AUTO ACCIDENT PATIENTS

Welcome to our office.

We will be happy to process your auto accident claim. The following is some information about our auto accident care policy.

If your auto accident company has not already been informed of your auto accident, contact them as soon as possible.

We will bill the insurance company directly. In order to do so, we must have all billing information necessary to process our claim.

In the event that your claim is denied by your auto insurance carrier, you will be responsible for payment.

Please supply us with your private healthcare insurance. If the auto claim is denied we will bill your private insurance. You are ultimately responsible for your incurred charges at this office if your insurance does not pay.

If you have any questions, please ask us before signing.

I understand and accept the statements of this document.

____

(Patient Signature)

____

(Print your name)

____

(Date)

NEW PATIENT 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 OR EMAIL?________________________________

Referral Information:

REFERRING PHYSICIAN:_____________REFERRED PATIENT:__________________

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

REFERRED DIRECTORY:____

WEBER CHIROPRACTIC LLC - DR. ANTHONY WEBER
1530 E 1st Street, Newberg Oregon 97132 - 503.538.7338

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

Patient Health Questionnaire

NAME________________________________ DATE___/___/___

1. Please describe your major concern:

____

____

a. Description
- ☐ Sharp Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Numb
- ☐ Shooting
- ☐ Gripping
- ☐ Burning
- ☐ Tingling

b. Frequency
- ☐ Constant (75-100%)
- ☐ Frequently (51-75%)
- ☐ Occasional (25-50%)
- ☐ Intermittent (25% or less)

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

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

No pain 1 2 3 4 5 6 7 8 9 10 Unbearable pain

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 a similar problem? _____yes _____no

If yes, whom did you see for that episode? __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 __Sitting __Movement/exercise __Inactivity

6. What makes your problem worse? __Nothing __Lying Down __Walking __Standing __Sitting __Movement/exercise __Inactivity

7. How would you rate your general stress level? ___ Little or No Stress ___Minimal Stress ___Moderate Stress ___Greatly Stressed

8. General Activity Level: ___No regular exercise program ___Light exercise program ___Moderate exercise ___Strenuous exercise

9. How are your complaints affecting your ability to be active?

___No effect
___Need limited assistance with common everyday tasks
___Have significant inability to function without assistance
___Some physical restrictions (able to perform light duty work and household tasks)
___Need assistance often
___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
___Full time, with restrictions
___Part time, not restrictions
___Part time, with restrictions
___Off work due to restrictions
___Full time homemaker
___Unemployed
___Retired
___Full time student
___Other

Patient Signature: ______________________________ Date___/___/______

(Please continue on page 2.)

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 ever had a listed condition in the past, please check the *Past* column. If a condition is troubling you presently, check it in the *Present* column.

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

Please check any of the following that apply to you.

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

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 __________%

Present Weight ________lbs Height ____ft, ____in

Doctor's Additional Comments/General Health Concerns:

____

____

____

____

____

____

____

____

____

____

____

____

____

Patient's Signature: ____ Date: ____/____/______

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Full Patients 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,
1530 E 1st Street, 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 two years from the date of my signature or until ____________________.

I may cancel this authorization at any time by sending written notice to Weber Chiropractic, 1530 E 1st Street, 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.

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

Name of Parent or Guardian ______________________ Phone Number ______________________

Relationship ______________________________

Signature of Parent or Legal Guardian ________________ Dated ______________________

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 construed as in "default" on the earlier of the following dates: (a) any Payer fails to pay any or 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 limiting 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 that 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 schedules 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 Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions 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.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign 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 unenforceable, 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 county 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 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 Agreement. I have reviewed the Office's "Assignment & 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 automobile accident, 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 (print): ______________________ Patient Signature: ______________________ Date: ___/___/___

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

Parent/Guardian Signature: ______________________ Date: ___/___/___

NAME:________________________________ DATE:______________
DATE & TIME OF ACCIDENT:______________ CITY:______________

Road conditions: ______wet ______dry ______icy ______________________other
Did the police come? ______ Were you taken to the hospital? ______ If so, where?__________
Were x-rays taken? ______ Were you given any prescription medication?______________

