WORKER'S COMPENSATION INTAKE FORM

Personal Information

FIRST NAME:_____ LAST NAME:_____ DATE:_____

DOB (mm/dd/yyyy):____/____/_____ AGE:_____ SEX AT BIRTH:_____
PRONOUNS:_____ HEIGHT:_____(feet)_____(inches) Weight (lbs):_____

MARITAL STATUS: _Single / Married / Divorced / Widowed_ (circle)

SPOUSES NAME:_____ NUMBER OF CHILDREN:_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____

PH #:_(_____)_____

Contact Information

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PH #:_(_____)_____ _Cell / Home / Work_ (circle)

EMAIL ADDRESS:_____

APPOINTMENT REMINDERS TEXT / EMAIL / OR BOTH? _____

Referral Information

REFERRING PHYSICIAN:_____ REFERRED PATIENT:_____

ADVERTISEMENT:_____ (Google / Yelp / Facebook / Internet / Etc.)

REFERRED DIRECTORY:_____

Patient Health Questionnaire

NAME:_____ DATE:____ / ____ / _____

1. **Please describe your major concern:**

_____

_____

a. Description

- ○ Sharp Pain
- ○ Dull Pain

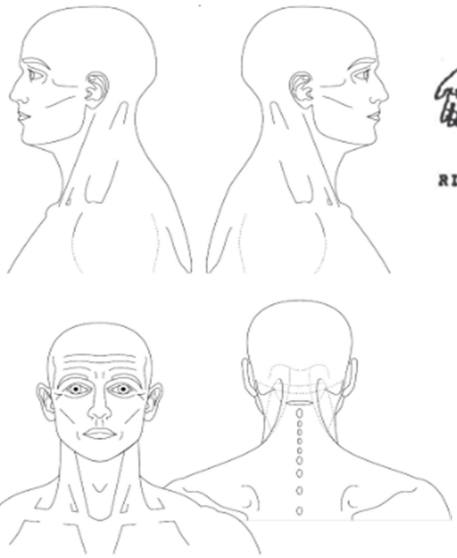
b. Frequency

- ○ Constantly (75-100%)
- ○ Frequently (51-75%)

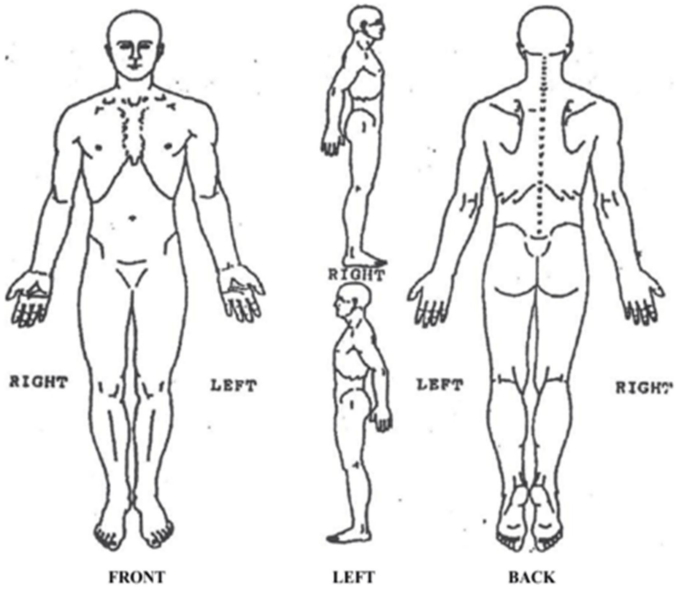
pain or other symptoms↓

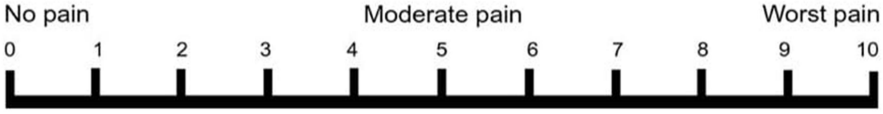
- ○ Ache
- ○ Weak
- ○ Throbbing
- ○ Numb
- ○ Shooting
- ○ Gripping
- ○ Burning
- ○ Tingling

