BILLING INFORMATION SHEET

ALL INFORMATION ON THIS SHEET MUST BE OBTAINED AND VERIFIED NO LATER THAN 7 BUSINESS DAYS FROM THE FIRST VISIT OF THE PATIENT TO THE CLINIC

PATIENT LAST NAME	
PATIENT FIRST NAME	
PATIENT ADDRESS, STREET NUMBER, STREET, CITY, STATE, ZIP	
PATIENT GENDER M/F	
PATIENT DOB MM/DD/YYYY	
WHAT KIND OF INJURY AUTO / WORK / OTHER	
DATE OF INJURY MM/DD/YYYY	
DATE OF FIRST TREATMENT MM/DD/YYYY	
CAR INSURANCE NAME	
CAR INSURANCE CLAIM #	
CAR INSURANCE CLAIM ADJUSTER TELEPHONE AND TEL EXTENTION	
HEALTH INSURANCE NAME IF NONE TYPE "NONE"	
HEALTH INSURANCE POLICY HOLDER IF SELF TYPE "SELF"	
HEALTH INSURANCE MEMBER ID	
IS THIS A MASS HEALTH SUBSIDIZED PLAN? Y / N	
WAS THIS COVERAGE IN FORCE ON THE DATE OF ACCIDENT Y / N	
IS THIS AN ERISA PLAN Y/N IF YES ASK FOR ERISA LETTER FROM INS	
OBTAIN HEALTH INSURANCE CARD PREFERRED TO OBTAIN Y / N	
WAS TAKEN TO THE HOSPITAL BY AMBULANCE Y / N	
OBTAIN HOSPITAL CHARGES Y / N	
OBTAIN ANY MEDICAL RECORDS RELATED TO THIS ACCIDENT Y / N	
SAW ANY OTHER MEDICAL PROVIDER? IF YES WHO/WHEN/REASON	
OBTAINED POLICE OR CRASH REPORT Y / N	
NONE OF THE WORKMAN'S COMP CASES SHOULD BE SCHEDULED UNLESS THE INFORMATION BELOW IS AVAILABLE ON THIS SHEET	
WC INSURANCE NAME, ADDRESS AND TELEPHONE NUMBER	
WC INSURANCE CLAIM#	
WC INSURANCE POLICY NUMBER	
EMPLOYER NAME AND TELEPHONE NUMBER	
ATTORNEY NAME	
ATTORNEY ADDRESS	
ATTORNEY TELEPHONE NUMBER	

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____ /_____/_____

WELCOME: The doctor and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

PERSONAL INFORMATION:

Name: (*First*)_____ (*Middle*)_____(*Last*)_____ Jr., II, III, IV
Address: _____ City: _____ State: _____ Zip: _____
Birth Date: _____ /_____/_____ Age:___ Marital Status (*Circle*): Divorced Married Single Separated Widowed
Gender (*Circle*): Male / Female Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____
Social Security #: _____-_____-_____ Email Address: _____@_____
Spouses Name: _____ Names & Ages of Children: _____
Is your spouse a patient in our office? □ **Yes** □ **No**

Employer /Employment Status □Employed □Unemployed □Full Time / □Part Time Student □Other
Business Name: _____ Occupation/Job Title: _____
Business Address: _____
Business Phone: (_____) _____-_____ Type of Work:_____
Is it ok to contact you at work? □ Yes □ No

Emergency Contact Information
Name: (*First*)_____ (*Middle*)_____(*Last*)_____ Jr., II, III, IV
Address: _____ City: _____ State: _____ Zip: _____
Relationship: _____ Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

PAYMENT/INSURANCE INFORMATION:

Is the condition(s) that brought you here today due to an automobile accident or on the job injury?
□ Yes □ No

Who besides yourself is responsible for your bill? □Self-Pay □□Health Insurance □Auto Claim
Personal Health Insurance Carrier: _____ Health ID Card #:_____
Insured Person's Name: _____ Group #: _____
Insured Person's Date of Birth: _____ /_____/_____
Insured Person's Social Security #: _____-_____-_____
Auto or Workers' Comp Insurance Carrier & Claim #: _____

