The Family Chiropractic Center
Patient Office Policy

To Our Patients:

Welcome to The Family Chiropractic Center. We are pleased that you have chosen what we believe is one of the best non-drug approaches to patient care available today. Our practice is committed to providing you with the finest personalized health care through comprehensive evaluation of your condition, concise explanation of our findings and recommendations, and the most effective treatment – expertly performed. We focus on alternative approaches for the treatment of degenerative and chronic conditions of the musculoskeletal system and believe that the body has superior recuperative capabilities when it is restored to proper balance and given the environment necessary to function optimally. The goal of The Family Chiropractic Center is to restore our patients to the most functional and distress-free state possible – without the use of pharmaceuticals or surgery. We understand the special needs of our patients and want your visit to our facility to be as comfortable and pleasant as possible.

The following information is provided to familiarize you with the policies and procedures of The Family Chiropractic Center, to allow us to serve you more completely, and to get the best results in the shortest amount of time. It is our experience that those who adhere to the following agreements get the best results.

New Patients
Initial visits are comprehensive information gathering sessions. Complete evaluation and review of your medical history are essential. In order to provide you with the most effective treatment, it is important that you complete the new patient documentation forms in as much detail and as accurately as possible.

Insurance
In an effort to keep costs down and still provide the best service for our patients, we have set up procedures and payment options. In this era of rising health costs, etc., we are doing our utmost to provide the best service for a fair cost. The two options available for insurance patients are:

- If you want to utilize your health insurance and have our office file, we will itemize services by procedures and code accordingly. We are in-network providers for BlueCross BlueShield and PHCS. We will file on out-of-network insurance if the deductible is $1000 or less.
- If you are self pay but file on your own with insurance or payflex, then for paperwork purposes, you are like an insurance patient and will have an additional $5.00 processing fee per visit.

Please provide the front office with your specific insurance information and our office manager will be happy to assist you with any questions or concerns about your individual needs.

Self Pay
If you are self pay, we will code by time and give you a receipt.

Also, please note that while we do accept personal injury coverage for auto accidents, these fees vary. We do not accept cases only utilizing a 3rd party liability for auto accidents.

Signing In
When you arrive, please take a clipboard, fill out the front side, in detail, and return it to the front desk. You will be called and assigned a treatment room as soon as the doctor is ready for you. Other patients may be called before you because of the particular services being received that day, or their doctor may be available before yours.

New Injuries
In the event you sustain a new injury, please let the front desk know when you schedule your appointment. There may be additional paperwork to be filed, or the doctors may need to refer you for x-rays of an injured area and perform an exam of the injured area before being able to treat.

Appointments
After your visit, please stop at the front desk to make or confirm your next appointment.

Missed Appointments
If you find it necessary to change your scheduled appointment, we will not charge you if you provide a minimum of 24 hour notice. The first missed appointment will be charged $25.00. Every missed appointment after that will be charged $50.00.

Payment of Bills
Payment is due at the time services are rendered. We will expect that you honor all financial agreements made with our office. If you find that you cannot fulfill your financial obligation, notify our financial manager immediately so that arrangements can be made. Our policy is that patients maintain a zero balance. Insurance companies are expected to pay their portion within 45 days of claim submission. If they do not, we expect the patient to call the insurance company. If an insurance company sends a check to your home, it should be brought or sent to our office as soon as possible. Please also bring in the attached explanation of benefits.

Rescheduling Appointments
We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. If you need to change this time, please reschedule your appointment for another time on the same day. If the same day is not possible, be sure to make up the missed appointment within one week.

Progress Evaluations & Re-examinations
Progress evaluations & re-examinations will be performed periodically to determine your rate of progress and future course of treatment. A special time will be set up for your re-evaluation appointments. If you haven't been treated for more than 3 months or after 12 visits, whichever comes first, you will need to be scheduled for a re-examination.

Upsets
We are here to serve you. Please speak with the staff or doctor about anything that could be upsetting you (i.e. long waits, staff insensitivity, treatment confusion). We see your comments as helping us to help you and others.

Technique
We are trained in a wide variety of adjusting techniques – AK, NET, ATM, DTS, activator, S.O.T. and diversified to name a few. Each patient's treatment protocol will be designed to meet their particular needs, whatever they may be. Our light force adjusting is specifically designed to meet the needs of young children and senior patients.

Nutrition plays a vital role in the recovery and maintenance of health. We use the most effective vitamins, minerals, herbs and natural health products available to facilitate your body's healing. Please discuss any concerns or questions about your nutrition before purchasing any item. There are absolutely no refunds on opened nutritional products.

BioAllergenix

To assist the body in its healing process, it is often necessary to rid the body of allergies or sensitivities. We utilize a non-invasive allergy evaluation and desensitization technique to achieve clearing of any allergies. Ask us for more information.

STAGES OF CHIROPRACTIC CARE

1. INTENSIVE CARE / RELIEF
   The purpose of this stage is in correcting and/or stabilizing the subluxation complex so that the body can begin its natural healing process. This is the time visits will be most frequent. This stage includes **any** new patient or established patient with an injury, exacerbation, accident or new condition. The completion of intensive care is determined by re-examination through chiropractic and physical examinations.

2. RE-CONSTRUCTIVE CARE (CORRECTIVE)
   This stage begins after the completion of the intensive care stage. The purpose is stabilizing and normalizing your body's capacity to function normally and express its natural healing process completely.

3. WELLNESS CARE
   This stage begins after the completion of the previous stage (re-constructive care). This stage is based on maintaining optimal health. The frequency of visits are less than during the previous stages because the body is functioning more effectively and without the hindrances that are seen in the intensive care stage; however, this is the most important stage for your long term health.