- ○ Occasional (25-50%)
- ○ Intermittent (25% or less)



Please mark the pictures where you have





c. Indicate the intensity of your pain at its lowest and highest level ↓

d. Your symptoms are:

_____ decreasing

_____ not changing

_____ increasing

e. Symptoms are worse in the:

_____Morning _____Night _____Increases during the day _____Same all day

2. **When did your concern begin? (Specific date if possible)**_____

Describe how your concern began:_____

_____

3. **Have you been treated for *this episode*?** _____ Yes _____ No

If yes, by whom? ____Chiropractor ____MD ____Osteopath ____Physical Therapist ____Occupational Therapist ____Other

Are you Currently being seen? _____ Yes _____ No

If yes, when and what treatment? _____ / _____ / _____

_____

4. **Have you been treated *in the past* for the same or similar problem?** _____ Yes _____ No

If yes, whom did you see for that episode? ____Chiropractor ____MD ____Osteopath ____Physical Therapist ____Occupational Therapist ____Other

When and what treatment did you receive? _____ / _____ / _____

_____

5. **What makes your problem better?** ___Nothing ___Lying Down ___Walking ___Standing ___Movement/Exercise ___Inactivity
6. **What makes your problem worse?** ___Nothing ___Lying Down ___Walking ___Standing ___Movement/Exercise ___Inactivity
7. **How would you rate your general stress level?** ___Little to None ___Minimal ___Moderate ___Great
8. **General Activity Level**: ___No Regular Exercise ___Light Exercise ___Moderate Exercise ___Strenuous Exercise
9. **How are your complaints affecting your ability to be active?**

___No effect

___Some restrictions (able to perform light duty work and household tasks)

___Need limited assistance with common everyday tasks

___Need assistance often

___Have significant inability to function without assistance

___Am totally impaired/disabled (cannot care for myself)

10. **Your physical activity at work is:**

___ Sitting more than 50% of workday ___Light manual labor ___Manual Labor ___Heavy manual labor ___Repeated Motion

11. **Your occupation**:_____ **Has your work status changed due to this complaint?**_____
12. **What is your current work status**?

___Full time, no restrictions ___Part time, with restrictions ___Unemployed ___Other

___Full time, with restrictions ___Off work due to restrictions ___Retired

___Part time, no restrictions ___Full time homemaker ___Full time student

Patient Signature:_____ Date:____ / ____ / _____

To assist your doctor in more thoroughly understanding your state of health, please provide information concerning past and present conditions and diseases. If you have had a listed condition in the past, please check the *PAST* column. If a condition is troubling you presently, check the *PRESENT* column.

Past	Present		Past	Present		Past	Present	
□	□	Neck Pain	□	□	General Fatigue	□	□	Diabetes
□	□	Shoulder Pain	□	□	Irregular Menstrual Flow	□	□	Epilepsy
□	□	Pain in Upper Arm or Elbow	□	□	Profuse Menstrual Flow	□	□	Ulcer
□	□	Hand Pain	□	□	Breast Soreness/ Lumps	□	□	Liver/Gallbladder Problems
□	□	Wrist Pain	□	□	Endometriosis	□	□	Kidney Stones
□	□	Upper Back Pain	□	□	PMS	□	□	Hepatitis
□	□	Low Back Pain	□	□	Loss of Bladder Control	□	□	Bladder Infection
□	□	Pain in Upper Leg or Hip	□	□	Painful Urination	□	□	Colitis
□	□	Pain in Lower Leg or Hip	□	□	Frequent Urination	□	□	Kidney Disorders (by condition)
□	□	Pain in Ankle or Foot	□	□	Abdominal Pain	□	□	Irritable Colon
□	□	Jaw Pain	□	□	Constipation/ Irregular Bowel Habits	□	□	HIV/AIDS
□	□	Swelling/Stiffness of Joints	□	□	Difficulty in Swallowing	□	□	Systemic Lupus
□	□	Fainting	□	□	Heartburn/ Indigestion	□	□	Chronic Cough
□	□	Visual Disturbances	□	□	Depression	□	□	Chronic Sinusitis
□	□	Convulsions	□	□	Dermatitis/ Eczema/Rash	□	□	Other:_____
□	□	Dizziness	□	□	Aortic Aneurysm			
□	□	Headache	□	□	High Blood Pressure			
□	□	Muscular Incoordination	□	□	Angina			
□	□	Tinnitus (Ear Noises)	□	□	Heart Attack			
□	□	Rapid Heart Beat	□	□	Stroke			
□	□	Chest Pain	□	□	Asthma			
□	□	Loss of Appetite	□	□	Cancer/Tumor			
□	□	Loss of Appetite	□	□	Prostate Problems			
□	□	Anorexia	□	□	Blood Disorder			
□	□	Abnormal Weight: ___Gain ___Loss	□	□	Emphysema (chronic lung disorders)			
□	□	Excessive Thirst	□	□	Arthritis/ Rheumatoid Arthritis			