PRIMARY COMPLAINT:

_____
When did it start? _____
Describe the condition:_____
What do you think caused the problem?_____
Rate the pain from 1-10: At it's worst ____ At the present time ___ At least severe ___
Does the pain travel? □ Yes □ No If yes, from where to where? _____
Is condition getting worse? □ Yes □ No
List the activities that this condition prevents you from doing? _____
List past treatment for this condition and if they helped _____
_____

SECOND COMPLAINT:

_____

When did it start? _____

Describe the condition:_____

What do you think caused the problem?_____

Rate the pain from 1-10: At it's worst ____ At the present time ___ At least severe ___

Does the pain travel? □ Yes □ No If yes, from where to where? _____

Is condition getting worse? □ Yes □ No

List the activities that this condition prevents you from doing? _____

_____

List past treatment for this condition and if they helped _____

_____

THIRD COMPLAINT:

_____

When did it start? _____

Describe the condition:_____

What do you think caused the problem?_____

Rate the pain from 1-10: At it's worst _____ At the present time ___ At least severe ___

Does the pain travel? □ Yes □ No If yes, from where to where? _____

Is condition getting worse? □ Yes □ No

List the activities that this condition prevents you from doing? _____

_____

List past treatment for this condition and if they helped _____

_____

LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:

_____

_____

_____

_____

_____

_____

LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:

_____

_____

_____

_____

_____

_____

LIST FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Is there any other information that you feel would be relevant to your current condition(s) that was not covered?
Please explain in the following section any information that you feel would be helpful to the doctor.

_____
_____
_____
_____

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process my insurance claims.

AUTHORIZATION OF ASSIGNMENT:

I authorize payment of medical benefits to *Chawla Chiropractic, PLLC* for services rendered to me.

REIMBURSEMENT POLICY:

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

ACCEPTANCE AS A PATIENT:

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment if I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information
gathering so that the doctor can determine whether to accept me as a patient.

_____
PATIENT PRINTED NAME

_____
PATIENT SIGNATURE

_____
DATE

HEALTH BENEFIT AFFIDAVIT

In accordance with Chapter 273 of the Acts of 1988, you are required to provide information regarding other health benefits (HMO, Medicare/Masshealth, etc.) available to you before processing a claim for Personal Injury Protection Benefits (P.I.P.).

Any medical expenses in excess of $2,000.00 will not be paid under P.I.P. , if those expenses will be compensated, paid or indemnified by an outside insurance carrier (HMO, PPO, etc.). Bills submitted for payment over the $2,000.00 limit must be accompanied by a statement from your health carrier as to their reason for non-payment. If your health insurance carrier does not cover your medical bills at 100 percent, P.I.P. may honor the partial outstanding charges.

If you have other benefits available to you, please complete SECTION ONE. In addition, if you have benefits available to you through any other policy (spouse, parent, legal guardian), please be sure to complete SECTION TWO, as well. If you do not have any other benefits available through your own policy or that of a household member, please sign SECTION THREE. For the purposes of P.I.P. benefits, coverage by Masshealth and Medicare is *not* considered health insurance.

SECTION ONE: Benefits Information - Policy Holder

Your Name: _____

Health Insurance Company: _____

Policy /Group Number: _____

Member Services Telephone Number: _____

Date: _____ Signature: _____

SECTION TWO: Additional Benefits Information - Not the Policy Holder

Health Insurance Company: _____

Policy /Group Number: _____

Policyholder: _____

Relationship: _____

Member Services Telephone Number: _____

Date: _____ Signature: _____

SECTION THREE: No Insurance

I certify that I do not have any accident and/or health benefits available to me through my own policy or that of a household member.

Date: _____ Signature: _____

I certify that I carry MassHealth/BMC HealthNet ☐ or Medicare/Medicaid ☐ . I do not have any accident and/or health benefits available to me through my own policy or that of a household member.

