Dr. Aaron T. Halle • Chiropractic Physician
1857 N. Kolb Road • Tucson, AZ 85715 • PH: 520-290-2229 • FX: 520-290-2236

Welcome to our office! *Thank you for choosing us as your chiropractic provider. Please complete the following information.*

Patient Information

I am a/an: ☐ New patient ☐ Existing patient/providing updated information

Legal name: ___ SSN: ___ Preferred name: ___

Birth date: ___ Age: ___ ☐ Male ☐ Female E-mail: ___

Address: ___ City, State, Zip: ___

Home phone: ___ Cell phone: ___ Work phone: ___

Employer: ___ Occupation: ___

Employer address: ___ City, State, Zip: ___

Are you: ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Prefer not to indicate

Health complaints/reasons for consulting this office: ___

Is this due to a: ☐ Work-related injury ☐ Vehicle accident/injury

Whom may we thank for referring you? ___

Please indicate whom we could contact in case of an emergency:

Name: ___ Relationship: ___

Home phone: ___ Cell phone: ___ Work phone: ___

Financial Information

Legal name of person responsible for this account: ___ Relationship to patient: ___

SSN: ___ ☐ Male ☐ Female E-mail: ___

Address: ___ City, State, Zip: ___

Home phone: ___ Cell phone: ___ Work phone: ___

Employer: ___ Occupation: ___

Employer address: ___ City, State, Zip: ___

Insurance Information

Legal name of insured: ___ Relationship to patient: ___

Insured's birth date: ___ SSN or Member ID No.: ___ Group No.: ___

Insurance company: ___ Insurance phone: ___

Insured's employer: ___ Work phone: ___

Employer address: ___ City, State, Zip: ___

Please indicate any secondary insurance you have: ___ Please tell me more about this ☐ Yes ☐ No

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, my minor child, and/or the individual that has appointed me as their legal representative or guardian (hereafter "I"), ever have a change in health, insurance, and or benefits. By signing this form, I certify I have insurance coverage with the above-named insurance company(ies), authorize the use of my signature on all insurance submissions, and assign directly to Halle Chiropractic, LLC. all insurance benefits payable for services rendered. I also hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/other legal entities ("payers") which may elect or be obligated to pay benefits to me for any medical condition(s), accident(s), injury(ies), illness(es), past or future condition, to pay directly to and exclusively in the name of Halle Chiropractic LLC, such sums as may be owing for charges incurred by me for any and all service(s) rendered. Whether or not reimbursed by any or all of these entities, I understand that I am financially responsible for all charges.

Halle Chiropractic, LLC. may use my healthcare information and may disclose such information to the above-referenced payers and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services.

___ Signature of patient, parent, or legal representative/guardian

___ Date

___ Printed name of patient, parent, or legal representative/guardian

___ Relationship to patient

Halle CHIROPRACTIC LLC

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PATIENT HEALTH HISTORY

Patient name (please print):____

PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD AND HOW OFTEN IT OCCURRED:

OCCASIONAL	FREQUENT	CONSTANT	MUSCLE & JOINT
			Arthritis
			Bursitis
			Carpal tunnel
			Foot trouble
			Hernia
			Low back pain
			Neck pain or stiffness
			Pain between shoulders
			Pain or numbness in:
			Shoulders
			Arms
			Elbows
			Hands
			Hips
			Legs
			Knees
			Feet
			Tail bone
			Poor posture
			Sciatica
			Spinal curvature (scoliosis)
			Swollen joints

OCCASIONAL	FREQUENT	CONSTANT	GENERAL
			Allergy
			Chills
			Convulsions
			Dizziness
			Fainting
			Fatigue
			Fever
			Headache
			Loss of sleep
			Nervousness/depression
			Neuralgia (nerve pain)
			Numbness
			Sweats
			Tremors
			Weight loss

OCCASIONAL	FREQUENT	CONSTANT	WOMEN
			Congested breasts
			Cramps or backache
			Excessive menstrual flow
			Hot flashes
			Irregular cycle
			Menopausal symptoms
			Painful menstruation
			Vaginal discharge
			Pregnant? ☐ Yes ☐ No