Patient Signature:_____ **Date:**_____/_____/_____

To assist your doctor in more thoroughly understanding your state of health, please provide information concerning past and present conditions and diseases. If you have had a listed condition in the past, please check the *PAST* column. If a condition is troubling you presently, check the *PRESENT* column.

Past	Present	
□	□	Pregnancy
□	□	Birth Control Pills
□	□	Hormone/Estrogen replacement
□	□	Medications (list if not listed elsewhere): _____ _____
□	□	Hospitalizations/Surgical Procedures: _____ _____
□	□	Tobacco
□	□	Alcohol
□	□	Drug or Alcohol Dependence
□	□	Coffee/Tea/Caffeinated Soft Drinks – cups/cans per day:_____

Present: Weight_____ lbs Height _____ft _____in

Please mark if a family member has had any of these:

□	Cancer	□	Epilepsy
□	Rheumatoid Arthritis	□	Chronic Back Problems
□	Diabetes	□	Chronic Headaches
□	Heart Problems	□	Lupus
□	Lung Problems	□	Other Conditions: _____ _____
□	High Blood Pressure		

____ **Yes** ____ **No** Do you have a permanent disability rating?

Location: _____

Date rating received: _____/_____/_____

Rating Percentage: _____ %

Doctor's Additional Comments/General Health Concerns:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature:_____ **Date:**_____/_____/_____

NOTICE TO PATIENT OF WORKERS' COMPENSATION BILLING PRACTICE

(Effective March 17th, 2010)

ORS 656.245 (1) entitled an injured worker to all reasonable and necessary medical services that the nature of the injury or the process of recovery requires. Therefore, all medical services provided for an on-the-job injury will first be submitted to the workers' compensation insurer in accordance with the Oregon Administrative Rules governing billing practices.

ORS 656.005 (12) allows a doctor of chiropractic medicine to be the attending physician for a period of 60 days from the date of first visit or for 18 visits, whichever first occurs, on the initial claim. After the 60th day or 18th visit, continued treatment will only be reimbursed by the workers' compensation insurance company if a medical doctor prescribes continued chiropractic treatment and provides a treatment plan to the insurance company prior to the commencement of treatment. Should the workers' compensation insurance company accept the claims for benefits and require the injured worker to participate in a Managed Care Organization (MCO) or the insurer required the injured worker to participate in an MCO prior to acceptance and guarantees payment of those medical benefits in writing, the injured worker would then by required to see a doctor on the insurance company's preferred doctor list for that MCO.

If a bill that has been submitted to the insurance company on an accepted claim has not been paid within 30 days, or has been submitted and the insurance company has denied payment of the bill, the bill will be forwarded to the patient with the explanation of the insurer's action. The patient may then retain the services of an attorney, whose fees will be paid by the insurance company, which may then request a hearing. No further billings will be submitted to the patient pending the outcome of litigation brought about by the patient's attorney. However, the patient may decide not to request a hearing but will then be responsible for payment of the bill. If the result of the hearing is that the bill is not the responsibility of the workers' compensation insurance company, the bill will be submitted to the patient's health insurance provider to be paid in accordance with the limits, terms and conditions of that policy. If the patient has no health insurance, the bill(s) will be submitted to the patient.

