



# WEBER CHIROPRACTIC

## 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: \_\_\_\_\_

## Patient Health Questionnaire

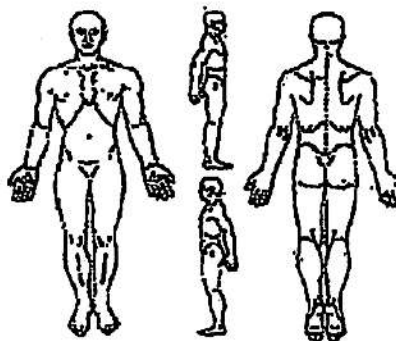
NAME \_\_\_\_\_

DATE / / \_\_\_\_\_

1. Please describe your major concern:

- |  |   |
|--|---|
| <p>a. Description</p> <p><input type="checkbox"/> Sharp Pain</p> <p><input type="checkbox"/> Dull Pain</p> <p><input type="checkbox"/> Ache</p> <p><input type="checkbox"/> Weak</p> <p><input type="checkbox"/> Throbbing</p> <p><input type="checkbox"/> Numb</p> <p><input type="checkbox"/> Shooting</p> <p><input type="checkbox"/> Gripping</p> <p><input type="checkbox"/> Burning</p> <p><input type="checkbox"/> Tingling</p> | <p>b. Frequency</p> <p><input type="checkbox"/> Constant (75-100%)</p> <p><input type="checkbox"/> Frequently (51-75%)</p> <p><input type="checkbox"/> Occasional (25-50%)</p> <p><input type="checkbox"/> Intermittent (25% or less)</p> |
|--|---|

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  Unbearable pain

1 2 3 4 5 6 7 8 9 10

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        Some physical 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, not restrictions        Full time homemaker        Full time student

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   |
|      |         | Tinnitus (Ear Noises)   |
|      |         | Rapid Heart Beat  |
|      |         | Chest Pains   |
|      |         | Loss of Appetite  |
|      |         | Anorexia  |
|      |         | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
|      |         | Excessive Thirst  |
|      |         | Chronic Cough   |
|      |         | Chronic Sinusitis   |
|      |         | General Fatigue   |
|      |         | Irregular Menstrual Flow  |
|      |         | Painful 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   |
|      |         | Inflamed Colon  |
|      |         | HIV/AIDS  |
|      |         | Systemic Lupus  |
|      |         | Other _____   |

Please check any of the following that apply to you.

Past	Present	
		Pregnancy
		Birth Control Pills
		Hormone/Estragen replacement
		Medications (List if not listed above)
		_____
		_____
		Hospitalization/Surgical Procedures
		_____
		_____
		Tobacco
		Alcohol
		Drug or Alcohol Dependence
		Coffee/Tea/Caffeinated Soft Drinks:
		caps/teas per day: _____

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

<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Chronic Back Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic Headaches
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Lupus
<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Other Conditions
<input type="checkbox"/> 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:

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Patient's Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

## **NOTICE TO PATIENT OF WORKERS' COMPENSATION BILLING PRACTICE**

**(Effective March 17<sup>th</sup>, 2010)**

ORS 656.245 (1) entitles an injured worker to all reasonable and necessary medical services provided to you for an on-the-job injury. The claim will first be submitted to the workers' compensation insurer in accordance with the Oregon Administrative Rules governing billing practices.

Should the workers' compensation insurance company accept the claims it may require you to participate in a Managed Care Organization (MCO). You would then be required to see a doctor on the insurance company's preferred doctor list. Our office may or may not be on that list. If it is on the list then we can continue to treat you. If it is not, then you will have to seek treatment elsewhere.

If a bill that has been submitted to the insurance company on an accepted claim has not been paid within 60 days, or has been submitted and the insurance company has denied payment of the bill, the bill will be forwarded to you with the explanation of the insurer's action. At that point you may retain the services of an attorney, whose fees will be paid by the insurance company, who may then request a hearing. No further billings will be submitted to you pending the outcome of litigation brought about by the patient's attorney. If the result of the hearing is that the bill is not the responsibility of the workers' compensation insurance company, then the bill will be submitted to your health insurance provider to be paid in accordance with the limits, terms and conditions of your policy. (If you have no insurance, then we expect you to pay the bill). Or you may decide not to request a hearing. You will then be responsible for payment of the bill. If you have health insurance, the bill(s) will be submitted to the Health Insurance Company on your behalf.

### **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 accept responsibility 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) \_\_\_\_\_ Phone \_\_\_\_\_  
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.

**SIGNED** \_\_\_\_\_ **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 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 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 two years from the date of my signature or until \_\_\_\_\_.

I may cancel this authorization at any time by sending written notice to Chehalem Valley & Weber Chiropractic, 2880 Hayes 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.

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

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 down-coded. 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: \_\_\_\_/\_\_\_\_/\_\_\_\_



## 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, located at 1630 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 of 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): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# 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

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is moderate and does not vary much.
- Ⓩ The pain comes and goes and is very severe.
- Ⓟ The pain is very severe and does not vary much.

## Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓩ Because of pain my normal sleep is reduced by less than 75%.
- Ⓟ Pain prevents me from sleeping at all.

## Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓜ Pain prevents me from sitting more than 1 hour.
- Ⓨ Pain prevents me from sitting more than 1/2 hour.
- Ⓩ Pain prevents me from sitting more than 10 minutes.
- Ⓟ I avoid sitting because it increases pain immediately.

## Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer than 1 hour without increasing pain.
- Ⓨ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓩ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓟ I avoid standing because it increases pain immediately.

## Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓩ I cannot walk more than 1/4 mile without increasing pain.
- Ⓟ I cannot walk at all without increasing pain.

## Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓩ Because of the pain I am unable to do some washing and dressing without help.
- Ⓟ Because of the pain I am unable to do any washing and dressing without help.

## Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor.
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓩ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓟ I can only lift very light weights.

## Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓩ Pain restricts all forms of travel except that done while lying down.
- Ⓟ Pain restricts all forms of travel.

## Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓜ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- Ⓩ Pain has restricted my social life to my home.
- Ⓟ I have hardly any social life because of the pain.

## Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- Ⓩ My pain is gradually worsening.
- Ⓟ My pain is rapidly worsening.

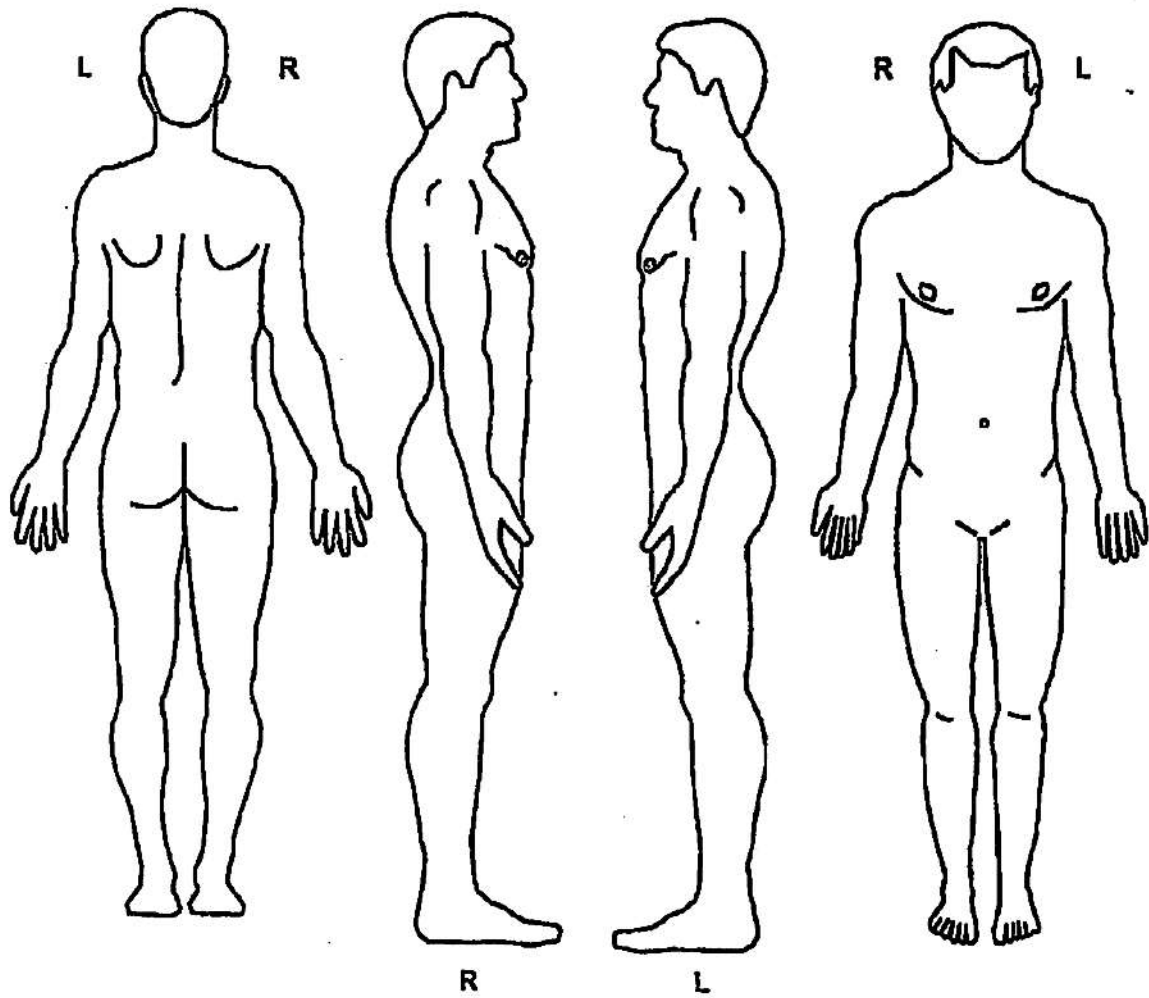
Index Score = (Sum of all statements selected / (# of sections with a statement selected x 5)) x 100 :

Back  
Index  
Score



# PAIN DRAWING

Name \_\_\_\_\_ Date \_\_\_\_\_



Mark as follows:

**A - Ache B - Burning N - Numbness P - Pins & Needles**

**S - Stabbing O - Other - Describe** \_\_\_\_\_