ARRANGEMENTS FOR YOU

It is our sincerest desire to provide care for you and your entire family.

This office is here to serve you to the best of our ability and at a reasonable fee. Thank you for choosing this office for your health care. No patient has ever been refused chiropractic care in this office due to finances. If at any time during your care at this office finances become a problem, please do not hesitate to discuss it with any of the staff. We are here to serve you and provide the services YOU need.

THANK YOU FOR TAKING PERSONAL RESPONSIBILITY FOR YOUR HEALTH AND FOR ALLOWING US TO SHARE IN YOUR WELL BEING.

YOURS IN HEALTH,

DRS. CHUCK AND JAN

I have read and understand the above policies and agree to abide by the above policies

_____ _____

Signature Date

The Family Chiropractic Center
1124 N. Locust
Denton, TX 76201

I have read and understand my rights under the HIPAA regulations but have refused a copy.

I have read and understand my rights under the HIPAA regulations and have taken a copy with me for my records.

_____Printed Name

_____Signature

_____Date

The Family Chiropractic Center
1124 N. Locust
Denton, TX 76201

Please complete the following information to be added to our special events mailing list:

Name and Mailing Address:

_____

_____

_____

The Family Chiropractic Center

CONFIDENTIAL PATIENT INFORMATION FORM – PLEASE PRINT

Last Name _____ First Name _____ Middle Initial _____ Date _____

Home Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Best # to Call _____ E-Mail _____

Date of Birth _____ Sex: Male Female

Social Security #: _____ Driver License # with State: _____

Guardian Social Security # (if patient is under 18 years of age): _____

Occupation _____ Employer Name _____

Employer Address _____

Office Phone _____ May we contact you at this number? Yes No

Do you have insurance? Yes No ***If you would like for us to file your claim, please give your insurance card to the front office staff to be copied, and we will call to verify your benefits.***

Marital Status: S M D W Spouse's name _____

Date of last physical exam _____ Doctor's name _____

Reported findings _____

List all surgeries / serious illnesses / hospitalizations (include years in brackets) _____

_____

List all broken bones / dislocations / major dental work (include years in brackets) _____

_____

Person to contact in case of emergency _____

Address _____ Phone _____

Name of closest relative not living with you _____

Address _____ Phone _____

Person responsible for account _____ Relationship to patient _____

I hereby give my consent to The Family Chiropractic Center to provide services to me and/or my family. I understand that there is a fee for services and that fees are payable at the time services are rendered. **I hereby agree to such fees and understand that I am liable for any and all legal fees and/or reasonable interest if collection services become necessary**.

Responsible
Party/Patient _____ Date _____

The Family Chiropractic Center

CONFIDENTIAL DETAILED HISTORY FORM – PLEASE PRINT

Last Name _____ First Name _____ Middle Initial _____

PERSONAL INFORMATION:

Height: _____ **Weight:** Current_____ One year ago_____ Change in the past two years _____

Vision: Corrected? Yes____ No____ What is your vision? RT_____ LT_____

Vision recently changed? Yes___ No___ How?_____

Chiropractic: Have you previously received chiropractic care? Yes____ No____ If "yes," date of last care:_____

Auto accidents: Past year_____ Past five years_____ Over five years_____ Describe:_____

_____

X-Ray history: (Include all X-rays, CAT scans / MRIs / dye studies / dental x-rays)

TYPE	AREA OF THE BODY	TYPE	AREA OF THE BODY
_____		_____	
_____		_____	
_____		_____	

Transfusions: Have you ever had a blood transfusion? _____ Blood type? _____

Dental visits: Every 6 months_____ Annual_____ Toothache/emergency only_____ Complete dentures_____

Psychological: Ever diagnosed as having a mental/emotional disorder? Yes_____ No_____ When? _____

Any family member diagnosed as having such disorders? Yes_____ No_____ When? _____

Drugs: Currently taking…nerve pills, pain killers, muscle relaxers, tranquilizers, birth control pills, "pep" pills, others.
Please list all the medications you are currently taking.

Name _____ Function/Purpose_____
Name _____ Function/Purpose_____
Name _____ Function/Purpose_____
Name _____ Function/Purpose_____
Name _____ Function/Purpose_____
Name _____ Function/Purpose_____
Name _____ Function/Purpose_____

Elimination: Approximately how many times during the day do you urinate? _____ night?_____

How often do you have a bowel movement? _____ any problem?_____

Women: Currently… Periods began at what age?_____ pain during cycle_____ regular menstrual periods_____
irregular menstrual periods_____ pre-menopausal_____ post-menopausal_____ hysterectomy_____

Allergies? Yes___ No___ List_____

Do you smoke? Yes___ No___ What? _____ # per day? _____ How many years? _____

Do you diet? Yes___ No___ Explain? _____

Take vitamins? Yes___ No___

What?_____Function?/Purpose_____
What?_____Function?/Purpose_____
What?_____Function?/Purpose_____
What?_____Function?/Purpose_____
What?_____Function?/Purpose_____
What?_____Function?/Purpose_____

Vegetarian? Yes___ No____ Eat red meat? Yes___ No___

Eat fast foods? Yes___ No___ # times/week _____

Drink coffee? Yes___ No___ # cups/day _____ Drink cola? Yes___ No___ # per day _____

Drink tea? Yes___ No___ # cups/day _____ Drink water? Yes___ No___ # glasses/day ____

