DR. Clay Suggs
OPTIMAL HEALTH & WELLNESS CENTER. 5819 NW LOOP 410 #152
SAN ANTONIO, TX 78238, (210)681-3333

Personal Information

Patient name: _____ Today's date: ___/___/_____
Phone: _____ Email: _____
Marital status: Single / Married / Separated / Divorced / Widowed.
Social Security Number: _____Date of Birth: ___/___/_____ age: _____ Gender: F / M

If you are under 18 years, who are your legal parents or guardian?

Father: _____Date of Birth: ___/___/_____Phone: (____) _____
Mother: _____Date of Birth: ___/___/_____Phone: (____) _____
Guardian: _____Date of Birth:___/___/_____Phone: (____)_____
Who do you normally live with? Mother and Father/Mother/Father/Guardian/None of these.

Mailing address:

Street: _____ City: _____ State: _____Zip:_____
Your Occupation: _____Employer:_____
Work Address: _____
Student at:_____ Full-Time / Part-Time.

Have you retained an Attorney? Yes/No Name: _____ Phone: (____) _____
Where there any Witnesses? Yes/No Name: _____Phone: (____) _____

Who should we contact in case of an emergency? _____ Phone: _____
what is your relationship to this person: _____

Is your condition or injury result from an automobile accident? Yes/No.
Did the condition or injury result from work-related cause? Yes/No.
Did it result from a work-related accident or cause? Yes/No (if yes, briefly describe): _____
_____

Do you have auto insurance? Yes/No Company: _____
Policy#: _____ Claim#: _____ Agents Name: _____

Nature of the accident:

Date of the Accident: ____/ ____/ 20____ Time: ___/ ___/ AM/PM
Location: _____
Weather: Clear / Cloudy / Rainy / Sunny. Visibility: _____
Street condition: Dry / Wet / Slick / Icy / Pavement / other: _____
Where you Driver/Passenger (if passenger): Front/Back Seat. Were police notified? Yes/No.
Where you wearing a seatbelt: Yes/No Shoulder Harness Yes/No headrest at head level? Yes/No
If at night: where your headlights on: Yes/No. Other drivers headlights on: Yes/No
Describe how the accident took place: _____
_____
Did you have any physical complaints BEFORE THIS ACCIDENT? Yes/No if yes, please describe in detail: _
_____
_____
Please describe how you felt: right before, during the accident, immediately after later that day and the

DR. Clay Suggs
OPTIMAL HEALTH & WELLNESS CENTER. 5819 NW LOOP 410 #152
SAN ANTONIO, TX 78238, (210)681-3333

next day: _____

_____

Automobile details: Year: _____ Make: _____ Model: _____
Vehicle damage: Front/Rear/Driver side/Passenger Sider/Bumper/Fender.
Is the car equipped with airbags? Yes/No Did they deploy? Yes/No.
Has seen the impact coming? Yes/No (if yes): Brace for impact? Yes/No.
Did the body hit anything else inside the car? Yes/No
Body Part: _____ What did it hit?: _____
Head Trauma?: Yes/No. Loss of consciousness?: Yes/No. How long?: _____
Remember the accident happening?: Yes/No
Did you go to the hospital? Yes/No Hospital Name: _____
How long there_____ Taken by ambulance? Yes/No X-rays Taken? Yes/No Neck/Mid back/Low back
Medication given?: Yes/No RX: _____
Other instruction: _____ Follow-up: _____

Encircle Symptoms you have noticed since the accident:
Neck stiff / sleeping problems / back pain / nervousness / tension / irritability / dizziness / head seems too heavy / pins and needles in arms / pins and needles in legs / numbness in fingers / numbness in toes / shortness of breath / fatigue / depression / lights bother eyes / loss of memory / ears ring / face flushed / buzzing in ears / loss of balance / fainting / loss of smell / loss of taste / diarrhea / feet cold / hands cold / stomach upset / constipation / cold sweats / other: _____

_____

Have you lost time from work as a result of this accident ? Yes / No
do you notice any activity restriction as a result of this injury? Yes / No Describe: _____

_____

Other pertinent information: _____

_____

Other Party's information
Name driver: _____ Agents Name: _____
Driver/Other vehicle Insurance: _____ Policy#: _____
Other automobile details: Year: _____ Make: _____ Model:

_____
Vehicle damage: Front/Rear/Driver side/Passenger Sider/Bumper/Fender.

Patient Health History:
Is there a chance you are pregnant? Yes/No (if yes for how long: ____ weeks)

Surgeries/Hospitalizations: Yes/No (if yes): Reasons and outcomes: _____

_____

Medications: _____

_____

DR. Clay Suggs
OPTIMAL HEALTH & WELLNESS CENTER. 5819 NW LOOP 410 #152
SAN ANTONIO, TX 78238, (210)681-3333

Do you have any of the following?:
Heart Disease / High blood pressure / kidney disease / Diabetes 1 or 2 / Thyroid disease / Asthma / Cancer / Tuberculosis / Ulcers / Stroke / Enlarged prostate / Seizures / Hives/Eczema / Hay fever / Catch colds easily / Frequent sinus trout / frequent influenza / HIV /AIDS / Fever /
Allergies:_____

Other Disorders:_____

Do you have any congenital (from birth) factors which relate to this problem? Yes/No describe: _____
_____
Family health history: Relation: _____ comment: _____

Patient Name (print): _____

Patient Signature: _____ Date: ____/____/20____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (print): _____
_____

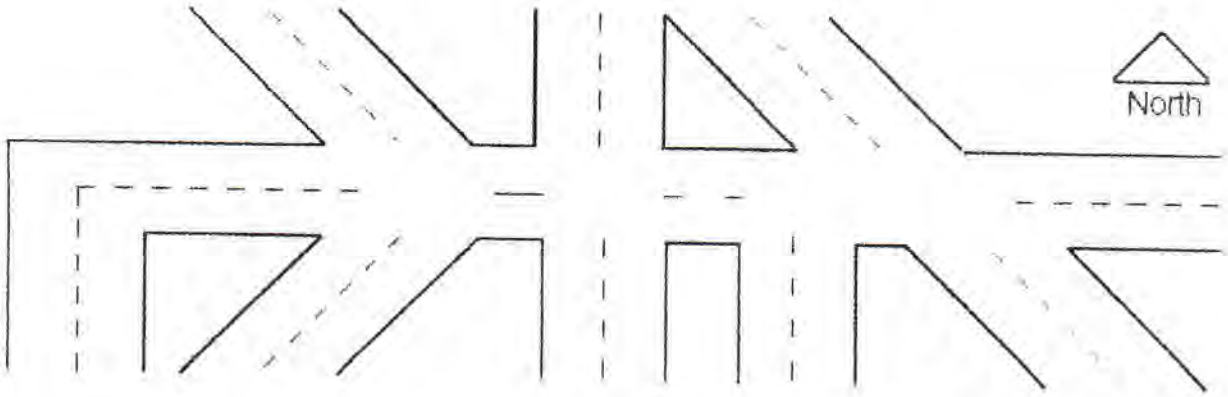
Parent/Guardian Signature:_____ Date: ____/ ____/20____

DR. Clay Suggs
OPTIMAL HEALTH & WELLNESS CENTER. 5819 NW LOOP 410 #152
SAN ANTONIO, TX 78238, (210)681-3333

Directions for completing accident diagram.

Use these tools to sketch the scene of your accident, writing in street or highway name or numbers.

- Number each vehicle [1] [2] etc. and show direction of travel by arrow [->] [<-] ect.
- Use a solid line to show path before the accident _____
- Use a broken line after the accident - - - - - - - -
- Show a pedestrian by using - - - - - - O
- Show distance and direction to landmarks – identify landmarks by name and number
- Indicate the direction North
- Draw traffic lights and write the color they were on.
- Draw signs that where on or next to the street that where important for the situation, for example stop signs.
- Write down estimated miles/hour next to the motor vehicles.



DR. Clay Suggs
OPTIMAL HEALTH & WELLNESS CENTER. 5819 NW LOOP 410 #152
SAN ANTONIO, TX 78238, (210)681-3333

Irrevocable Healthcare Power of attorney

By this power of attorney:

I, _____, (hereinafter, "principal") of Bexar County, state of Texas, do appoint my healthcare provide Dr. B. Clay Suggs (hereinafter, "Attorney"), as my true and lawful attorney-in-Fact. In principal's name, and for Principal's use and benefit, said Attorney is hereby authorized to:

1. Endorse any and all check or other forms of reimbursement made payable to principal (or members of Principal's family) by any auto insurance, health insurance, or 3rd party liability insurance companies which are relate to medical treatment provided by Attorney to Principal (or members of Principal's family) over to Attorney
2. Demand and direct any and all auto, health or liability insurance companies during the course of Principal's (or members of Principal's family) medical treatment with Attorney on personal injury cases or major medical matters, to make all reimbursement checks for such treatment payable to Attorney and to send such checks directly to Attorney.