PATIENT ACKNOWLEDGEMENT

By signing this document, I acknowledge that the above information has been provided to me and applies to any treatment that is provided by this medical service provider. I further acknowledge that, based on the above, I may be responsible for the payment of the services provided by this provider.

_____ _____

Date Patient signature

Worker's Compensation Form

Patient's Name: _____ Date of Birth: _____ Age: _____

Time of Injury: _____AM_____PM Date of Injury: _____ Last Day Worked: _____

Returned to Work On: _____ Occupation: _____ SS#:_____

Employer's Business Name (be specific): _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Describe your Symptoms in Detail: _____

Was body part injured before: _____Yes _____NO

If yes, give details: _____

Please explain in detail where and how this accident occurred:

_____

_____

Does employer know this? ____Yes ____No To whom reported? _____

Name of witness to accident: _____ Hospitalized? ____ Yes ____ No

If hospitalized, give name of hospital: _____

Industrial Accident Coverage:

Name of Insurance Carrier: _____ Claim# _____

Carrier's Address: _____ City: _____

State: _____ Zip: _____ Phone: (____)_____

I have read the above information and certify it to be true to the best of my knowledge and belief and hereby authorize this office to do what is necessary, in accordance with state statutes, for the care and management of this complaint.

SIGN: _____ **DATE**: _____

Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other procedures by Weber Chiropractic LLC. The following points have been explained to me, to my satisfaction, and I have had an opportunity to discuss them with the Dr. and/or other clinic personnel.

-Chiropractic care is the science, philosophy and art of locating and correcting spinal joint dysfunction (misalignments) and as such, is oriented toward improvement of spinal function relative to range-of-motion, muscular and neurologic aspects. There has been no promise implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic.

-I understand that the chiropractor will use his/her hand or a mechanical device upon my body to adjust a joint which may cause an audible "pop" or "click".

-As with the practice of medicine, the practice of chiropractic is not an exact science, but relies upon information related by the patient, information gathered during the examination, and the doctor's interpretation thereof, as well as the doctor's judgement and expertise in working with similar cases.

-It is not reasonable to expect my chiropractor to be able to anticipate, or explain all possible risks and complications of a given procedure on any particular visit. And I wish to rely on the doctor to exercise professional judgment during the course of any procedures, which he/she feels at the time to be in my best interest.

-An undesirable result, or side effect, does not necessarily indicate error in judgement or an improper treatment.

-As with any health care procedure there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to sprains/strains, dislocations, fractures, disc injuries, or cerebral-vascular accidents. These complications are extremely rare occurrences.

Clinic Account Policy

-Payment is expected at the time of service.

-As a service to you, we will bill your insurance company. We will ask you to pay the amount your insurance company will not pay at the time of each office visit. I.e.; deductible, percentage, co-pay, non-covered service.

-We make every effort to get accurate information from insurance companies. However, insurance companies make mistakes. For example, sometimes they tell us they'll cover certain charges and then not pay them when they receive the billing. For this reason, we periodically review accounts and may have to inform you of a balance due.

-Information received from the insurance company IS NOT A GUARANTEE OF BENEFITS. You are responsible for all charges incurred in this office.

-If you have a personal injury (automobile accident) account, we'll bill your insurance company. The insurance company may not cover 100% of your bill. You are responsible for the difference. We'll keep you updated on the payment activity on your account, and ask that you keep us updated on any new information you may receive regarding your account. We reserve the right to charge 18% interest per year on any outstanding claims over 30 days.

-Weber Chiropractic has a 24-hour cancellation policy, a $60 fee will be charged for missed appointments.