Drink alcohol? Yes___ No___What?_____ # per day?_____ # per week? _____

Play sports? Yes___ No___ What? _____ Currently in training? Yes___ No____

Describe your exercise program: _____

_____

Have hobbies? Yes___ No___ What? _____

Energy level: Sufficient for normal activities? Yes___ No___ Comment: _____

Work schedule: # business work hours/week _____ # home work hours/week _____

Sleep: # hours/night _____ quality? _____

age of mattress _____ comfortable? Yes___ No___ use a bed board? Yes_____ No_____

PLEASE INDICATE BY CHECKING IN THE APROPRIATE SPACE ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING OR HAVE EXPERIENCED IN THE PAST

THIS IS A CONFIDENTIAL HEALTH REPORT

__Alcoholism	__Cold sores	__Goiter	__Miscarriage	__Scarlet fever
__Anemia	__Diabetes	__Gout	__Multiple sclerosis	__Stroke
__Appendicitis	__Diptheria	__Heart disease	__Mumps	__Tuberculosis
__Arteriosclerosis	__Eczema	__Influenza	__Pleurisy	__Typhoid fever
__Arthritis	__Emphysema	__Lumbago	__Pneumonia	__Ulcers
__Cancer	__Epilepsy	__Malaria	__Polio	__Venereal disease
__Whooping cough	__Fever blisters	__Measles	__Rheumatic fever	__Chorea

Family history of:

__arteriosclerosis
__cardiovascular disease
__oral contraceptives
__TIAs
__diabetes
__hypertension
__antihypertensive meds
__other
__stroke
__other _____

O=OCCASIONAL F=FREQUENT C=CONSTANT

O	F	C	GENERAL
Y	Y	Y	Allergy
Y	Y	Y	Chills
Y	Y	Y	Convulsions
Y	Y	Y	Dizziness-on standing
Y	Y	Y	Dizziness-bending over
Y	Y	Y	Dizziness-other
Y	Y	Y	Fainting
Y	Y	Y	Fatigue
Y	Y	Y	Fever
Y	Y	Y	Headache
Y	Y	Y	Loss of sleep
Y	Y	Y	Loss of weight
Y	Y	Y	Nervousness/depression
Y	Y	Y	Neuralgia
Y	Y	Y	Numbness
Y	Y	Y	Sweats
Y	Y	Y	Tremors

O	F	C	MUSCLE & JOINT
Y	Y	Y	Arthritis
Y	Y	Y	Bursitis
Y	Y	Y	Foot trouble
Y	Y	Y	Hernia
Y	Y	Y	Low Back pain
Y	Y	Y	Lumbago
Y	Y	Y	Neck pain or stiffness
Y	Y	Y	Pain between shoulders
			Pain or numbness in:
Y	Y	Y	Arms
Y	Y	Y	Elbows
Y	Y	Y	Hands
Y	Y	Y	Hips
Y	Y	Y	Legs
Y	Y	Y	Knees
Y	Y	Y	Feet
Y	Y	Y	Painful tail bone
Y	Y	Y	Short leg
Y	Y	Y	Sciatica
Y	Y	Y	Spinal curvature
Y	Y	Y	Swollen joints

LIST JOINTS:_____

_____

_____

_____

_____

WHAT ADDITIONAL INFORMATION FO YOU BELIEVE WE SHOULD KNOW?

O	F	C	GASTRO-INTESTINAL
Y	Y	Y	Belching or gas
Y	Y	Y	Colitis
Y	Y	Y	Colon trouble
Y	Y	Y	Constipation
Y	Y	Y	Diarrhea
Y	Y	Y	Difficult digestion
Y	Y	Y	Distension of abdomen
Y	Y	Y	Excessive hunger
Y	Y	Y	Gall bladder trouble
Y	Y	Y	Hemorrhoids
Y	Y	Y	Intestinal worms
Y	Y	Y	Jaundice
Y	Y	Y	Liver trouble
Y	Y	Y	Nausea
Y	Y	Y	Pain over stomach
Y	Y	Y	Poor appetite
Y	Y	Y	Vomiting
Y	Y	Y	Vomiting of blood
Y	Y	Y	Heartburn/indigestion

O	F	C	EYES, EARS, NOSE & THROAT
Y	Y	Y	Asthma
Y	Y	Y	Colds
Y	Y	Y	Crossed Eyes
Y	Y	Y	Deafness
Y	Y	Y	Dental Decay
Y	Y	Y	Earache
Y	Y	Y	Ear discharge
Y	Y	Y	Ear noises
Y	Y	Y	Enlarged glands
Y	Y	Y	Enlarged thyroid
Y	Y	Y	Eye pain
Y	Y	Y	Failing vision
Y	Y	Y	Far sightedness
Y	Y	Y	Gum trouble
Y	Y	Y	Hay fever
Y	Y	Y	Hoarseness
Y	Y	Y	Nasal obstruction
Y	Y	Y	Near sightedness
Y	Y	Y	Nosebleeds
Y	Y	Y	Sinus infection
Y	Y	Y	Sore throat
Y	Y	Y	Tonsillitis

O	F	C	CARDIO-VASCULAR
Y	Y	Y	Hardening of arteries
Y	Y	Y	High blood pressure
Y	Y	Y	Low blood pressure
Y	Y	Y	Pain over heart
Y	Y	Y	Poor circulation
Y	Y	Y	Rapid heart beat
Y	Y	Y	Slow heart beat
Y	Y	Y	Swelling of ankles

O	F	C	RESPIRATORY
Y	Y	Y	Chest pain
Y	Y	Y	Chronic cough
Y	Y	Y	Difficult breathing
Y	Y	Y	Spitting up blood
Y	Y	Y	Spitting up phlegm
Y	Y	Y	Wheezing

