

Dr. William M. Lawson, DC
9701 Brodie Lane, Ste. 202
Austin, Texas 78748
512.326.2520 Phone
www.lawson-chiropractic.com

PATIENT INFORMATION

Patient Name _____ Social Security Number _____ Date _____
Address _____ City _____ State _____ Zip _____
Email _____ Home Phone _____ Cell Phone _____
Birth Date _____ Age _____ Sex _____ M _____ F
 Minor Single Married Partnered Separated Divorced Widowed
Occupation _____ Employer/School _____ Employer Phone Number _____
Employer Address _____ City _____ State _____ Zip _____
Emergency Contact Name _____ Relationship _____
Home Phone _____ Cell Phone _____ Work Phone _____
Whom may we thank for referring you? _____ OR _____ Insurance Co. _____ Website _____ Other _____

INSURANCE INFORMATION

Insurance Company _____ Insurance Phone Number _____
Group Number _____ ID Number _____ Is patient covered by additional insurance? Yes No
Subscribers Name _____ Birth date _____ Social Security Number _____
Relationship to Patient _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date of Injury _____
Type of Accident? Auto Work Other Attorney Name (if applicable) _____

PRESENT COMPLAINT

Reason for Visit _____
When did your symptoms appear? _____
What makes it worse? _____ What makes it better? _____
Have you had similar symptoms in the past? Yes No When? _____
What treatment have you received for your current condition? Surgery Physical Therapy Chiropractic Care
 Medication(s) X-rays Other None Diagnostics Performed _____
Name and address of other doctor(s) who have treated you for this condition.
Name _____ Address _____
Name _____ Address _____

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HEALTH HISTORY

Check the following that you have had:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Alcohol/drug addiction | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Blood transfusions |
| <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Colitis | <input type="checkbox"/> Collagen vascular disease | <input type="checkbox"/> Depression/ anxiety |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Disease/ Attacks | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> HIV/ AIDS |
| <input type="checkbox"/> Joint/ back pain | <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Liver disease/problems |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Mental disorder | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Reflux/ ulcers |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Seizures/ epilepsy | <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Sickle cell |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Suicidal tendencies | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Urine discoloration | | | |

Are you pregnant? Yes No Due Date _____

Exercise: None Moderate Daily Heavy Habits: Drink Alcohol Smoke

Injuries / Surgeries you have had

| Date | Description |
|-------|-------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

ACCIDENT INFORMATION

Type of Accident Auto Collision On the Job Injury Other Date of Injury _____

Time of Injury _____ Street Location _____

Have you lost any days from work? Yes No How many days? _____

Name of Insurance Company Involved _____

Address _____ Phone Number _____

Claim Number _____ Adjuster Name _____

Legal Representation? Yes No Attorney's Name & Phone Number _____

Mark any of the following symptoms that have appeared since your accident

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Ringing in Ear |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Numbness in Fingers |
| <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Cold Sweat | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Mid Back Pain |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Fever | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Arm Pain |
| <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heavy Headed |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Stiff Neck | |

Welcome to the office of Dr. William M. Lawson, DC

OUR FINANCIAL POLICY AND HOW IT WORKS

Insurance coverage varies greatly. Everyone has different insurance that normally changes on a yearly basis, therefore, we cannot predict whether your policy will cover the services we provide in our office. As a courtesy to you, we will do an insurance verification and contact your insurance company to determine the amount and extent of coverage.

OUR RESPONSIBILITIES

- We will verify your insurance benefits.
- We will bill your insurance for you as a courtesy.
- We will provide guidance in getting your bill paid if necessary.

YOUR RESPONSIBILITIES

- Please know and understand your insurance coverage.
- Please pay your deductible, copayment or coinsurance at the time of the of your treatment.
- Please read and keep your Explanations of Benefits statements from your insurance company.
- Please follow up promptly with claims that are not paid by your insurance company, or you will be billed directly for them.

I have read and understood the above statements.

Patient or Responsible Party Signature

Date

CONSENT FOR TREATMENT

CHIROPRACTIC CARE:

All health care professionals are regulated by laws and boards. These health care professionals are required to give you, the patient, advanced notice of any care risks, because health care is not an exact science. It is not reasonable to expect any doctor to foresee all risks and or complications. Informed consent information regarding any risks such as paraplegia, quadriplegia, brain damage, stroke, disc injury, breaks, fractures, dislocations, drug reactions, death or loss of function of any organ or limb, or disfiguring scars associated with physical care, drugs, surgery and or treatment is an undesirable result, but it does not necessarily indicate an error in clinical judgment. No guarantee of cure or results has been made to you, the patient in the clinic. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgery. The practice of chiropractic can include exams and diagnostic testing. In some cases, this includes the utilization of specialized instrumentation, lab tests, radiological exams, nutritional advice, rehabilitation, physical therapy, etc . . . There is a special procedure unique to chiropractic: the chiropractic adjustment, chiropractic manipulative therapy, CMT. Adjustments are made by chiropractors to correct and or reduce or stabilize vertebral or extremity aberrant motion. The goal of chiropractic health care is to reduce or stabilize the nerve interference caused by the aberrant motion of the joint and surrounding soft tissue structures. Adjustments are usually performed by hand but may be performed by hand guided instruments. An adjustment is the application of a specific force applied to a segmental contact point, usually on a vertebra, to reduce or stabilize the joint and its surrounding environ. You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur seldom enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care. The risks may include musculoskeletal sprain strain, disc injuries, dislocations, fractures, neurological deficits, Horner's syndrome, vertebral artery syndrome, stroke, etc... The chances of this occurring have been estimated by experts to be approximately only 1 per 400,000 treatments to 1 per 1, 000,000 treatments.

CHIROPRACTIC ACUPUNCTURE:

A patient, in coming to the Doctor, gives the Doctor permission and authority to care for the patient in accordance with the tests, diagnosis and analysis. The Chiropractic Acupuncture or other clinical and or oriental procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to an injury. The Doctor, of course, will no give health care if he is aware that such care may be contra indicated. Again, it is the responsibility of the patient to make it known or to learn though health care procedures whatever he or she is suffering from: Latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor. The patient should look to the correct specialist for the proper diagnostic and clinic procedures. The Doctor provides a specialized, non-duplicating health service. The Doctor is licensed in a specialized practice and is available to work with other types of providers in your health care regime. Chiropractic Acupuncture is a very specialized type of care.

The purpose of Primary Care is to promote natural health. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the procedures. Sometimes the response is phenomenal. In most cases, there is more gradual but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same specialized care. It depends on the patients nervous system and body balance. Many medical failures find quick relief through this specialized care. In turn, we must admit that conditions that do not respond to this type of care may come under control or be helped through specialized health care sciences. The fact is that the Science of Acupuncture, Chi, Chiropractic, Osteopathy and Physical Medicine may never be so exact as to provide definite answers to all problems. All make great studies in alleviating pain, controlling disease and balancing the body.

Please discuss any questions or problems with the Doctor BEFORE signing this consent for treatment statement of policy.

I have read and understand the foregoing. I agree to the Specialized Care and I have no expectations of any absolute results.

Patient or Responsible Party Signature

Date

===== *Welcome to the office of Dr. William M. Lawson, DC* =====

ASSIGNMENT OF BENEFITS

The Undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician or facility named above the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits a payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms or the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owned by an insurance company, in accordance with Article 21.55 of the Texas Insurance Code or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility name above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 60 days (electronic/paper) following your receipt of such bill for services to the extent such bills are payable under the terms of demand specifically conforms with Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court costs, and interest from judgment, upon violation.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to cut a separate draft to pay in full all services rendered, payable directly to the physician/facility named above.

STATUE OF LIMITATIONS: I waive my rights to claim any Statute of Limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this chiropractic clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of my care my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

RESPONSIBILITY: You, the patient, are ultimately responsible for payment of all charges incurred regardless of insurance or third party status.

A photocopy of this instrument shall serve as original.

I have read and understand the foregoing policies and all of my questions have been answered to my full satisfaction in a way that I can understand.

Patient or Responsible Party Signature

Date

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CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND/OR HEALTHCARE OPERATIONS.

Through the use of this consent form, **Lawson Enterprises, Inc.**, referred to as the "office" or this "office" is notifying you and you agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or healthcare operations.
2. If you do not consent to the above use and/or disclosure, Federal Rules do not require or oblige this office/practice to treat you in the absence of your consent.
3. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosures necessary to carry out treatment, payment and/or healthcare operations, is available for you to read and you are hereby encouraged to do so prior to signing this consent form.
4. The following appointment reminders will be used by this office: a) a postcard mailed to you at the address provided by you; b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.
5. This office reserves the right to change its privacy practice that are described in the above referenced notice, in accordance with applicable law, and make available to all patients any and all revised and current notices.
6. You have a right to request that this office restrict how protected health information is used and or disclosed to carry out treatment, payment and /or healthcare operations.
7. This office is not required to agree to any restrictions on your health information that you have requested.
8. If this office agrees to a requested restriction, then the restriction will be binding on this office/practice.
9. This consent is valid for seven years. You have the right to revoke this consent, in writing, at any time for all *future* transactions with the understanding that any revocation will not apply to the extent that this office/practice has already taken action in reliance of previously signed consent.
10. Should you revoke this consent at any time, the office retains its right to refuse treatment based upon the revocation and the future lack of such consent.
11. You must sign and date all consents and authorizations requested to which you agree.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Patient/Individual Responsible (Please Print)

Signature of Patient/Individual Responsible

Date Signed

Witness