OCCASIONAL	FREQUENT	CONSTANT	EYES, EARS, NOSE, & THROAT
			Asthma
			Colds
			Crossed eyes
			Deafness
			Dental decay
			Earache
			Ear discharge
			Ear noises
			Enlarged glands
			Enlarged thyroid
			Eye pain
			Failing vision
			Farsighted
			Gum trouble
			Hay fever
			Hoarseness
			Nasal obstruction
			Nearsighted
			Nose bleeds
			Sinus infection
			Sore throat
			Tonsillitis

OCCASIONAL	FREQUENT	CONSTANT	GASTROINTESTINAL
			Belching or gas
			Colitis
			Colon trouble
			Constipation
			Diarrhea
			Difficult digestion
			Distension of abdomen
			Excessive hunger
			Gall bladder trouble
			Hemorrhoids
			Intestinal worms
			Jaundice
			Liver trouble
			Nausea
			Pain over stomach
			Poor appetite
			Vomiting
			Vomiting of blood

OCCASIONAL	FREQUENT	CONSTANT	CARDIOVASCULAR
			Hardening of arteries
			High blood pressure
			Low blood pressure
			Pain over heart
			Poor circulation
			Rapid heart beat
			Slow heart beat
			Swelling of ankles

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PATIENT HEALTH HISTORY (*continued*)

OCCASIONAL	FREQUENT	CONSTANT	GENITOURINARY
			Bed wetting
			Blood in urine
			Frequent urination
			Inability to control kidneys
			Kidney infection or stones
			Painful urination
			Prostate trouble
			Pus in urine

OCCASIONAL	FREQUENT	CONSTANT	RESPIRATORY
			Chest pain
			Chronic cough
			Difficult breathing
			Spitting up blood
			Spitting up phlegm
			Wheezing

OCCASIONAL	FREQUENT	CONSTANT	SKIN
			Boils
			Bruise easily
			Dryness
			Hives or allergy
			Itching
			Skin eruptions (rash)
			Varicose veins

PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

☐ Alcoholism ☐ Chorea ☐ Epilepsy ☐ Malaria ☐ Pleurisy ☐ Thyroid
☐ Anemia ☐ Cold sores ☐ Fever blisters ☐ Measles ☐ Pneumonia ☐ Tuberculosis
☐ Appendicitis ☐ Diabetes ☐ Gout ☐ Miscarriage(s) ☐ Polio ☐ Typhoid fever
☐ Arteriosclerosis ☐ Diphtheria ☐ Heart disease ☐ Multiple sclerosis ☐ Rheumatic fever ☐ Ulcers
☐ Arthritis ☐ Eczema ☐ HIV/AIDS ☐ Mumps ☐ Scarlet fever ☐ Venereal disease
☐ Cancer ☐ Emphysema ☐ Influenza ☐ Parkinson's ☐ Stroke ☐ Whooping cough
☐ Other, please list:

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you ever had previous chiropractic care? ☐ Yes ☐ No If yes, date of last care and doctor name or location:___________________________

What is your major complaint? ____

Other complaints?____

How long have you had these complaints?_____________________________ Have you had these or similar complaints in the past? ☐ Yes ☐ No

What activities aggravate your complaints? ☐ Coughing ☐ Sneezing ☐ Reaching ☐ Bending ☐ Lifting ☐ Sitting ☐ Standing ☐ Walking

☐ Other, please describe:____

Are these complaints getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Are these complaints interfering with your ☐ Work ☐ Sleep ☐ Daily routine ☐ Other, please describe___________________________________

Are your complaints the result of an ☐ On the job accident ☐ Auto accident ☐ Other, please describe___________________________________

Was the accident within: ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Briefly describe your accident:____

Please list previous diagnoses and treatments you've received for these complaints:____

____

How long has it been since you've felt good?__________________ What do you believe is wrong?____

Please list surgical operations and years:____

Please list drugs you currently take:____

Age of mattress:________ ☐ Comfortable ☐ Uncomfortable Do you use a bed board? ☐ Yes ☐ No