O	F	C	SKIN
Y	Y	Y	Boils
Y	Y	Y	Bruise easily
Y	Y	Y	Dryness
Y	Y	Y	Hives of allergy
Y	Y	Y	Itching
Y	Y	Y	Skin eruptions (rash)
Y	Y	Y	Varicose/spider veins

O	F	C	GENITO-URINARY
Y	Y	Y	Bed-wetting
Y	Y	Y	Blood in urine
Y	Y	Y	Frequent urination
Y	Y	Y	Inability to control kidneys
Y	Y	Y	Get up at night to urinate
Y	Y	Y	Kidney infection or stones
Y	Y	Y	Painful urination
Y	Y	Y	Prostate trouble
Y	Y	Y	Pus in urine

O	F	C	FOR WOMEN ONLY
Y	Y	Y	Cramps or backache
Y	Y	Y	Excessive menstrual flow
Y	Y	Y	Hot flashes
Y	Y	Y	Irregular cycle
Y	Y	Y	Lumps in breast
Y	Y	Y	Menopausal symptoms
Y	Y	Y	Painful menstruation
Y	Y	Y	Vaginal discharge

ARE YOU NOW PREGNANT? YES NO

SIGNATURE **DATE**

THE FAMILY CHIROPRACTIC CENTER

DOCTOR/PATIENT RELATIONSHIP IN CHIROPRACTIC

* INFORMED CONSENT FORM *

Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical, and spinal conditions. It is important to understand what to expect from chiropractic health care services.

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Complexes (VSC). When VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body, and gives the body an opportunity to use its inherent recuperative powers.

A patient, in coming to the chiropractor, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnoses, and analyses. The chiropractic adjustment or other clinical procedures are usually beneficial, and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or health care if he/she is aware that such care may be contra-indicated. It is the responsibility of the patient to make it known, or to learn through health care procedures, whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the chiropractor. The chiropractor provides a specialized, non-duplicating health service. The chiropractor is licensed in a special practice and is available to work with other types of providers in your health care regime.

At The Family Chiropractic Center, we use a combination of different treatment procedures. We will use our hands, our adjusting table, and/or our activator device to deliver safe and gently adjustments. This may cause an audible "pop" or "click," much as you experience when you crack your knuckles. You may or may not experience or feel a sense of movement in the joint being adjusted.

Conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions that do not respond to chiropractic care may come under the control, or be helped through, medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both make great strides in alleviating pain and controlling disease.

With any health care procedure there are certain complications that may arise, and we strive to inform you of such risks. High force, extreme rotation adjustments of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Massage and trigger point therapies have an associated risk of bruising and/or release of emboli. Heat therapies may cause first and second-degree burns and/or hemorrhage. Risks associated with over-the-counter medications and prescription drugs are undesirable side effects such as liver damage and patient dependence. The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, and an extended convalescent period. The risks associated with remaining untreated are the formation of adhesions and reduction of mobility depending on the severity.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to The Family Chiropractic Center to perform the treatment and acknowledge that no guarantee as to the results that may be obtained from this treatment has been given to me.

I understand that full payment is due at time of service and that all nutritional products once taken off premises are ineligible for return/refund. Our office endeavors to treat people with all needs, so if special circumstances exist, please discuss these with the doctors or office manager. I also understand and agree to pay for scheduled appointments that I am unable to keep and was not able to give at least 24 hours notice of wishing to cancel. I understand that your time and my time are valuable. If for any reason there is a balance in any account (insurance or nutrition), and payment is not made within 30 days of request for payment, TFCC is entitled to charge me up to 2% interest per month.

Patient Name (please print):_____ Patient Signature:_____

Parent/Guardian (print):_____ Parent/Guardian Signature:_____

Date:_____

AUTOMOBILE INJURY QUESTIONAIRE

Please circle or check off the appropriate response and add any comments as required.

NAME: _____Date of Accident _____ Hour _____ AM____ / PM _____

Where did accident happen? Describe the accident in your own words:

_____

_____

_____

_____

Who received a citation for the accident? Myself Other Driver Both Drivers Neither

In the auto collision, you were the ____Driver _____Passenger ____Pedestrian

Driver: If driver, which hands were on the steering wheel? **Left Right Both**

Passenger: If passenger, were you sitting in **Front Right Rear Left Rear**

Did your vehicle **strike** another vehicle? **Yes No** Was your vehicle **struck by** another vehicle? **Yes No**

At the time of the collision was your vehicle ____stopped _____moving, approximate speed: _____mph

Angle of impact. First Collision: **Front Back Left Right** If Second Collision: **Front Back Left Right**

What was the approximate speed of the vehicle that hit your vehicle? **1st _____mph 2nd _____mph**

What kind of seat belts were you wearing? _____lap belt only _____lap & shoulder belt ____ not wearing seat belt

Was there an air bag in your vehicle? **Yes No** Did the airbag deploy? **Yes No**

Did you brace for impact? **Yes No** If yes: ____ I braced with my hands _____ I braced with my feet

Which way were you facing at the time of impact? **Straight ahead Left Right**

Are the head restraints (rests) in your vehicle adjustable? **Yes No**

At the time of impact, do you know their approximate position **Yes No** _____

If possible, we would like to obtain a picture of you in the vehicle, so we can better assess your body position in the vehicle at the time of this accident because this is a major risk factor in rear impact collisions? Please let us know.