Date: _____ Signature: _____

APPLICATION FOR BENEFITS – PERSONAL INJURY PROTECTION

Date	Date of Accident	Claim Number
Your Name:		Telephone Number: Home: ( ) ____-_____ Work: ( ) ____-_____
Your Address:		Date of Birth: / Social Security Number
Date of Accident: Time: A.M. P.M. / /		Place of accident(Street, City or Town, State)
Brief description of accident:		
At Time of Accident: Were you the driver of the car? ___Yes ___No Were you a passenger in the car? ___Yes ___No Were you a pedestrian? ___Yes ___No		
As a result of this accident, were you injured ___Yes		
Describe Your Injury:		
Please Describe Names and Addresses Of All Medical Providers You Have Seen And What Procedures Have Been Done To This Date:		
At the time of your accident, were you in the course of your employment? ___Yes ___No		
If you lost time: Date disability from work began:		Date you returned to work:
Employer and address	Occupation	From To
Signature:		Date:

AUTHORIZATION FOR MEDICAL INFORMATION

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under you observation or treatment, including the history obtained, x-ray and physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the Massachusetts Personal Injury Protection Benefits Law.

_____

Signature Date

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are authorized to provide this information in accordance with the Massachusetts Personal Injury Protection Benefits Law.

_____

Signature Date

AUTHORIZATION FOR RELEASE OF COVERAGE INFORMATION BY EMPLOYER OR OTHER MEDICAL EXPENSE PROVIDER

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding any policy, contract or agreement I have with or through you to provide, pay for or reimburse the cost of medical expenses. This information is required to determine the benefits available to me under the Massachusetts Personal Injury Protection Benefits Law.

_____

Signature Date

REVIEW OF SYSTEMS

Patient Name: _____ Patient File #: _____ Today's Date: _____ /_____/_____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, ***circle*** "None."

Constitutional:
☐**None**
☐Chills
☐Daytime Drowsiness
☐Fatigue
☐Fever
☐Night Sweats
☐Weight Gain
☐Weight Loss

Eyes/Vision:
☐**None**
☐Blindness
☐Blurred Vision
☐Cataracts
☐Change in Vision
☐Double Vision
☐Eye Pain
☐Field Cuts
☐Glaucoma
☐Itching *(around the eyes)*
☐Photophobia
☐Tearing
☐Wears Glasses or Contacts

Ears, Nose and Throat:
☐**None**
☐Bleeding
☐Dental Implants
☐Dentures
☐Difficulty Swallowing
☐Discharge
☐Dizziness
☐Ear Drainage
☐Ear Infection*(s)*
☐Ear Pain
☐Fainting
☐Headaches
☐Head Injury *(history of)*
☐Hearing Loss
☐Hoarseness
☐Loss of Smell
☐Nasal Congestion
☐Nose Bleeds
☐Post Nasal Drip
☐Rhinorrhea *(runny nose)*
☐Sinus Infections
☐Snoring
☐Sore Throats
☐Tinnitus *(ringing in the ears)*
☐TMJ Disorder

Cardiovascular:
☐**None**
☐Angina *(chest pain or discomfort)*
☐Chest Pain
☐Claudication *(leg pain or achiness)*
☐Heart Murmur
☐Heart Problems
☐Orthopnea *(difficulty breathing while lying)*
☐Palpitations *(irregular or forceful heart beat)*
☐Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
☐Shortness of Breath
☐Swelling of Leg*(s)*
☐Ulcers
☐Varicose Veins
☐High Blood Pressure
☐High Cholesterol

Gastrointestinal:
☐**None**
☐Abdominal Pain
☐Belching
☐Black, Tarry Stools
☐Constipation
☐Diarrhea
☐Difficulty Swallowing
☐Heartburn
☐Hemorrhoids
☐Indigestion
☐Jaundice *(yellowing of the skin)*
☐Nausea
☐Rectal Bleeding
☐Abnormal Stool Caliber *(quality)*
☐Abnormal Stool Color
☐Abnormal Stool Consistency
☐Vomiting
☐Vomiting Blood

