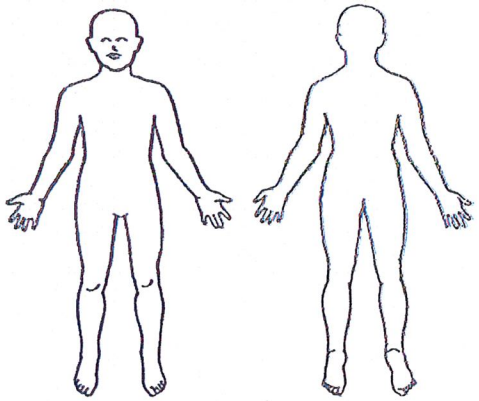
KIRSCHNER
Chiropractic & Wellness Centre

Kirschner Chiropractic & Wellness Centre / Arcadia Chiropractic Clinic **NEW PATIENT INTAKE**

Today's Date:____/____/_____ Patient Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr.
First Name_____ Nick Name_____
Last Name _____ Middle Name _____SSN_____
Address 1 _____
City_____ State_____ Zip Code _____
Primary Phone _____Secondary Phone _____Mobile Phone_____
Home email _____ Work Email _____
Contact Method: ❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth: ____/____/____Age:_____Gender: ❑ Male ❑ Female ❑ Unspecified **Marital Status:** ❑ Single ❑ Married ❑ Other
Do you have Children? ❑Yes ❑No **Employment Status** *(check one)* ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed **Business Name:**_____ **Title/ Occupation:**_____
Whom can we thank for referring you to our office?:_____

PLEASE CIRCLE YOUR AREAS OF PAIN



Nature of Your Injury:

❑Auto-Accident ❑Work Injury ❑Other
Date Symptoms Appeared:_____
Had Symptoms Prior? ❑Yes ❑NO **When:**_____
Previous Chiropractic Care? ❑Yes ❑No
With Whom:_____ **When:**_____
Are you Pregnant? ❑Yes ❑No
On A Scale of 1 (low) to 10 (Severe) please rate your PAIN LEVEL today:_____

Race: ❑ White ❑ Black/African American ❑ Hispanic ❑Other ❑ I choose not to specify
Multi-Racial: ❑Yes ❑No ❑ Unknown
Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify
Preferred Language: ❑ English ❑ Spanish ❑ I choose not to specify
Do you currently smoke/ chew tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

Briefly list your main health problems: _____

Have you had an X-ray or CT scan or MRI in the past 28 days? ❑ Yes ❑ No **If YESWhere:**_____

Last Physical Examination:_____ **With Whom:**_____

Please tell us if you have been treated for any condition in the last two years:

_____

_____

Who was the last doctor you saw? _____ **when** _____

Patient Signature:_____ **Date:**_____

TO BE PERFORMED BY CLINICAL STAFF:

Height: _____inches **Weight:** _____ pounds **BP:** _____/_____ **Eye Dominance:** Right Left

Health Scan Results:

_____

_____

YOUR HEALTH HISTORY IS IMPORTANT TO US! Patient Name:_____

Current medications, including frequency and dosage if known:

_____

_____

_____

If there are no current medications, check here: ❑

List any known allergies you have had to any medications:

_____

_____

If no allergies are known, check here: ❑

Do you currently take:

☐Multi-vitamins
☐Fish Oils/ Omegas
☐Aspirin
☐Calcium
☐Weight loss Products
☐B Vitamins
☐D Vitamins
☐Greens or Protein Powders
☐Other _____

Our office uses a variety of science based, high quality nutritional supplements. Do you have any concerns about:

☐Increasing Energy
☐Joint Flexibility
☐Allergies
☐Digestions
☐Stress
☐Weight loss/ Control
☐Cholesterol
☐Pain Management
☐Genetic Predispositions due to disease

Regarding your symptoms:

Symptoms	NO	YES	Details
Do you experience pain every day?			
Does your pain wake you up?			
Does your pain affect your daily activity?			

Condition	NO	YES	When	Details
Have you any broken bones?				
Have you been hospitalized?				
Have you had any surgeries?				
Have you had a concussion?				
Previous Auto Accidents?				

Of Your Habits:	NONE	LIGHT	HEAVY	FREQUENCY
Alchol Consumption				
Coffee/ Tea				
Drugs				
Soft Drinks/ Energy Drinks				
Other				

Is there a family history of:

☐ CANCER ☐ HEART DISEASE ☐ Arthritis ☐ OTHER:_____

Is there anything else you would like to bring to the Doctor's attention that has not been previously discussed? If so, please note:

_____

_____

Patient Signature: _____ Date: _____

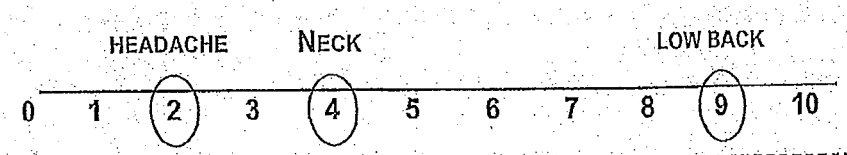
QUADRUPLE VISUAL ANALOGUE SCALE

Name _____ Number _____ Date _____

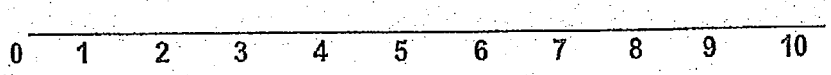
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate which score is for which complaint.