Did your body strike anything in vehicle at time of impact? **Yes No**

If yes, specify what part of your body struck interior of vehicle. (ie… head, chest, chin, shoulder, Right / Left Knee)

Steering Wheel _____ Dashboard _____ Windshield _____

Roof_____ Left Side Door _____Right Side Door_____

Left Side Window. _____ Right Window _____ Other _____

Did the seat back bend or break ? **Yes No**

Immediately following the accident, how did you feel? dizzy/dazed disoriented unconscious nervous nauseous upset weak Other _____

Was your vehicle drivable? **Yes No** Was your vehicle totaled? **Yes No**

Did you go to the hospital? **Yes** **No** Were you admitted to the hospital? **Yes** **No** If yes how long? _____

If you went to hospital, when? **At time of accident** **Next day** **Other** _____

How did you get to hospital? **Ambulance** **Police** **Friend/Family member** **Self** **Other**_____

Name of Hospital:_____

Attended by Dr. _____

What treatment was given?

___placed in a cervical collar
___x-rayed
___given stitches
___given instructions regarding concussions
___given instructions regarding sprains and strains
___instructed to call a Orthopedic Surgeon
___instructed to call a private physician
___Bandaged
___given pain medication
Other _____

Have you seen any other doctor as a result of this accident? **Yes** **No** If so, please provide information below.

Doctor's Name:_____
Treatment Given:_____
Time Frame Treatment Given_____ Did this treatment help?

Yes **No** Describe how your pain levels improved or failed to improve?

_____

_____

_____

Please list all activities below that are impaired or limited in any manor as a result of this accident:

1. ***Have you lost any time from work due to your injuries?*** ***Yes*** ***No***

   If yes please give dates: _____

2. Type of e mployment:_____

3. Have you had any previous injuries or accidents? **Yes** **No** Description of previous Accident:
   _____

4. Is there any residual pain from the previous injury? **Yes** **No** If there is residual pain from a prior auto or work related accident, please list any residual pain and please rate this pain level on a 0 to 10 scale as explained above.

_____.

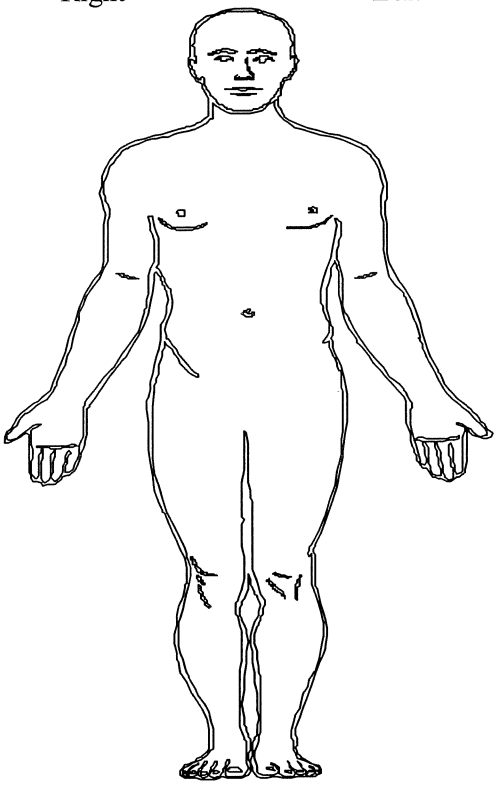
_____.

_____.

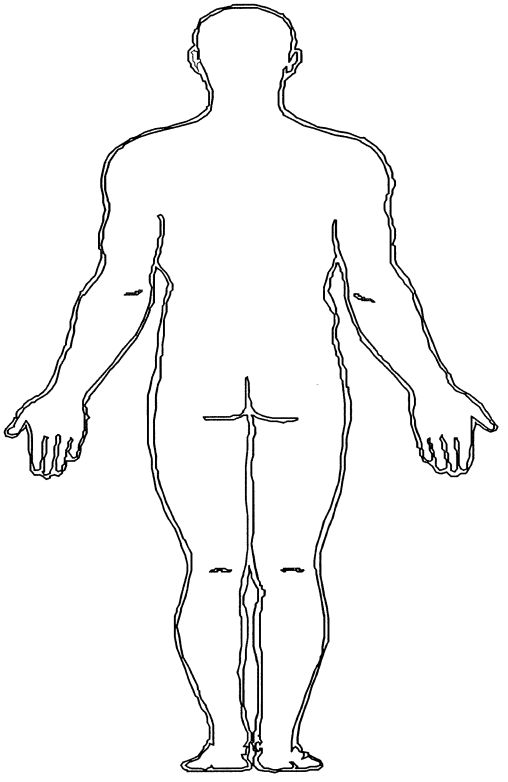
I, _____, certify that the complaints listed below are true as related by me and directly related to the automobile accident for which I seek treatment. I wish to be treated for these complaints and any additional complaints or problems, which may arise during the course of my consultant, exam and treatment(s).

Please circle ALL the areas of your pain complaint(s). Also circle and label any brusies or cuts as a result of this accident.

Right Left



Left Right



Use the following pain scale below to describe the complaint(s) that you have circled in the diagram above.

No Pain = 0
Mildly Uncomfortable = 2
Uncomfortable = 4
Very Uncomfortable = 6
Unable to Work = 8
Terrible Pain = 10

CHIEF COMPLAINTS OR SYMPTOMS:

WHEN COMPLETING THE FOLLOWING COMPLAINT SECTION PLEASE BE THOROUGH. ANY AREA(S) OF PAIN THAT YOU LIST, SUCH AS NECK PAIN, MUST HAVE CORRESPONDING ACTIVITIES THAT AGGRAVATE THIS PAIN. FOR EXAMPLE, ACTIVITIES SUCH AS TURNIG YOUR HEAD WHILE DRIVING OR READING OR WORKING ON THE COMPUTER MAY ALL INCREASE NECK PAIN.

