	**How Often**/Cuantas al Dia
_____	_____	_____
_____	_____	_____

3. **Have you ever had the following?** / ¿Ha tenido el siguiente?

[ ] Allergy/alergias	[ ] Arthritis/artritis	[ ] Hypertension/hipertensión
[ ] Diabetes/diabetes	[ ] TB/tuberculosis	[ ] Asthma/asma
[ ] Headache/dolores de cabeza	[ ] Cancer/Cancer	[ ] fainting/desmayos

[ ] kidney disease/enfermedad del riñon [ ] heart disease/enfermedad del corazón
[ ] bladder problems/problemas de la vejiga [ ] Thyroid disorder/desórdenes de la tiroides
[ ] Other / Otro: _____

FAMILY HEALTH HISTORY

Age of: Mother_____
Father _____

HISTORIAL FAMILIAR

Edad de: Madre _____
Padre_____

Has anyone in the family ever had any of the following?
¿Alguien en la familia sufrio de alguna de las siguientes condiciones?

[ ] Diabetes/diabetes	[ ] Hypertension/hipertensión
[ ] Ulcers/úlceras	[ ] TB/tuberculosis
[ ] Arthritis/arthritis	[ ] Kidney disease/enfermedad de riñon
[ ] Seizures/ataquees	[ ] Asthma/asma
[ ] Allergy/alergias	[ ] Cancer/Cancer

H. SURGICAL HISTORY / HISTORIAL QUIRURGICO:

1. **Describe all surgeries you have had** / Describa todas las cirugias que haya tenido

TYPE OF SURGERY / TIPO DE CIRUGIA	**DATE** / FECHA
_____	____/____/____
_____	____/____/____
_____	____/____/____

I. TRAUMA

1. **Describe trauma you had in the past (auto accidents, falls, sports injuries, etc), & care received:** Describa cualquier trauma que haya sufrido en su vida (accidentes de auto, caídas, etc) & el tipo de cuidado: _____
   _____
2. **Have you ever broken a bone?**/¿Alguna vez se ha roto un hueso? ☐ YES / *SI* ☐ NO
   What area? / ¿En que area?: _____
3. **At what time of the day do you feel your best?**/¿A qué hora del día usted se siente su mejor?
   _____
4. **At what time of the day do you feel your worst?**/¿A qué hora del día usted se siente su peor?
   _____
5. **Are you involved in any kind of counseling or self-improvement program?**
   ¿Asiste a alguna clase de consejeria o programa de auto-mejora? ☐ YES / *SI* ☐ NO
6. **Do you suffer from any unexplained attacks of anxiety, fatigue, or depression?**
   ¿Padece de algún ataque inexplicable de la ansiedad, de la fatiga, o de la depresión?
   ☐ YES / *SI* ☐ NO
   Explain/Explique: _____
7. **Are you under any unusual stress right now? (friends, work, home, changes in life, etc)?**
   ¿Esta bajo stress en este momento (amigos, trabajo, casa, cambios en la vida, etc.)?
   ☐ YES / *SI* ☐ NO
   Explain/Explique: _____

I hereby certify that my statements are true and complete to the best of my knowledge.
Yo por la presente certifico que la validez de mis declaraciones al mejor de mi conocimiento.

_____ ____/____/____

PATIENT'S SIGNATURE (PARENT OR GUARDIAN IF PATIENT IS A MINOR) **DATE / FECHA**
FIRMA DEL PACIENTE (PADRE O APODERADO SI EL PACIENTE ES UN MENOR)

WELLISTICS CONDITIONING CENTER.
AUTHORIZATION & CONSENT FOR CARE

I, the undersigned, hereby authorize **Wellistics Conditioning Center**, to administer treatments ordered by my physician, the doctor of chiropractic and/or other licensed 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.

Wellistics Conditioning Center 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 **Wellistics Conditioning Center** for any & all services rendered.