I have read the above consent, or had it read to me and I am comfortable with the information provided and consent to chiropractic treatment and management on that basis.

_____ _____ _____

Patient's Name (printed) Patient's Signature (Parent or Guardian) Date

Weber Chiropractic LLC Notice of Privacy Practices

_____ I have received a copy of Weber Chiropractic's Notice of Privacy Practices.

Initial

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Full Patient Name:_____ Date of Birth:_____

Signature: _____ Date:_____

I authorize the following health care provider to disclose my health information including; medical records, chart notes, billing statements, hospital records, laboratory reports, records pertaining to mental health treatment, claims, and all other medical information to:

Weber Chiropractic LLC

1530 E. 1st St. Newberg, OR 97132

Phone:(503) 538-7338 Fax: (503) 538-7339

Name of Provider releasing records: _____

Address: _____

_____

Phone Number:_____ Fax Number:_____

The purpose of this disclosure is : _____ to assist in my routine treatment.

_____ Other: _____.

_____ This authorization is valid for **2 years from the date of my signature** or until_____.

(Initial)

I may cancel this authorization at any time by sending a written notice to Weber Chiropractic, 1530 E. 1st. St. Newberg, OR, 97132. Cancellation of the authorization will not affect any actions taken prior to receiving my cancellation notice. My treatment, payment, or eligibility may not be conditioned upon completing this authorization. The information disclosed pursuant to the authorization may be subject to Federal confidentiality rules published in the "Notice of Privacy Practices". Unless otherwise permitted by the "Notice of Privacy Practices," these rules prohibit the recipient of substance abuse information from further disclosing it without express consent. I acknowledge that certain disclosures are permitted by law and if permissible disclosures occur, federal law may no longer protect the privacy of this information.

If this authorization is signed by a person acting on behalf of another person, please complete the following:

Name of Parent or Guardian : _____

Relationship:_____ Phone Number: _____.

Signature of Parent or Legal Guardian: _____

FINANCIAL POLICY AND AGREEMENT

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Definitions. In this Agreement, "Office" and "Clinic" shall refer to Anthony Weber, DC, PC, located at 1530 E 1st Street, Newberg, OR 97132; "Financial Policy" or "Agreement" shall refer to this document.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract. I agree to pay the full amount of my Charges to the Office promptly upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office. I agree that (1) any delay by the Office in making demand for payment, any delay in paying the full amount of my Charges, and any partial payments received by the Office towards my Charges, shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment in-full promptly upon demand, and shall not constitute an "accord and satisfaction" of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments, and (2) my account with your Office shall be considered as in "default" on the earlier of the following dates: (a) any Payer fails to pay any of all of the Charges in-full and directly to the Office upon receipt of those Charges within (i) thirty (30) days, or (ii) the period established by the earliest prompt pay deadline imposed on the Payer by law or contract, whichever occurs later, (b) I do not pay any or all of the Charges in-full within fourteen (14) days of demand, and (c) the Office attempts to charge my credit card in compliance with a written Payment Arrangement, but the charge is declined or not approved.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). For example (without finalizing this Agreement), I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I further understand that a Payer may Deny Payment stating that the individual provider who actually renders the treatment or procedure is out-of-network. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I also understand a Payer may require certain Charges to be pre-certified or pre-authorized. I understand that there may be many other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I agree that if I have any questions about the Terms of Non-Coverage, I can ask to see copies of the Office's verification (e.g. eligibility, pre-authorization) forms to gain further understanding. I further agree that should the Office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or the Office may in my opinion not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office responsible or liable in any of the foregoing instances.

Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize the Office to submit my Charges as well as a copy of the Assignment & Lien, to any and all Payers, not including in accident cases my health benefit plan or Medicare. Notwithstanding the foregoing, In the event that the Office determines in its sole discretion that it has any reasonable basis for either submitting or not submitting my Charges and/or other documentation to a Payer. I hereby authorize the Office to take such action without condition or restriction. I understand that some or all of these Payers may utilize fee scheduled which (a) the Office has agreed to accept, directly with said Payers in writing, or (b) law expressly imposes on the Office to accept (collectively, "Mandatory Fee Reductions"), I further understand that the Mandatory Fee Reduction imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are imposed on the Office by virtue of laws which regulate or restrict "balance billing". I hereby waive the application of such laws. In the event that no Mandatory Fee Reductions are actually imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

FINANCIAL POLICY AND AGREEMENT CONTINUED

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sing my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse, or my dependents. In such cases, my printed name, followed by the phrase, "(by Dr. Anthony Weber, DC, PC)," shall serve as a properly authorized endorsement. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement 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 agreement. I agree that each and every provision of this Agreement is reasonably necessary. However, should any provision of this Agreement be found to be invalid, illegal, or enforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located and is performable in the country where the Office is located. In any action based upon this Agreement, I hereby consent to personal jurisdiction and venue of any court in said country and waive all objections based on improper jurisdictions, venue, or forum inconvenience. I further waive any statue of limitations which may apply in any action based upon this Agreement. I have reviewed the Office's "Assignment and Lien" and Health Insurance Election forms and further agree to the terms and definitions set forth in these documents. Said documents are incorporated herein by reference. In the event that my condition is related to an accident, including without limit to automobile accidents, I understand that there will be an administrative fee necessary to cover the costs of verifying multiple Payers, filing and terminating liens, and submitting notices of same to Payers

I have read, understood, and agree to the terms of this Agreement.

Patient Name (printed):_____ **Date:**_____

Patient Signature:_____

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

_____

Parent/Guardian Signature:_____ **Date:**_____

Assignment, Lien, and Authorization

For Direct Payments by My Payers to Anthony Weber, DC, PC

Purpose. The purpose of this Assignment & Lien is to assist the Office in obtaining Proceeds from various payers for the payment of my Charges. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment & Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to Anthony Weber, DC, PC, located at 1530 E 1st Street, Newberg, OR 97132; "Assignment & Lien Document", "Assignment & Lien", and "Assignment" 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 obliged to pay or disburse Proceeds, either now or in the future, "Proceeds" shall include without limit, the Proceeds from any settlement, judgement, or verdict. The Proceeds from any promise to pay or reimburse the Proceeds relating to "health-care-insurance receivables" and "payment intangibles" such as are denied 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 underinsure motorist, no-fault, medical payment benefits, personal injury protection, 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 & Lien), any Collection Costs incurred by the Office, delinquency penalties and interest to the maximum extent permitted under law or at the annual rate of eighteen percent (18%), whichever is greater, and any other charges incurred by me at the Office; "Collection Costs" shall include without limit any pre- and post-judgment court costs, filing fees, service of process charges, attorney's fee, fees or costs associated with requests for reconsideration, independent reviews, appeals, mediation, arbitration, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Assignment and Lien 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 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 wither 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. I further intend for this Assignment & 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, the attachment and perfection of which shall relate back and be effective as 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 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 filing in all relevant jurisdictions as the Office sees fit in its sole discretion. I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or written request sent through the U.S. Postal Service Certified Mail. Consistent with these terms, I hereby direct any and all Payers to pay the Proceeds directly to, immediately to, and exclusively in the name of the Office to the full extent of my Charges. 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 & 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.

Assignment, Lien, and Authorization Continued

For Direct Payments by My Payers to Anthony Weber, DC, PC

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys who receive(s) Proceeds from one or more Payers, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding such Proceeds, 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 [ay my Charges. If I have dispute regarding the Charges, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the Office. 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 or obtaining Proceeds.

Disclosure Directives. 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 Determined 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 and 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 my by the Office to all Payers, including without limit a copy of my Charges and a copy of this Assignment & Lien, unless otherwise agreed to in writing.

Miscellaneous. Except as provided in this paragraph, this Assignment & 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 & Lien. I agree that each and every provision of this Assignment & Lien is reasonably necessary. However, should any provision of this Assignment & Lien be found invalid, illegal, or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment & Lien shall nevertheless remain in full force and effect. This Assignment & 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 & 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 & Lien.