Neck Pain: **Left** **Right** **Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.
Circle all areas of radiation, if any:

left shoulder	left arm	left forearm	left hand	base of skull
right shoulder	right arm	right forearm	right hand	none

The neck pain also seems to be related to: headaches upper back pain

List any particular activity that aggravates this condition:

1._____2._____3._____

Upper Back Pain: **Left** **Right** **Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

Select or list the areas of radiation, if any or circle none.

left neck	left shoulder	left arm	none
right neck	right shoulder	right arm	Other _____

List any particular activity that aggravates this condition:

1._____2._____3._____

Middle Back Pain: **Left** **Right** **Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

List any particular activity that aggravates this condition:

1._____2._____3._____

Low Back Pain: **Left** **Right** **Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

Select the areas of radiation, if any: left hip left thigh left knee left foot

no radiation of pain right hip right thigh right knee right foot

List any particular activity that aggravates this condition:

1._____2._____3._____

Shoulder Pain: **Left** **Right** **Bilateral**
Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

List any particular activity that aggravates this condition:

1._____2._____3._____

Elbow Pain: **Left** **Right** **Bilateral**
Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

List any particular activity that aggravates this condition:

1._____2._____3._____

Wrist Pain: **Left** **Right** **Bilateral**
Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

List any particular activity that aggravates this condition:

1._____2._____3._____

Hip Pain: **Left** **Right** **Bilateral**
Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

List any particular activity that aggravates this condition:

1._____2._____3._____

Knee Pain: **Left Right Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the intensity (severity) of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

List any particular activity that aggravates this condition:

1._____2._____3._____

Foot Pain: Left Right Bilateral

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

List any particular activity that aggravates this condition:

1._____2._____3._____

Other Complaints:

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the intensity (severity) of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

List any particular activity that aggravates this condition:

1._____2._____3._____

The following are complicating factors that have a tendency to slow down healing and response to care; please circle all apply:

☐age greater than 45
☐Metabolic disorders such as diabetes, fibromyalgia, chronic fatigue, celiac disease, lupus
☐History of numerous injuries or auto accidents, > 4 minor or greater than 1 major
☐Congenital anomalies of the spine such as spina bifida
☐Developmental anomalies of the spine
☐Rheumatoid arthritis or other arthritides affecting the spine
☐Ankylosing spondylitis or other spondylarthropathy
☐Degenerative disc disease
☐Disc protrusions (HNP)
☐Scoliosis
☐Prior cervical spinal surgery
☐Prior lumbar spinal surgery
☐Prior vertebral fracture
☐Osteoporosis
☐Spinal stenosis or foraminal stenosis
☐Prior spinal injury
☐Smoker
☐Prior drug or alcohol abuse
☐ Poor diet
☐ Poor fitness habits
☐ Overweight greater than 25 lbs.

When did the majority of your symptoms related to this accident first occur?

Immediately Within 2 hours By the next day Other _____

Circle symptoms you have noticed since your accident:

Headache	Numbness in fingers	Depression
Light bothers eyes	Buzzing in ears	Loss of taste
Diarrhea	Constipation	Dizziness
Head seems too heavy	Nervousness	Fatigue
Loss of memory	Numbness in toes	Anxiety
Cold feet	Loss of balance	Fear of driving in a car
Pins & needles in arms	Cold sweats	A loss of concentration
Face flushed	Irritability	Jaw clenching
Cold hands	Shortness of breath	Grinding of teeth at night
Pins & needles in legs	Fainting	Nightmares
Ringing in ears	Fever	Difficulty with sleeping at night
Upset stomach	Chest Pain	
Tension	Loss of smell	

Date: _____ Patient Signature: _____

AUTO ACCIDENT INSURANCE VERIFICATION

Patient's Name _____ Date of Accident _____

Patient's Insurance Information:

Insured's Name _____

Name of Insurance Co. _____

Mailing Address _____

_____

Phone # _____ Policy # _____

Claim # _____ Adjuster's Name _____

What are the PIP limits? _____

Have you filed a PIP claim and requested an application? Yes No Not required

******Patient needs to request an application from their insurance company to utilize their Personal Injury Protection******

Third Party's Insurance Information:

Insured's Name _____

Name of Insurance Co. _____

Mailing Address _____

_____

Phone # _____ Policy # _____

Claim # _____ Adjuster's Name _____

ATTORNEY

Name _____

Address _____

Phone number _____

Patient's Signature Date

The Neck Disability Index

Patient name:_____ Date:_____

Please read instructions:
This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

SECTION 2-PERSONAL CARE (Washing, Dressing, etc.)

☐ I can look after myself normally, without causing extra pain.
☐ I can look after myself normally, but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help, but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3-LIFTING

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights, but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

SECTION 4-READING

☐ I can read as much as I want to, with no pain in my neck.
☐ I can read as much as I want to, with slight pain in my neck.
☐ I can read as much as I want to, with moderate pain in my neck.
☐ I can't read as much as I want, because of moderate pain in my neck.
☐ I can hardly read at all, because of severe pain in my neck.
☐ I cannot read at all.

SECTION 5-HEADACHES

☐ I have no headaches at all.
☐ I have slight headaches that come infrequently.
☐ I have moderate headaches that come infrequently.
☐ I have moderate headaches that come frequently.
☐ I have severe headaches that come frequently.
☐ I have headaches almost all the time.