Respiration:
☐**None**
☐Asthma
☐Coughing up blood
☐Shortness of Breath
☐ History of COVID-19
☐ Sputum Production
☐ Wheezing

Endocrine:
☐**None**
☐Cold Intolerance
☐Diabetes
☐Excessive Appetite
☐Excessive Hunger
☐Excessive Thirst
☐Frequent Urination
☐Goiter
☐Hair Loss
☐Heat Intolerance
☐Unusual Hair Growth
☐Voice Changes

Skin:
☐**None**
☐Changes in Nail Texture
☐Changes in Skin Color
☐Hair Growth
☐Hair Loss
☐Hives
☐Itching
☐Paresthesia (numbness, prickling, or tingling)
☐Rash
☐History of Skin Disorders
☐Skin Lesions or Ulcers
☐Varicosities

Nervous System:
☐**None**
☐Dizziness
☐Facial Weakness
☐Headaches
☐Limb Weakness
☐Loss of Consciousness
☐Loss of Memory
☐Numbness
☐Seizures
☐Sleep Disturbance
☐Slurred Speech
☐Stress
☐Strokes
☐Tremors
☐Unsteadiness of Gait

Allergy:
☐**None**
☐Anaphylaxis *(history of)*
☐Food Intolerance
☐Itching
☐Nasal Congestion
☐Sneezing

Hematology:
☐**None**
☐Anemia
☐Bleeding
☐Blood Clotting
☐Blood Transfusion*(s)*
☐Bruises easily
☐Fatigue
☐Lymph Node Swelling

Psychological:
☐**None**
☐Anhedonia *(inability to experience joy or enjoy life)*
☐Anxiety
☐Appetite Changes
☐Behavioral Change*(s)*
☐Bipolar Disorder
☐Confusion
☐Convulsions
☐Depression
☐Insomnia
☐Memory Loss
☐Mood Change*(s)*

Female:
☐**None**
☐Birth Control Therapy
☐Breast Lumps / Pain
☐Burning Urination
☐Cramps
☐Frequent Urination
☐Hormone Therapy
☐Irregular Menstruation
☐Urine Retention
☐Vaginal Bleeding
☐Vaginal Discharge

Male:
☐**None**
☐Burning Urination
☐Erectile Dysfunction
☐Frequent Urination
☐Hesitancy or Dribbling
☐Prostate Problems
☐Urine Retention

Patient Signature: _____

FOR OFFICE USE ONLY:
I have reviewed the above ROS with the above named patient: _____ _____
Doctor Signature Date

NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE)

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications:
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say, "yes" to all reasonable requests.

Ask us to limit what we use or share:
You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-packet in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information:
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.

Choose someone to act for you:
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:
You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

Marketing purposes. Sale of your information. Sharing of psychotherapy notes.

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you:

We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization:

We can use and share your health information to run our practice, improve your care, and contact your when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services:

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:

We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research:

We can use or share your information for health research.

Comply with the law:

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:
We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions:
We can share heath information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain to privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice:
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

OPTIONAL Additional Items:
1) Open Room: We utilize an open therapy room. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to be treated in a private room if requested.

_____

PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

Notice to Patient:
We are required to offer you a copy of our HIPAA notice, which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

Patient Acknowledgement:
I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____
Patient Printed Name

_____
Patient Signature or legal representative

_____
If legal representative, state relationship

_____
Date

FOR OFFICE USE ONLY:
We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient but it could not be obtained because:
___ the patient refused to sign
___ we were not able to communicate with the patient
___ due to an emergency situation it was not possible to obtain a signature
___ other (please provide details):
_____

_____
Name of patient

_____
Name of staff member

_____
Signature of staff member

_____
Date

NOTICE OF DOCTOR'S LIEN/ASSIGNMENT OF BENEFITS

Patient:_____ Date of Accident:_____

I do hereby authorize _____ to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved. I also acknowledge that such doctor or his/her representative(s) may provide further consideration in exchange for this lien/assignment; including deposition testimony, trial testimony, and requested report(s).