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

I grant **Wellistics Conditioning Center** exclusive and irrevocable rights to coordinate benefits with other insurance coverage, and to collect from other parties for expense reimbursement if my injury or illness was caused by, or is reimbursable by that party.

I understand that **Wellistics Conditioning Center** 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, Guardians name (Please Print): _____

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

Date: _____

WELLISTICS CONDITIONING CENTER.

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 PHI 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 diagnosis 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 to 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/disclosure 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 PHI 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 may 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 of spreading it.

Health Oversight: We may disclose PHI to a health oversight agency authorized by law, i.e. audits, investigators, 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.

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 practice's 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 be disclosed to those involved in your care. Requests must be written, signed, dated & state restrictions requested, and to whom you want restrictions to apply. We are not required to agree to all requests. 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. Examples are: "Do not use my PHI for the education of students." Or "Do not send communications to my home." Ask staff for a copy; it will serve as your receipt.

To request confidential communications: We may honor realistic requests. We may request payment, an 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 requests; 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. 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 agreed to accept this notice electronically.

Complaints: You may file a complaint by notifying our Privacy officer, 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.

WELLISTICS CONDITIONING CENTER.

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, Wellistics Conditioning Center., 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, and
- A tool for clinic operations, i.e. assessing quality & competence of medical professionals.

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, and
- The right to restrict how my records are used or disclosed to carry out treatment, payment or health care operations.

I understand Wellistics Conditioning Center. 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 Wellistics Conditioning Center. reserves the right to alter notice and practices prior to completion, in accord with Section 164.520 of the Code of Federal Regulations. If Wellistics Conditioning Center. 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's 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.

WELLISTICS CONDITIONING CENTER.

IRREVOCABLE ASSIGNMENT OF PROCEEDS AND CONVEYANCE LIEN INTEREST

(Not a Statutory Lien)

Re: Medical Reports and Lien for _____.

I hereby authorize_____, my doctor and Wellistics Physical Therapy Center., (hereafter "the treating facility"), to furnish my attorney and/or insurance carrier, with reports of any examination, treatment, prognosis, (including notes, 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 Interest and Assignment of Proceeds in favor of the above named doctor and/or the doctor's designated treating facility. This Irrevocable Lien Interest 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").
- The Insurance Carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on account to the above named doctor and treating facility, as evidenced by medical bills submitted by the doctor and/or treating facility, shall be paid directly to the above named doctor and treating facility by the insurance carrier out of settlement proceeds to which I am entitled, or withheld from any settlement or award which I shall be entitled and be paid directly to the above named doctor and/or facility.
- As consideration for my execution of this Irrevocable Lien Interest 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 consideration for forbearance of his legal right to require payment by me at the time such services were rendered, said doctor and treating facility relied upon my express declaration and intention to execute and instruct that this Irrevocable Lien Interest 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 _____

WELLISTICS CONDITIONING CENTER.

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 Wellistics Conditioning Center., 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 any way staged for the purpose of filing a fraudulent claim.

- By my signature below, I acknowledge nobody 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: Wellistics Conditioning Center. 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 Wellistics Conditioning Center., 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 costs, attorney fees and any other legally compensable amounts owed. I agree to assist, 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 Wellistics Conditioning Center., 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. For attorney fees, penalties, court costs and interests from judgment upon violation. I further instruct you to make such payment via draft or check to be sent to Wellistics Conditioning Center., 714 Phosphor Ave. Metairie, LA 70005.

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 costs. I understand that you are not required to exhaust remedies against a third party before requiring me to pay.

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 costs if incurred.

A photocopy of this document shall serve as the original.

_____ _____

Signature of Patient or Responsible Party Date

_____

Relationship of Signatory to Patient

WELLISTICS CONDITIONING CENTER
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 Report(s)_____ Film(s)_____
Medical Records_____ Other_____
Medical Reports_____

To be released to: Wellistics Conditioning Center.
Address: 714 Phosphor Ave Metairie, LA 70005
Phone: (504) 224-8400 Fax: (504) 272-0237

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 released within 15 business days of receipt of this notice.