SECTION 6-CONCENTRATION

☐ I can concentrate fully when I want to, with no difficulty.
☐ I can concentrate fully when I want to, with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

SECTION 7-WORK

☐ I can do as much work as I want to.
☐ I can do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

SECTION 8-DRIVING

☐ I can drive my car without any neck pain.
☐ I can drive my car as long as I want, with slight pain in my neck.
☐ I can drive my car as long as I want, with moderate pain in my neck.
☐ I can't drive my car as long as I want, because of moderate pain in my neck.
☐ I can hardly drive at all, because of severe pain in my neck.
☐ I can't drive my car at all.

SECTION 9-SLEEPING

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr sleepless).
☐ My sleep is mildly disturbed (1-2 hrs sleepless).
☐ My sleep is moderately disturbed (2-3 hrs sleepless).
☐ My sleep is greatly disturbed (3-5 hrs sleepless).
☐ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-RECREATION

☐ I am able to engage in all my recreation activities, with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some neck.
☐ I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
☐ I am able to engage in few of my recreation activities, because of pain in my neck.
☐ I can hardly do any recreation activities, because of pain in my neck.
☐ I can't do any recreation activities at all.

The Revised Oswestry Disability Index (for low back pain/dysfunction)

Patient name:_____Date:_____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

☐ The pain comes and goes and is very mild.
☐ The pain is mild and does not vary much.
☐ The pain comes and goes and is moderate.
☐ The pain is moderate and does not vary much.
☐ The pain comes and goes and is very severe.
☐ The pain is severe and does not vary much.

SECTION 2-PERSONAL CARE

☐ I would not have to change my way of washing or dressing in order to avoid pain.
☐ I do not normally change my way of washing or dressing even though it causes some pain.
☐ Washing and dressing increases the pain, but I manage not to change my way of doing it.
☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
☐ Because of the pain, I am unable to do some washing and dressing without help.
☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3-LIFTING

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights, but it causes extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
☐ Pain prevents me from lifting heavy weights off the floor.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can only lift very light weights at the most.

SECTION 4-WALKING

☐ I have no pain on walking.
☐ I have some pain on walking, but it does not increase with distance.
☐ I cannot walk more than one mile without increasing pain.
☐ I cannot walk more than 1/2 mile without increasing pain.
☐ I cannot walk more than 1/4 mile without increasing pain.
☐ I cannot walk at all without increasing pain.

SECTION 5-SITTING

☐ I can sit in any chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 1/2 hour.
☐ Pain prevents me from sitting more 10 minutes.
☐ I avoid sitting because it increases pain right away.

SECTION 6-STANDING

☐ I can stand as long as I want without pain.
☐ I have some pain on standing, but it does not increase with time.
☐ I cannot stand for longer than one hour without increasing pain.
☐ I cannot stand for longer than 1/2 hour without increasing pain.
☐ I cannot stand for longer than 10 minutes without increasing pain.
☐ I avoid standing because it increases the pain right away.

SECTION 7-SLEEPING

☐ I get no pain in bed.
☐ I get pain in bed, but it does not prevent me from sleeping well.
☐ Because of pain, my normal night's sleep is reduced by less than 1/4.
☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
☐ Because of pain, my normal night's sleep is reduced by less than 3/4.
☐ Pain prevents me from sleeping at all.

SECTION 8-SOCIAL LIFE

☐ My social life is normal and gives me no pain.
☐ My social life is normal, but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
☐ Pain has restricted my social life and I do not go out very often.
☐ Pain has restricted my social life to my home.
☐ I have hardly any social life because of the pain.

SECTION 9-TRAVELLING

☐ I get no pain while travelling.
☐ I get some pain while travelling, but none of my usual forms of travel makes it any worse.
☐ I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
☐ I get extra pain while travelling, which compels me to seek alternative forms of travel.
☐ Pain restricts all forms of travel.
☐ Pain prevents all forms of travel except that done lying down.

SECTION 10-CHANGING DEGREE OF PAIN

☐ My pain is rapidly getting better.
☐ My pain fluctuates, but is definitively getting better.
☐ My pain seems to be getting better, but improvement is slow at present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

The Family Chiropractic Center - Loss of Enjoyment/Duties Under Duress Summary

Patient Name: _____ Date: _____

Complete the following questionnaire as it relates to how your injury(s) affect your performance of your living and work duties. Place a check in front of the day-to-day **living or work duties that are painful or difficult for you to perform as a result of the injuries** you sustained. Then mark the appropriate box designating reason for difficulty. Include those duties/responsibilities, which require that you reduce the time you are capable of performing them.

Job description:

_____

N/A	**Work**	**Reason for the Difficulty/Limitation**			
_____	Lifting	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Bending	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Sitting	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Walking	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Computer Duties	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Other: _____	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform

N/A	**Studies/School**	**Reason for the Difficulty/Limitation**			
_____	Lifting	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Bending	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Sitting	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Walking	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Computer Duties	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Studying	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Other: _____	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform

N/A	**Domestic Duties**	**Reason for the Difficulty/Limitation**			
_____	Vacuuming	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Taking Care of Kids	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Cleaning	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Preparing Meals	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Other: _____	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform

N/A	**Household Duties**	**Reason for the Difficulty/Limitation**			
_____	Yardwork	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Transportation	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Shopping	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Taking Out Trash	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform
_____	Other: _____	□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform

N/A	**Sports**	**Reason for the Difficulty/Limitation**			
Name Sport: _____		□ Increased Pain	□ Restricted Movement	□ Weakness	□Cannot Perform

Pre-Accident Level of Participation: □ Socially □ Competitively □ Professional

Patient Signature: _____ Date: _____

The Rivermead Post-Concussion Symptoms Questionnaire*

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

0 = Not experienced at all
1 = No more of a problem
2 = A mild problem
3 = A moderate problem
4 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches.....	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, Easily upset by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties besides those listed above and those noted on the automobile injury questionnaire? If so please list below.