Age of pillow:_________ ☐ Comfortable ☐ Uncomfortable Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Arch supports (orthotics)

HAVE YOU EVER:

Been knocked unconscious? ☐ Yes ☐ No Describe:____

Used a crane, crutch, or other support? ☐ Yes ☐ No Describe:____

Been treated for a spine or nerve disorder? ☐ Yes ☐ No Describe:____

Had a fractured bone? ☐ Yes ☐ No Describe:____

Been hospitalized for other than surgery? ☐ Yes ☐ No Describe:____

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PATIENT HEALTH HISTORY *(continued)*

DO YOU:

Now take vitamins or minerals?	☐ Yes ☐ No	Describe:_______________
Think you may need vitamins or minerals?	☐ Yes ☐ No	Describe:_______________
Have an allergy to any drug?	☐ Yes ☐ No	Describe:_______________

APPROXIMATE DATE OF LAST:	**Less than 6 months**	**6–18 months**	**Over 18 months**	**Never**
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest x-ray	☐	☐	☐	☐
Spinal x-ray	☐	☐	☐	☐
Dental x-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS:	**Heavy**	**Moderate**	**Light**	**None**
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

List below all conditions for which you have been treated in the past 10 years:

____

____

____

____

____

____

FAMILY HEALTH INFORMATION – Many health problems are the result of hereditary spinal weakness; therefore, information about your family members will give the doctor a better understanding of your current health status.

Relation:_______________ Past health problems:_______________ Present health problems: _______________

Relation:_______________ Past health problems:_______________ Present health problems: _______________

Relation:_______________ Past health problems:_______________ Present health problems: _______________

_______________________________ _______________
Signature of patient, parent, or legal representative/guardian Date

_______________________________ _______________
Printed name of patient, parent, or legal representative/guardian Relationship to patient

Halle Chiropractic, LLC

1857 N. Kolb
Tucson, AZ 85715
(520) 290-2229
(520) 290-2236 fax

Date:____________________

To:______________________

____

____

I hereby authorize the release of my x-rays and/or copies of all records and request that they are transferred to:

____

C/O Halle
1857 N. Kolb Rd.
Tucson, AZ 85715
(520) 290-2229
(520) 290-2236 fax

____
Patient Name (please print)

____
Patient Signature

DOB:____________________

SS#__________________

Halle Chiropractic, LLC
Aaron T. Halle, DC

HIPAA Compliant Patient Authorization

This authorization is requested in order to meet federal and state privacy guidelines. By signing you give the doctor and staff permission to use your personal information and health information for areas outlined below. This information is being requested so that we can better meet your health care needs. However, should you decline to authorize any of the items listed, it will not affect the treatment that we provide to you. You may also put certain limitations on the use of your information. This must be done in writing. You are not required to sign this form, but rather are only requested to do so.

You have the right to inspect your records at any time. You also have the right to change the authorizations previously given at any time. All requests must be in writing. Please allow a reasonable time for our clinic to carry out your request.

Copies of all of the documents we ask you to sign, read and agree to are kept in a book in our lobby. These forms are available to view at any time.

Your personal information will never be given to any group or individual for purposes of advertising or referrals outside of this clinic. It will only be used by our staff and only regarding your healthcare.

Please complete the following:

May we contact you on your home phone and leave a message? **YES** **NO**
Home phone number: ______________________

May we contact you on your cell phone and leave a message? **YES** **NO**
Cell phone number: ________________________

May we contact you at your work and leave a message if you are not there: **YES** **NO**
Work phone number: _______________________

Please email me with Special or Holiday hours and office news. **YES** **NO**
Email address, PRINT CLEARLY: _________________________________

May we send a "Thank you" to the person(s) that referred you to our office? **YES** **NO**

May we discuss your medical condition and account information with any member of your family?
YES **NO**
If yes, please name the members allowed:
____

I authorize the staff and Dr. Halle at Halle Chiropractic, LLC to use my personal and health information as outlined above and in the Notice of Privacy Practices already disclosed to me.