I hereby authorize and direct you, my current and any successor attorney(s); together with any responsible insurance company, to pay directly to Chawla Chiropractic, LLC such total sums as are currently due *(OPTIONAL: in the amount of $_____)* and may become due and owing him/her in the future for all chiropractic and related services rendered me both by reason of this accident (OPTIONAL: and by reason of any other bills) that are due his office and to further withhold such total sums from any settlement, judgment, court order or verdict as may be necessary to adequately protect and fully compensate said doctor for such total sums. I hereby further give a lien or assignment of my potential benefits on my pending/prospective case to said doctor against any and all insurance benefits, referenced below, and proceeds of my settlement, judgment, court order or verdict which may be paid to you, my attorney, and/or myself as a result of the injuries or illness for which I have been or will be treated from a chiropractic scope of care perspective in connection with such accident; (OPTIONAL: including any unpaid services for chiropractic care provided prior to such accident.)

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for services rendered me and that this agreement is made for said doctor's additional protection and in consideration of his awaiting payment and other services provided by him, as referenced above. I further understand that such payment is not contingent on any settlement, judgment, court order or verdict by which I may eventually recover said fee and that my doctor may take appropriate and timely action to enforce payment against me for all such outstanding chiropractic bills.

I agree to promptly notify said doctor prior to any change or addition of attorney(s) used by me in connection with this accident, and I instruct my present attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s). I further acknowledge and agree that this executed lien/assignment shall be binding upon any subsequent and/or additional attorney(s) regardless of whether this written document is expressly acknowledged by such attorney.

I request that my attorney(s) and any applicable insurance company acknowledge this lien/assignment by signing below and returning to the doctor's office. The undersigned agrees that a copy of this lien may be forwarded to third parties responsible for payment to the patient and that such third parties can act directly in protecting such lien/assignment. Such insurance benefits shall include any coverages provided to the patient(s) for liability, disability, medical payments coverage, no-fault, health and accident, workers compensation and any other applicable benefits. Such insurers are directed and authorized to withhold and reimburse to my doctor such amount as necessary to satisfy the total sum owed by me for chiropractic services. (OPTIONAL: The undersigned patient further acknowledges and agrees that in the event the enforceability and/or appropriate amount subject to this lien/assignment is litigated, the prevailing party will be awarded attorney's fees and costs.)

This agreement shall be binding upon the patient's heirs, successors, personal representatives or assigns.

_____ _____

Dated Patient's Signature
(or Parent/Legal Guardian if Patient is Minor)

The undersigned, being attorney of record for the above patient (and/or insurance company representative), does hereby acknowledge receipt of this notice and hereby agrees to honor and comply with all the terms of the above agreement and agrees to protect adequately and/or otherwise withhold such sums from any settlement, judgment, court order or verdict as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney and/or insurer further acknowledge that in the event the enforceability and/or appropriate amount subject to this lien/assignment is litigated, the prevailing party will be awarded attorney's fees and costs. This agreement shall be binding upon any successor, agent, representative, employee or substituted and/or added attorney(s) of the patient with the same force and effect.

_____ _____

Dated Attorney/Insurance Representative Signature

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

TELEMEDICINE INFORMED CONSENT

NOTICE TO PATIENT:

Tele-health, tele-medicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health. There are non-face-to-face patient-initiated communications.

PATIENT ACKNOWLEDGEMENT:

I understand the concept of tele-medicine and the particular electronic format this office uses. I understand that there have been great advancements in tele-medicine technology, however there may be problems in the communication. I understand that there may be limitations beyond our control. I understand that I may need to seek a face-to-face encounter with another healthcare provider instead accepting these tele-medicine visits. I understand that these tele-medicine visits may be only a one-time occurrence and that follow-up treatment may require a face-to-face encounter. I understand that specific procedures may require an additional informed consent process. I understand that there are no guarantees with tele-medicine.

_____

PATIENT PRINTED NAME

_____

Patient Signature

_____

DATE