1. _____	0	1	2	3	4
2. _____	0	1	2	3	4

Signature: _____ Date: _____

*King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592. 06/23/08

ASSIGNMENT, UCC LIEN, AND AUTHORIZATION

FOR DIRECT PAYMENTS BY MY PAYERS TO TILLOTSON & NIX CHIROPRACTIC CENTER, LLC dba THE FAMILY CHIROPRACTIC CENTER.

PURPOSE AND CONSIDERATION; TERMS WHICH PAYERS MAY BE REQUIRING. The purpose of this Assignment & UCC Lien is to assist the Office in obtaining Proceeds from various Payers (including without limit my Attorney) for the payment of my Charges. In consideration for receiving / continuing health care at the Office based on terms which Payers may be requiring, as well as on terms set forth in various documents of the Office, I agree to the following and direct all Payers as follows:

DEFINITIONS. In this Assignment & UCC Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to TILLOTSON & NIX CHIROPRACTIC CENTER or THE FAMILY CHIROPRACTIC CENTER located at 1124 N. LOCUST ST, DENTON, TX 76201; "Assignment & UCC Lien Document," "Assignment & UCC Lien," "Assignment & Lien," and other like phrases shall refer to this document. "Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, adjuster, claims handler, medical examiner, individual reviewer or review entity, at-fault party, individual, 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 settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, the proceeds relating to "health-care-insurance receivables" and "payment intangibles" 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, Medicare and Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical expense or payments benefits ("Medpay"), personal injury protection ("PIP"), lost wages, lost services, property damage, errors & omissions, and malpractice; "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 & UCC Lien, any Additional Costs incurred by the Office as defined herein, 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; "Additional Costs" shall include without limit any costs incurred by the Office relating directly or indirectly to (i) the goods or services associated with my Charges, (ii) this Assignment & UCC Lien, (iii) the application or enforcement of any law relating to the issue of the Office's Charges, secured interests or its goods and services, (iv) any effort or action to collect my Charges either from me or from any Payer, or (v) any legal or medico-legal action, process, or claim of any nature against, or by, the Office or its employees for any reason relating to the foregoing items, (i)-(iv), of the previous clause ("Medico-Legal Process"). "Additional Costs shall further include without limit an hourly fee of $20.00 for our Office's administrative staff time, as well as an hourly fee of $200.00 for any lost-time at work by any treating or diagnosing health care provider employed by or contracted with our Office, relating to any of the foregoing items. "Medico-Legal Process" shall include without limit civil and administrative proceedings, mediation, arbitration, interpleader actions, cross-claims or counterclaims, requests for reconsideration, independent reviews, and internal appeals. Costs associated with such Medico-Legal Processes shall also include without limit any pre- and post-judgment costs, filing fees, service of process charges, and attorney's fees. In determining the Office's Charges, I hereby waive any defense or argument that such costs shall not apply or be awarded based on the claim that the Office's goods or services were somehow (i) not sufficiently necessary or effective, related to an accident, documented or otherwise warranted, or (ii) inappropriately directed, delivered, conducted or administered.

ASSIGNMENT AND UCC LIEN TERMS. (i) 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 and 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. (ii) UCC Lien Terms: I further intend for this Assignment & UCC Lien to create a security interest under the applicable Uniform Commercial Code; accordingly, I hereby grant to the Office a primary, non-contingent security interest in all of my Claims to Proceeds to the extent permitted by law for the purpose of securing payment of my Charges ("UCC Lien"), 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 filings 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. (iii) Other Assignment and UCC Lien Terms: Consistent with the foregoing 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. To the extent that any law, including

without limit a lien statute, purports to limit, reduce, or modify the distribution of Proceeds in any manner inconsistent with this Assignment & UCC Lien including without limit through the reservation of a portion of the Proceeds exclusively to me, I hereby waive such

limits, reductions, or modifications. Such waiver shall not adversely affect or prejudice any rights which the Office may have and elect to exercise under said law.

SPECIFIC DIRECTION TO ANY ATTORNEY I RETAIN, SUCH AS IN ACCIDENT CASES. In the event that I retain one or more attorneys relating to my Claims to Proceeds, I hereby direct (and the Office hereby requests) each attorney to review the terms of this Assignment & UCC Lien, including without limit the fact that I may become responsible for various costs arising hereunder. Accordingly, I respectfully request that each attorney not unilaterally assume to arbitrate potential disputes relating to this Assignment & UCC Lien. I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of such Proceeds shall be primarily to pay my Charges. If I have a dispute with the Office, attorney, or any other party for any reason, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the Office for any portion of the Charges. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney's fees and costs, or other expenses of obtaining Proceeds.

DISCLOSURE DIRECTIVES TO ALL PAYERS. I hereby direct each and every Payer to immediately release to the Office any 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 the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information" shall also 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 & UCC Lien, unless otherwise agreed to in writing.

MISCELLANEOUS. Except as provided in this paragraph, this Assignment & UCC Lien 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 & UCC Lien. I agree that each and every provision of this Assignment & UCC Lien is reasonably necessary. However, should any provision of this Assignment & UCC Lien 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 & UCC Lien shall, nevertheless, remain in full force and effect. I agree to indemnify and hold the Office harmless for Charges, including without limit any Additional Costs as defined herein. This Assignment & UCC Lien 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 & UCC Lien, 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 & UCC Lien.

I have read, understood, and agree to the terms of this Assignment & UCC Lien.

Patient Name (print): _____Patient Signature: _____ Date: _____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient

(please print):_____Parent/Guardian Signature: _____ Date: _____