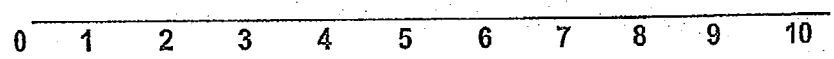
EXAMPLE:



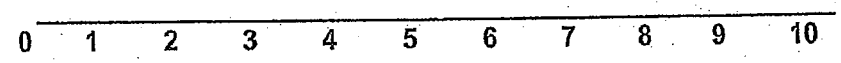
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

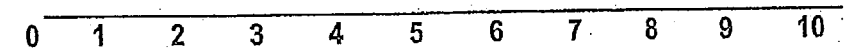


3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain AT ITS WORST (How close to "10" does your pain get at its best)?



What percentage of your awake hours is your pain at its worst? _____%

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. *Scandinavian Journal of Rehabilitation Medicine* 27, 145-151.

Financial Patient Name:_____

My account is a:

□CASH □INSURANCE □MEDICARE □WORKMEN'S COMP □AUTO INSURANCE

If there are any other parties responsible for your bills at our facilities please fill in the information below:

Primary Insurance Company: _____ Telephone Number: _____
Plan Name: _____ Policy Number: _____ Group Number: _____
Are you the policy holder? □YES □ NO If not, who is: _____
Policy Holder DOB: _____ SSN: _____ Relationship: _____

Secondary Insurance Company: _____ Telephone Number: _____
Plan Name: _____ Policy Number: _____ Group Number: _____
Are you the policy holder? □YES □ NO If not, who is: _____
Policy Holder DOB: _____ SSN: _____ Relationship: _____

I, _____ (print name) acknowledge, understand and agree that any health/ accident / workmen's compensation insurance policies are an agreement between myself and the insurance company. I understand that all services rendered are MY responsibility and that if my insurance does not cover services, any unpaid fees are MY responsibility. I also understand that the office holds the right to charge my account for any appointment that I fail to show for (No Show Fee) or fail to cancel 24 hours in advance.

Patient Signature: _____ Date: _____

PLEASE MAKE SURE TO PROVIDE A CURRENT COPY OF YOUR INSURANCE CARD AND ID TO THE FRONT DESK

Welcome! The Doctors and Staff welcome you and intend to provide you with the best care possible. We will conduct a thorough examination and history to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care we will refer you to the appropriate provider. If you are a candidate for chiropractic care, a treatment plan will be recommended to fit your specific needs.

Patient Signature: _____ Date: _____

1. I _____ (patient name) give permission for **Kirschner Chiropractic & Wellness Centre/ Arcadia Chiropractic Clinic** to give me medical treatment.
2. I allow **Kirschner Chiropractic & Wellness Centre/ Arcadia Chiropractic Clinic** to file for insurance benefits to pay for the care I receive.
   I understand that:
   - **Kirschner Chiropractic & Wellness Centre/ Arcadia Chiropractic Clinic** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my provider.

Patient Signature: _____ Date: _____

Notice of Privacy Practices Acknowledgment

Kirschner Wellness Chiropractic & Wellness Centre
Arcadia Chiropractic Clinic

I understand that the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly or indirectly.

2. Obtain payment from third-party payers.

3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been notified that a copy of *Notice of Privacy Practices* is located in the waiting room and that I may review it and have any/all questions that I may have answered. I understand that your Notice of Privacy Practices contains a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

X_____ _____

Patient Name or Legal Guardian (PRINT) **Date**

X_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____

Attempt:_____

Staff Name:_____

Authorization to Release Health Information To Process Insurance Claims

Kirschner Chiropractic & Wellness Centre
Arcadia Chiropractic Clinic

I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. I have read the above Patient Financial Policy and have provided the Practice with true and correct insurance information.

I verify that I have no other insurance coverage than that listed above. I authorize the release of any medical or other information necessary to process any claims filed on my behalf. I also request payments of any insurance benefits including those from government programs to the party who accepts assignment on any claims filed. I authorize payment of medical benefits to the physician or supplier for services submitted on claims for services provided to me. Finally, I will notify the Practice promptly of any changes in my health insurance coverage.

*The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.*

X_____
Patient Name (PRINT)

X_____ _____
Signature of Patient or Legal Representative **Date**

Kirschner Wellness Centre & Arcadia Chiropractic Clinic
www.kirschnerwellness.com
What type of patient were you? _____
When were you a patient at our office? From_____ to _____
Phone Number:__(___)_____

Patient Name:_____
Other Names Used:_____
S.S.N.:_____
D.O.B.:_____
Current Address:_____

CONSENT FOR RELEASE OF INFORMATION

Florida law requires information contained in medical records be held in strict confidence and not released without you, the patient's, written authorization. The authorization(s) you, the patient, sign on this page will remain in effect until you request in writing that your authorization be withdrawn, which you may do at any time. However, revocation will not apply to the information which has already been released. You have the right to receive a copy of any part of this authorization upon your request. For you, the patient's, protection we will ask to see a form of identification.