The following questions pertain to YOU, the patient, and the vehicle YOU were in:

1. **WHERE** were **YOU** seated in the vehicle?______________________________
2. Were you braced for impact?______________________________
3. Did you lose consciousness?______________________________
4. How far is the top of the headrest or seat back from the top of your head?______________
5. Were you wearing a seatbelt?______Was it a lap belt?_______ or shoulder-lap belt_______?
6. Year________, make________________ and model________________ of your vehicle.
7. Was your car stopped at time of impact? ______If not, estimated speed of your vehicle_____
8. Did you strike anything at the time of impact?_______ If yes, specify from the following list:

Steering wheel________ Dashboard________ Windshield________ Side Door________
Arm Rests________ Side Window ________ Other ______________________________

9. What part of your body struck? Chest _______ Chin _______ Knee _______ Head ________
Shoulder ________ Foot ________ Arm ________ Hand ________ Other ______________

10. What bleeding cuts did you get during this accident? ______________________________
11. What bruises did you get? ______________________________
12. What is the cost damage to the vehicle you were in?______________________________
13. At the time of impact were you ______looking straight ahead ______looking right ______looking left
14. Immediately following the accident, how did you feel?______________________________
15. Describe your symptoms now: ______________________________
16. Check symptoms you have noticed since the accident:

______headache
______neck pain
______stiff neck
______sleeping problems
______back pain
______nervousness
______tension
______irritability
______chest pain
______dizziness
______head seems to heavy
______loss of balance

______pins & needles in legs
______numbness in fingers
______numbness in toes
______shortness of breath
______fatigue
______depression
______lights bother eyes
______loss of memory
______ears ring
______face flushed
______buzzing in ears

______fainting
______loss of smell
______loss of taste
______diarrhea
______cold feet
______hands cold
______stomach upset
______constipation
______cold sweats
______fever
______pins & needles in arms

17. Are you allergic to any medications? Yes No If yes, please list.__________________

____

____

How did the accident happen? Please use space below to describe your accident:________________________

Accident Diagram

= Yield Sign
=Stop Sign
=Stop Light
=One way (sign), arrow indicates direction
=Pedestrian
=Your vehicle
=Other vehicle

The following questions pertain to the OTHER VEHICLE involved in the accident:

What is the year ______; make ____________ and model of the vehicle ____________?
Was the other vehicle moving at the time of the collision? ______

Have you reported this accident to any insurance company?__________________________If yes, which one(s)
______ my own ______my drivers ______owner of my drivers vehicle
______ the other driver's ______ the owner of the other vehicle

INSURANCE COMPANY ACCIDENT INFORMATION:

If a claim number has been assigned, please list the number______________________
Name of insurance company associated with this claim number ______________________
Phone number______________________ Name of Agent ______________________

Your auto insurance company: ______________________________________
Address: ______________________________________ Phone #______________
Policy number: ______________________________ Agent:______________

Driver of other vehicle:
Name: ____
Address: ____

Other driver's auto insurance company: ______________________________
Address: ____
Policy number: ______________________________________

Which insurance company is paying your claim: ______________________________

Have you notified your insurance company and opened a Personal Injury Protection claim?
Yes__________ No__________

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 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 payments 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 fees, fees or costs associated with requests for reconsideration, independent reviews, appeals, mediation, arbitration, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Assignment 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 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. 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 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. 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.

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 pay my Charges. If I have a 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 of 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 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 & 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 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 & 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 (print): ______________________________

Patient Signature: ______________________________ Date: ___/___/___

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

Neck Index

Form N1-100

rev 3/27/2003

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 (1-2 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 hours 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 light to 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 cannot drive my car as long as I want because of moderate neck 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 neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
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.

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

Neck Index Score

Back Index

Form BI100

rev 3/27/2003

Patient Name ______________________________ *Date* ________

This questionnaire will give your provider information about how your back 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.

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.

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.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
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 increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

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.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

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 significant affect on my social life apart from 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.