______________________________ ______________________________ __________________
Print (patient name) **Signature (patient, parent or guardian)** **Date**

____
Witness Signature

rev. 01/01/2019

Halle CHIROPRACTIC LLC

Dr. Aaron T. Halle • Chiropractic Physician
1857 N. Kolb Road • Tucson, AZ 85715 • PH: 520-290-2229 • FX: 520-290-2236

INFORMED CONSENT

Patient name (please print):____

I hereby request and provide consent for Halle Chiropractic LLC (Dr. Halle) to perform chiropractic manipulation and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me or on the patient named below, for whom I am the parent or am legally responsible.

I understand that chiropractic manipulation is a specific adjustment for subluxation, that is, a joint that has lost its ability to move and function properly. Abnormal movement patterns and improper function will continue and may negatively impact nerve activity unless corrected. In order to correct this, I understand that Dr. Halle will use his hands or the necessary instruments to move joints within the affected area. The movement of joints can create an audible “pop” or “click.” This is caused by gasses within the joint being released when it is adjusted.

I understand and am informed that, as in the practice of medicine, there are some risks to treatment in the practice of chiropractic. These risks can include but are not limited to fractures, disk injuries, dislocations, and sprains. These are rare and can result from an underlying weakness in or illness associated with the bones. Another risk is stroke; however, the chances for stroke are far rarer. A scientific study stated there is a 1 in 5.58 million chance for a stroke to be caused by a chiropractic adjustment (Haldeman et al, 1999). Despite the rarity of these risks, we conduct examinations and tests to identify if you may be susceptible to an injury or if an existing injury exists that would lead to health complications.

Other chiropractic procedures involve physiotherapy such as electrical muscle stimulation, traction, decompression, ultrasound, infrasound, application of cold and/or hot packs, exercises, stretching protocols, gait modification, and/or balancing. I understand these procedures may result in muscle strain, muscle spasms, ligament sprain, burns, dizziness, and other symptoms.

I do not expect Dr. Halle to be able to anticipate and explain all risks and complications. I wish to rely upon Dr. Halle to exercise judgment during the course of the procedure(s) which he feels at the time is/are in my best interest. I understand that Dr. Halle’s judgment is based upon the facts known to him professionally as well as those that I have personally disclosed to him. I understand the importance of disclosing all medical information to Dr. Halle so I can be treated appropriately. I will notify Dr. Halle immediately to explain any negative symptoms so a necessary evaluation may be performed and corrective actions may be employed.

I have had an opportunity to discuss the nature and purpose of chiropractic manipulation and other procedures with Dr. Halle. I understand that results are not guaranteed.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions and have had my questions answered satisfactorily. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. By signing below, I state that I have weighed the risks involved with recommended treatment and have decided it is in my best interest to undergo the recommended treatment. Having been informed of the risks, I hereby give my consent to undergo the recommended treatment.

____ ________________________
Signature of patient, parent, or legal representative/guardian Date

____ ________________________
Printed name of patient, parent, or legal representative/guardian Relationship to patient

Halle Chiropractic, LLC

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:__________________________ **Last Name:**__________________________

Email address: __________________@__________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** ___________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): ___________________

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (____________)	Offspring: (____________)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____ Date: ________________

For office use only

Height: _________ Weight:____________ Blood Pressure:______/______ Heart Rate _________

Financial Policy Summary

Dr. Aaron T. Halle, DC/ Halle Chiropractic, LLC

Notice

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a State or Federal program with a mandated fee schedule.
- Self-Pay patients (patients that are uninsured or underinsured) may choose a pre-payment plan or "prompt payment" discount plan.
- Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of **January 1, 2019** our office will be unable to extend any type of discounts other than those listed above.