This Special Power of Attorney is created for Attorney's benefit to secure Attorney's right to payment for healthcare services provided and shall be irrevocable throughout the duration of the healthcare services provided and shall be irrevocable throughout the duration of the healthcare services proved by Attorney to Principal arising from an injury or major medical condition sustained either by Principal or members of Principal's family.

GIVING AND GRANTING to said Attorney full power and authority to do all and every act and thing whatsoever requisite and necessary to be done relative to any of the foregoing as fully to all intents and purposes as Principal might or could do if personally present.

All that said Attorney shall lawfully do or cause to be done under the authority of this Power of Attorney is expressly approved.

Patient Name (print): _____

Patient Signature: _____ Date: ____/____/20____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (print): _____

Parent/Guardian Signature:_____ Date: ____/____/20____

State of Texas County of Bexar

On, ____/____/20____, before me, _____, personally know to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s) or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal

NOTARY Signature _____

DR. Clay Suggs
OPTIMAL HEALTH & WELLNESS CENTER. 5819 NW LOOP 410 #152
SAN ANTONIO, TX 78238, (210)681-3333

Assignment of proceeds. Lien, and Authorization

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ('payers'), which may elect or be obligated to pay, provide or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past , present or future ("condition") to pay directly and exclusively in the name of Dr. B. Clay Suggs ("Dr. Clay") such sums as may be owing to DR. Clay for charges incurred by me which relate, directly / indirectly, to my respect to my charges. This lien shall apply to all payers and to the full extent permitted by law for the purposes of this Assignment, Lien, and Authorization (herein. "Agreement") "benefits" shall include, but not be limited to proceeds from any settlement judgment or verdict, as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payment benefits, personal injury protection, no-fault coverage, worker's compensation benefits and any other benefits or proceeds payable to me for the purposes state herein.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protections cannot be revoked or modified without expresses written consent of this office.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I further authorize and direct all payers to release to Dr. Clay any information regarding any coverage or benefits which may have including, but not limited to the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize DR clay to endorse/sign my name on any and all checks listing me as a payee which are presented to this office for payment of an account relating to me, my spouse, or an of my dependents. I further authorize Dr. Clay to apply any credit balances on charges incurred by me 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.

I understand that I remain personally responsible for the total amounts due Dr. Clay for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its options. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Dr. Clay for all costs of such collection efforts, including, but not limited to all court costs and all attorney fees.

This Agreement shall not be modified or revoked without mutual written consent of Dr. Clay and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office, to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Dr. Clay and myself. However, should any provision of this agreement be found to be invalid, illegal or unenforceable for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall nevertheless remain full force and effect.

Patient Name (print): _____

Patient Signature: _____ Date: ____/____/20____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (print): _____

Parent/Guardian Signature: _____ Date: ____/____/20____

DR. Clay Suggs
OPTIMAL HEALTH & WELLNESS CENTER. 5819 NW LOOP 410 #152
SAN ANTONIO, TX 78238, (210)681-3333

Assignment and authorization for direct payments by my payers to: Optimal health & wellness

Purpose. The purpose of this Assignment is to assist the office in obtaining proceeds from various Payers for the payment of my charges. Accordingly, I agree to the following and direct all payers as follows:

Definitions. In this Assignment, the following terms shall have the following meaning: "office" and "clinic" shall refer to Optimal health & wellness located at 5819 NW LOOP 410 #152
SAN ANTONIO, TX 78238; "payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, and any other entity, which may elect or be obligated to pay or disburse Proceeds, either now or in the future, or which may be involved directly or indirectly in determining the obligation to pay or disburse Proceeds, either now or in the future: "proceeds" shall include without limit, the proceeds from any promise to pay or reimburse, the proceeds relating to "health-care-insurance receivables" as such are defined by the applicable Uniform Commercial Code, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicaid, "charges" shall include without limit the full fees for the Office's goods and services (including without limit treatment, diagnostic services, medical equipment, supplies, supplements, narrative reports, photocopies, pre-authorization requests, no-shows, depositions, and testimony, whether rendered before or after the date of this Assignment, any collection Costs incurred by the Office, delinquency penalties and interest to the maximum extent permitted under law or at the annual rate of eighteen percent (18%), whichever is greater, 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 of process charges, attorney's fees, fees or costs associated with requests for reconsideration, independent reviews, appeals, mediation, arbitration, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Assignment Terms. I hereby assign to the office to the extent permitted by law, but only to the extent of my Charges all of my claims to rights to, and interests in, Proceeds, Whether resolved or unresolved, including without limit ownership rights, which I may have now or in the future relating directly or indirectly to my Charges, condition, or causes of my condition ("Claims to Proceeds"), including without limit any and all causes of action, receivables, payment intangibles, and remedies that I might have against or with respect to any payer now or in the future, and the right to prosecute, seek, settle or otherwise resolve such Claims to Proceeds either in my name or in the Office's name an as the office otherwise sees fit. I agree that this assignment shall be effective as of the date and time the initial cause of my condition occurred. I further intend for this Assignment to create a security interest under the applicable Uniform law for the purpose of securing payment of my Charges, the attachment and perfection of which shall relate back to, and be effective as of, the date and time that the initial cause of my condition occurred, I further authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency relating to such security interests, and to make such filing in all relevant jurisdictions as the office sees fit in its sole discretion. I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my agreement with the office, such security interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Service Certified mail. Consistent with these terms, I hereby direct any and all payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the full extent of my charges.

Disclosure Directives. I hereby direct each and every Payer to immediately release to the Office nay pertinent information relating to (a) any coverage I may have and (b) any Proceeds Determination by the Payer relating to the Office's Charges. "Pertinent Information" shall include without limit copies of all documents, records and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record or other information was relied upon in making the proceeds determination. "Proceeds Determination" shall include without limit any determination by the payer to pay, deny or delay payment of any Proceeds relating to the Office's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or for me by the office to all Payers, including without limit a copy of my Charges and a copy of this Assignment, unless otherwise agreed to in writing.

Miscellaneous. Except as provided in this paragraph, this Assignment shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment. I agree that each and every provision of this Assignment is reasonably necessary. However, should any provision of this Assignment be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment shall, nevertheless, remain in full force and effect. This Assignment shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment. I have read understood, and agree to the terms of this Assignment.

Patient Name (print): _____

Patient Signature: _____ Date: ____/____/20____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (print): _____

Parent/Guardian Signature: _____ Date: ____/____/20____

DR. Clay Suggs
OPTIMAL HEALTH & WELLNESS CENTER. 5819 NW LOOP 410 #152
SAN ANTONIO, TX 78238, (210)681-3333

Informed Consent:

There are inherent risks in every health care delivery system. Chiropractic health care is no exception. We want you to be informed of potential problems associated with chiropractic health care before consenting treatment. Chiropractic care has the least therapeutic risk of any care we know of.

Chiropractic is a system of health care delivery. Therefore, as with any health care, we cannot promise a cure of any symptom, disease, or condition as a result of treatment in this office. We will always provide you our best care, and if results are suboptimal. We will refer you to another provider who will assist your situation. Chiropractic manipulation/adjustments consist of the moving of bones joints, muscles, ligaments and nerves, with the use of the Doctor's hands or with the use of a tool. Frequently, the maneuvers are associate with 'pop' or 'click' sounds and sensations in the area being treated. These are sounds of improvement. Very occasionally unexpected symptoms can occur.

Stroke: I have never had this happen but it has been reported in literature. Stroke means a portion of the brain fails to receive enough oxygen via the blood vascular system. The results can be temporary or permanent, resulting in dysfunction of the brain, with very rare complications of death. The vertebral arteries are found inside the neck vertebrae. The manipulation/adjustment commonly associated with vertebral artery stroke is called "extension-rotation-thrust atlas adjustment". This type of manipulation/adjustment may also be potentially related to vertebral artery stroke, but there is no real certainty. The most recent studies estimate the incidence of this type of stroke in 1 per three million. This means the average Chiropractic provider would practice hundreds of years before statistically associate with a stroke event.

Disc Herniation: Disc herniation's that cause pressure on the spinal nerve or the spinal cord are frequently successfully treated with chiropractic care. Yet occasionally chiropractic treatment will aggravate a problem. Rarely surgical intervention may be necessary in spite of Chiropractic care, these events are so rare that no statistical literature is available to calculate the probability.