Changing degree of pain

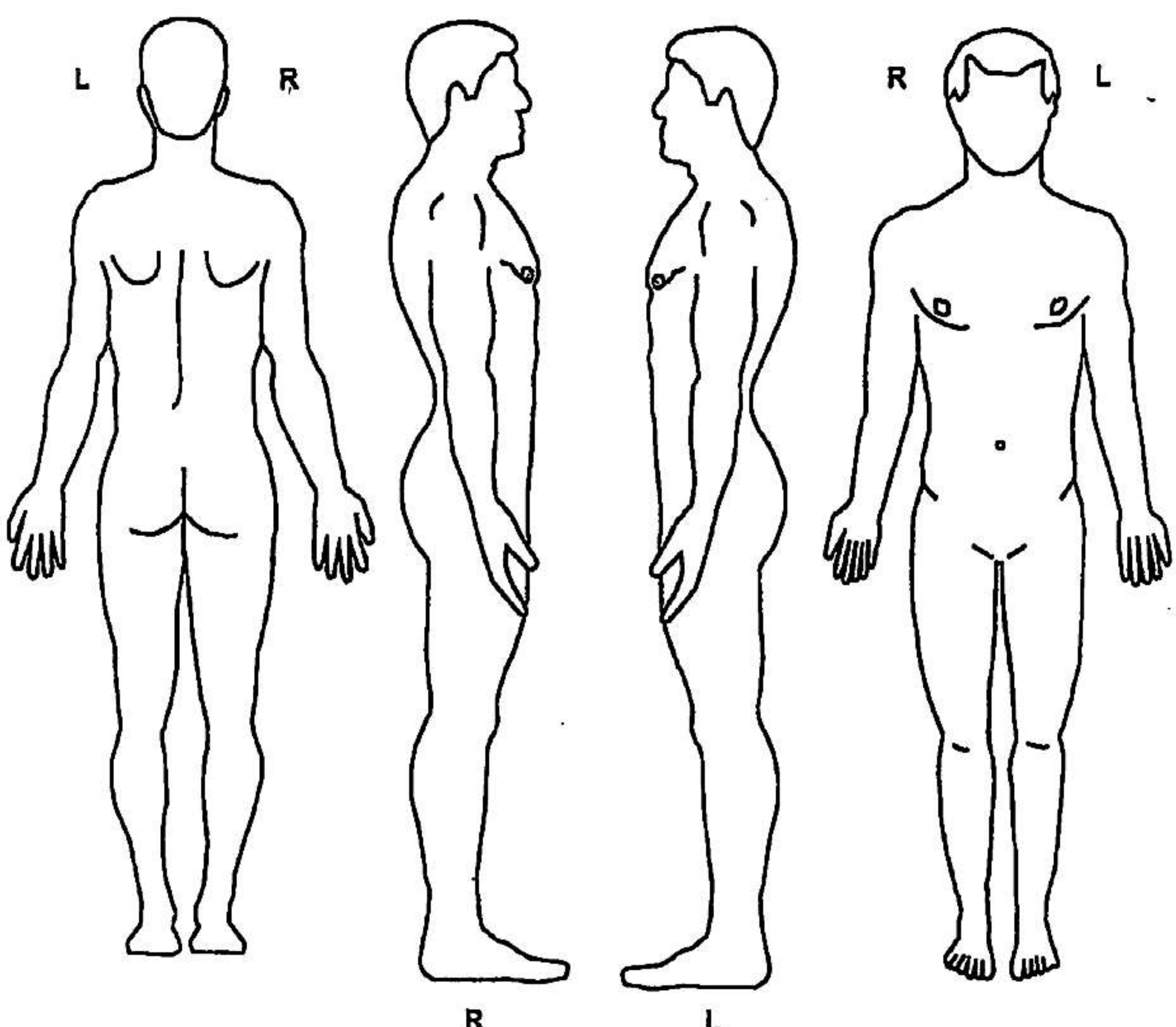
⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

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

Back Index Score

PAIN DRAWING

Name ______________________________ Date __________



Mark as follows:
A - Ache B - Burning N - Numbness P - Pins & Needles
S - Stabbing O - Other - Describe ______________________________