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

Patient Name (printed):_____ **Date:**_____

Patient Signature:_____

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

_____

Parent/Guardian Signature:_____ **Date:**_____

Neck Index

Form N1 – 100

Patient Name _____ **Date**_____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

⓪ I have no trouble sleeping
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-3 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 sleepless).

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage to lift medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I can't drive my car as long as I want because of moderate pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Recreation

⓪ I am able to engage in all my recreation activities without pain.
① I am able to engage in my usual activities with some pain.
② I am able to engage in most but not all activities because of pain.
③ I am only able to engage in a few recreation activities.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index Score

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index

Form N1 – 100

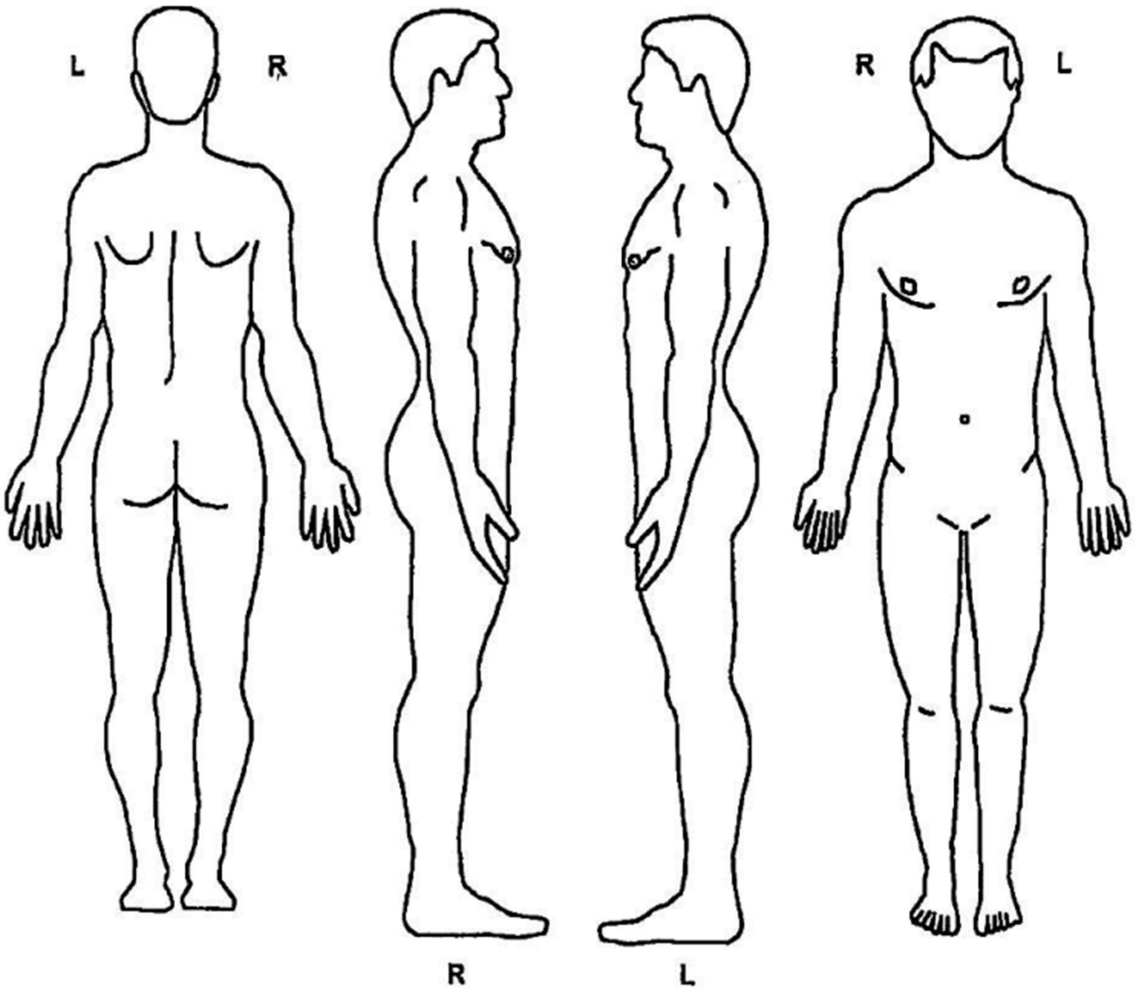
Patient Name _____ **Date**_____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity ⓪ The pain comes and goes and is very mild. ① The pain is mild and does not vary much. ② The pain comes and goes and is moderate. ③ The pain is moderate and does not vary much ④ The pain comes and goes and is very severe ⑤ The pain is very severe and does not vary much	**Personal Care** ⓪ I don't have to change my way of washing / dressing in order to avoid pain. ① I don't change my way of washing / dressing though it causes some pain. ② Washing / dressing increases the pain but I manage not to change my way. ③ Washing / dressing increases the pain and I change my way of doing it. ④ Because of pain I'm unable to do some washing / dressing without help. ⑤ Because of pain I'm unable to do any washing / dressing without help.
Sleeping ⓪ I get no pain in bed. ① I get pain in bed but it does not prevent me from sleeping well. ② Because of pain my normal sleep is reduced by less than 25%. ③ Because of pain my normal sleep is reduced by less than 50%. ④ Because of pain my normal sleep is reduced by less than 75%. ⑤ Pain prevents me from sleeping at all.	**Lifting** ⓪ I can lift heavy weights without extra pain. ① I can lift heavy weights but it causes extra pain. ② Pain prevents me from lifting heavy weights off the floor. ③ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (e.g. on a table). ④ Pain prevents me from lifting heavy weights off the floor but I can manage light to medium weights if they are conveniently positioned. ⑤ I can only lift very light weights.