**Personal checks returned for unsufficient funds will be subject to the charges imposed on our office by the financial institution.*
**Any outstanding balance over 60 days may be charged interest at one-and-one-half percent (1.5%) per month.*
**Any outstanding balance over 90 days may be subject to collection by an outside agency. You will be responsible for paying your outstanding balance, the accrued monthly interest, all collection fees, and any other fees incurred as a result of the collection effort.*

~~~~~~

I understand and agree to the following:

- **I have read or had read to me, the policies and procedures of Halle Chiropractic, LLC. I understand that these policies and procedures are not intended to be all inclusive. By signing below, I agree to comply with stated or implied policies and procedures.**
- **I have read or been given a copy of the Notice of Privacy Practices and understand that any questions may be directed to clinic Management.**
- **The doctor(s), employees, or designated agents of this clinic may use my protected health information in the manner described in the Notice of Privacy Practices.**

Patient signature:____Date:____________________
Patient Name (print):______________________________________
~~~~~~

AUTO ACCIDENT FORM

one

ABOUT YOU

Name: ____________________

Date: ____________________

two

DETAILS OF ACCIDENT

Date and time of accident: ____________________

In your words, please describe the accident: ____________________

If a traffic violation was issued, what was the citation issued for and to whom was it issued? ____________________

Names of other people in your vehicle? ____________________

Did the police come to the accident site? ❑ Yes ❑ No

Was a police report filed? ❑ Yes ❑ No

Were there any witnesses? ❑ Yes ❑ No

Were you wearing a seatbelt? ❑ Yes ❑ No

Were you wearing a shoulder belt? ❑ Yes ❑ No

Was this vehicle equipped with airbags? ❑ Yes ❑ No

If yes, did it/they inflate? ❑ Yes ❑ No

In relation to the base of your skull, where was the headrest?
❑ Above ❑ Below ❑ At base of skull

Were you trying to restrain or grab another person?
❑ Yes ❑ No

Did any part of your body strike anything in the vehicle?
❑ Yes ❑ No

If yes, please describe ____________________

Did the impact to your vehicle come from the:
❑ Front ❑ Rear ❑ Right Side ❑ Left Side ❑ Other

During impact, were you facing: ❑ Right ❑ Left ❑ Forward

Were you ❑ Aware or ❑ Surprised by the impact?

Were you braced for the impact? ❑ Yes ❑ No

What was the approximate speed of your vehicle? ____________________

What was the speed of the other vehicle? ____________________

three

AFTER INJURY

Did accident render you unconscious? ❑ Yes ❑ No

If yes, for how long? ____________________

Please describe your symptoms immediately after the accident: ____________________

Have you gone to a hospital or seen any other doctor? ❑ Yes ❑ No

When did you go? ____________________

How did you get there? ❑ Ambulance or ❑ Private transportation

Name of hospital and/or attending doctor? ____________________

Was he/she a ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S.

Describe any treatment you received: ____________________

Were X-rays taken? ❑ Yes ❑ No

Was medication prescribed? ❑ Yes ❑ No

What recommendations were made? ____________________

Did you receive any broken bones or bleeding cuts? ❑ Yes ❑ No

If so, explain ____________________

Have you been able to work since this injury? ❑ Yes ❑ No

Are your work activities restricted as a result of this injury? ❑ Yes ❑ No

If yes, explain ____________________

Indicate the symptoms that are a result of this accident:

❑ Dizziness	❑ Difficulty Sleeping	❑ Jaw Problems	❑ Nausea
❑ Memory loss	❑ Irritability	❑ Arms/Shoulder Pain	❑ Back Pain
❑ Headache/s	❑ Fatigue	❑ Numb Hands/Fingers	❑ Lower Back Pain
❑ Blurred Vision	❑ Tension	❑ Chest Pain	❑ Back Stiffness
❑ Buzzing in Ear	❑ Neck Pain	❑ Shortness of Breath	❑ Leg Pain
❑ Ears Ringing	❑ Neck Stiff	❑ Stomach Upset	❑ Numb Feet/Toes
❑ Other			

Is your condition getting worse? ❑ Yes ❑ No

Is your condition ❑ Constant ❑ Comes and goes

Indicate your degree of comfort while performing the following activities:

Activity	Comfortable	Uncomfortable even if only sometimes	Painful
Lying on back	❑	❑	❑
Lying on side	❑	❑	❑
Lying on stomach	❑	❑	❑
Sitting	❑	❑	❑
Standing	❑	❑	❑
Stretching	❑	❑	❑
Walking	❑	❑	❑
Running	❑	❑	❑
Sports	❑	❑	❑
Working	❑	❑	❑
Lifting	❑	❑	❑
Bending	❑	❑	❑
Kneeling	❑	❑	❑
Pulling	❑	❑	❑
Reaching	❑	❑	❑