Soft tissue: Soft tissues refer primarily to muscle, muscle tendons, ligaments, blood vessels and other tissue. Seldom a chiropractic manipulation/adjustment, traction, electro muscle stimulation, massage therapy, etc. may irritate some muscle or ligament fiber. The result is a temporary increase in pain, but there is no long term effect for the patient. These events are so rare that no statistical literature is available to calculate probability.

Physical therapy burns: Some if the therapy machines we use generate heat. Both heat and ice are used in office and is frequently recommended for home use. Everyone's skin sensitivity is different, and rarely either heat or ice can burn or irritate the skin. The result is temporary pain and possible blistering of the skin. These events are so rare that no statistical literature is available to calculate probability.

Soreness: It is common for Chiropractic manipulation/adjustment and some therapies. Massage, traction, exercise etc. to cause temporary increase in soreness in the region treated. This is nearly always a temporary and brief symptom while your body is undergoing therapeutic change. It is not dangerous, but please advise your doctor.

Medications: there are known risks to patients that take blood thinners. Yes/No initial: __Type: _____

Other Problems: if other problems or complications may arise from chiropractic treatment. These other problems are so rare that it is not possible to anticipate or explain them to advance of treatment.

Complications Patients with an aortic aneurysm are at risk and need to advise the Doctor and staff if you have one Yes/No.

IF you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below:

Patient Name (print): _____

Patient Signature: _____ Date: ____/____/20____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (print): _____

Parent/Guardian Signature:_____ Date: ____/____/20____

DR. Clay Suggs
OPTIMAL HEALTH & WELLNESS CENTER. 5819 NW LOOP 410 #152
SAN ANTONIO, TX 78238, (210)681-3333

Patient Statement of Privacy Rights.

As a patient of this practice, you have the right to privacy of your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the health information Accountability and Portability Act of 1996 (HIPAA). HIPAA was enacted to give you, the patient of a health care provider and covered under a health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that health care providers and other must achieve to protect the privacy of Personal Health Information, and to hold violators accountable, with appropriate penalties for violation of a patient's right to privacy.

As a patient of this practice:

1. You are entitled to an individually delivered , written notification of your Privacy Rights at the time of your first visit to this practice's facility. The document you are reading is this notice.
2. You are entitled to see your medical records.
3. You are entitled to receive a copy of your medical records. (forms are available upon request). As per allowance by HIPAA the charge will be 25 cents per page.
4. You are entitled to make an amendment to your Patient Health Information within those records. (forms are available upon request).
5. While the doctor has a right to deny inclusion of amendments into a patient file, you have the right to disagree with the doctor's refusal of such inclusion of amendment to those records. (forms are available upon request). If the doctor disagrees, he shall supply you with written notification of such disagreement.
6. The doctor has a right to a rebuttal to the patient's disagreement. But any time a file is sent out of the office, a copy of that rebuttal must be included in the file.
7. You have the right to specify how access to your health information is restricted and from whom.
8. You have the right to indicate the method and/or phone numbers and/or addresses to which telephonic and written communications to you shall be forwarded.
9. all covered entities under HIPAA, such as this practice or other health care providers, or business associates such as billing companies or claims administrators, as are designated by the HIPAA Privacy Rule, and with whom this practice must work on your behalf from the standpoint of effective treatment or billing of medical services and administration of such services, shall be part of a "chain of trust" under applicable Business associate Agreements whenever applicable with those parties. This means that those parties are bound to maintain the same privacy and security of your health information, as are we.
10. No personal health information shall be given out to any entity not related to your treatment and the billing of medical services rendered, without your written authorization
11. You are entitled to this practice's best efforts to maintain the security of Personal Health Information on your behalf within and outside this office.
12. This practice shall provide Personal Health Information to required parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf), and so as to maintain the intent of HIPAA in establishing that standard.
13. You have the right to inquire of this office and gain correct and appropriate answers to any questions regarding your privacy rights at any time, consistent with those rights as covered by HIPAA.
14. You have the right to contact the Department of Health and Human services, Office of Civil Rights, which administrates HIPAA, with questions or to file a complaint at, Toll Free: 1-877-696-6775 or e-mail: www.hhs.gov/ocr

Patient affirmation of receipt of patient's statement of privacy rights.

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with the law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Patient Name (print): _____

Patient Signature: _____ Date: ____/____/20____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (print): _____

Parent/Guardian Signature: _____ Date: ____/____/20____