Sitting ⓪ I can sit in any chair as long as I like. ① I can only sit in my favorite chair as long as I like. ② Pain prevents me from sitting more than 1 hour. ③ Pain prevents me from sitting more than 1/2 hour. ④ Pain prevents me from sitting more than 10 minutes without pain. ⑤ I avoid sitting because it increases pain immediately.	**Traveling** ⓪ I get no pain while traveling. ① I get some pain while traveling but none of my usual ways make it worse. ② I get extra pain while traveling but it doesn't cause me to find alternate ways to travel. ③ I get extra pain while traveling which cause me to find alternate ways to travel. ④ Pain restricts all forms of travel except that done while lying down. ⑤ Pain restricts all forms of travel.
Standing ⓪ I can stand as long as I want without pain. ① I have some pain while standing but it does not increase. ② I cannot stand for longer than 1 hour without increasing pain. ③ I cannot stand for longer than 1/2 hour without increasing pain. ④ I cannot stand for longer than 10 minutes without pain. ⑤ I avoid standing because it increases pain immediately.	**Social Life** ⓪ My social life is normal and gives me no extra pain. ① My social life is normal but increases the degree of pain. ② Pain has no great effect on my social life other than limiting my more energetic interests (e.g. dancing, etc.). ③ Pain has restricted my social life and I do not go out very often. ④ Pain has restricted my social life to my home. ⑤ I have hardly any social life because of the pain.
Walking ⓪ I have no pain while walking. ① I have some pain while walking but it doesn't increase. ② I cannot walk more than 1 mile without increasing pain. ③ I cannot walk more than 1/2 hour without increasing pain. ④ I cannot walk more than 1/4 mile without increasing pain. ⑤ I cannot walk at all without increasing pain.	**Changing degree of pain** ⓪ My pain is rapidly getting better ① My pain fluctuates but overall is definitely getting better. ② My pain seems to be getting better but improvement is slow. ③ My pain is neither getting better or worse. ④ My pain is gradually worsening. ⑤ My pain is rapidly worsening. Back Index Score

PAIN DRAWING

Name:_____ Date:_____



Mark as follows:

A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing

O = Other – Describe:_____

_____