Were any of the above symptoms present just prior to accident? ❑ Yes ❑ No

Do you feel these symptoms are a result of this accident: ❑ Yes ❑ No

Have you retained an attorney: ❑ Yes ❑ No

If yes, whom: ____________________

His/Her phone # ____________________

VEHICLE YOU WERE IN

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenter

Driver (if other than you): ____________________ Phone #: ____________________

Who is vehicle registered to? ____________________ Phone #: ____________________

Insurance:

Name of insured: ____________________ Phone #: ____________________

Insurance company: ____________________ Policy #: ____________________

Address: ____

Adjuster's name: ____________________ Phone #: ____________________

OTHER VEHICLE

Driver: ____________________ Phone #: ____________________

Who is vehicle registered to: ____________________ Phone #: ____________________

Insurance:

Name of insured: ____________________ Phone #: ____________________

Insurance company: ____________________ Policy #: ____________________

Address: ____

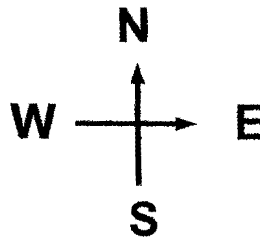
Adjuster's name: ____________________ Phone #: ____________________

DIAGRAM ACCIDENT

A=Your Vehicle

B=Other Vehicle

C=Other Vehicle



Street Name

Street Name

Halle Chiropractic, LLC
1857 N. Kolb Rd.
Tucson, AZ 85715

Date of Accident/Injury: ________________________
Patient's Name: _______________________________________

Please provide the following information regarding *your* Automobile Insurance:
Insurance Company Name: ____
Policy holder's name: ____
Policy Number: ____
Agents Name: _________________________ Phone #: _________________________
Medical Payments Coverage?: YES (limit $__________) NO (circle one)
Claim No.: ____
Claims Adjuster Name: ________________________Phone: _____________________
Claims Address: ____
____
Notes: (office use only)____
____
____

Please provide the following information regarding the *other driver's* (responsible party's) Automobile Insurance:
Insurance Company Name: ____
Policy holder's name: ____
Policy Number: ____
Claim Number: ____
Claims Adjuster's Name: ___________________________Phone: _________________
Claims Address: ____
____
Notes: (office use only)____
____
____

Please provide the following information if you are using an Attorney to settle your claim:
Your Attorney's Name: ____
Name of Firm: ____
Address: ____
____
Phone: _____________________________ Fax: ______________________________
Notes: (office use only)____
____
____

ADVANTAGE
MEDICAL SUPPLY
8902 E. 39th St.
Tucson, AZ 85730
520-750-7555 FAX: 520-750-1754

INVOICE

DATE

INVOICE # **6800**

BILL TO:

Halle Chiropractic
1857 N. Kolb Rd.
Tucson, Az 85715
520-290-2229

SHIP TO:

Halle Chiropractic
1857 N. Kolb Rd.
Tucson, Az 85715
520-290-2229

TERMS	REP	SHIP	VIA	P.O. #	PROJECT
DUE NET 30 ...	RON	3/13/2012	COURIER		

QTY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
1	6012-EA	Ice-Pack 6"x12" Cold or Hot Reuseable 1/EA	15.00	15.00T

Thank you for your business.

Sales Tax (9.1%) $1.37

Total **$16.37**

CUSTOMER SIGNATURE:____

PAYMENT INFORMATION: Reference # Payment Amount:

Dr. Aaron T. Halle
Chiropractic Physician

1857 N. Kolb Road • Tucson, AZ 85715 • PH: 520-290-2229 • FX: 520-290-2236

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

In consideration of your undertaking to care for me, I agree to the following:

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

I authorized payment of any medical benefits from my insurance company and or attorney to be paid directly to Halle Chiropractic, LLC. **for any services rendered to me.**

______________________________ ______________________
Signature **Date**

Backing You Up When You Need It The Most