The below initial records are to be released **FROM:**

_____
_____
_____

The below initial records are to be released **TO:**

_____
_____
_____

AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL INFORMATION

To release, initial by (a.,b.,c.,d.,e.) any or all that apply. There cannot be any blanks. Initial all and CROSS OUT any part(s) that do(es) not apply.

__**a.** The general medical record created by the facility.

__**b.** The following information from the medical record:_____

__**c.** Labs Reports

__**d.** Radioloy Reports

__**e.** Other:_____

For the purpose of:_____

I understand authorizing the use or disclosure of the information above in voluntary. I need not sign this form to ensure medical treatment.

X_____ _____ _____
Signature of Patient or Legal Representative **Relationship to Patient** **Date**

X_____ _____
Witness Signature **Date**

USE THIS SPACE ONLY IF PATIENT REVOKES CONSENT

_____ X_____ _____
Date Consent Revoked Patient or Legal Representative's Signature Relationship to Patient

X_____ _____
Witness Signature Date

Arcadia Chiropractic Clinic, Inc/Kirschner Chiropractic & Wellness Centre

AUTO ACCIDENT HISTORY

INSTRUCTIONS: Please complete the questions to the best of your ability. Be as descriptive as possible and check all descriptors that apply. If you need assistance, please ask a staff member. Please inform the doctor if there are circumstances surrounding your accident that have not been covered here.

NAME: _____ Today's Date_____/_____/_____

HISTORY OF OCCURANCE: Accident Date_____/_____/_____

I was the/a: __Pedestrian __Driver __Passenger Left Front __Passenger Central Front __Passenger Right Front __Passenger Left Rear __Passenger Central Rear __Passenger Right Rear

What was your point of impact? __Head On __Rear-End __Left Front __Left Rear __Right Front __ Right Rear

Did you feel pain immediately following impact? ___Yes ___No

If no, how long after accident before pain started?_____

Where did you go after the accident? ____Home ____Work ____ Hospital ER ____Private Doctor

Have you received any of the following? ___XRay ___CT Scan ___MRI ___Lab Work ___Treatment/Medication

If yes, where? _____

How did you get there? __Drove Self __Someone Else Drove __Ambulance __Police __Other

What type of car were you driving? __Compact __Mid-Size __Full-Size __SUV __Pick-Up Truck __Motorcycle

2nd Vehicle involved was a? __Compact __Mid-Size __Full-Size __SUV __Pick-Up Truck __Motorcycle

3rd Vehicle involved was a ? __Compact __Mid-Size __Full-Size __SUV __Pick-Up Truck __Motorcycle

Road Conditions were? ___Dry ___Icy ___Wet ___Clear ___Foggy ___Dark Other:_____

Road Type? ____Concrete ___Asphalt ___Gravel ___Dirt ___Other_____

Were you aware the accident was going to occur?_____

Were you wearing your seat belt? _____Did your airbags deploy?_____Do you have a headrest?_____

At the time of the accident you were looking?__Straight Ahead ___Left ___Right ___Looking up___Looking Down

Were you pushing the break (stopping) either during or before impact? ____Yes ___No

Was your car moving before the impact?___Yes ___No If yes, approximately how fast?_____(mph)

Was the driver of the 2nd vehicle breaking (stopping)? ___Yes __No

Was the 2nd vehicle moving before impact? ___Yes ___No If yes, approximately how fast?_____(mph)

Was the 3rd vehicle moving before impact? ___Yes ___No If yes, approximately how fast?_____(mph)

As a result of the accident were traffic citations issued to you? _____Y/N To the other drivers? _____Y/N

PLEASE DESCRIBE ANY FURTHER ACCIDENT DETAILS HERE:_____

_____

_____

Please check any symptoms you have noticed since the accident:

____Headache ____Irritability ____Numbness in Toes ____Hands/Feet Cold ____Neck Pain

____Chest Pain ____Shortness of Breath ____Buzzing in Ears ____Neck Stiffness ____Dizziness

____Fatigue ____Loss of Balance ____Stomach Upset ____Constipation ____Diarrhea ____Fever

____Depression ____Head seems Heavy ____Sleeping Problems ____Fainting Spells ____Back Pain

____Pins/Needles in Arm ____Pins/Needles in Leg ____ Lights Bother Eyes ____Loss of Taste/Smell

____Tension ____Numbness in Fingers ____Ringing in Ears ____Knee Pain R/L _____

Any other symptom not listed above:_____

FAMILY HISTORY:

Please list any other doctors you have seen for this condition or for any condition that you are currently being treated for:_____

Significant Childhood Illnessess?_____

Significant Adult Illnessess?_____

Surgeries?_____

Significant Injuries?_____

Please describe your family history:

General Family:	Alive	Deceased	Health Conditions/Diseases
Father:			
Mother:			
Paternal Grandfather			

FAMILY HISTORY CONT.

	Alive	Deceased	Health Conditions/Diseases
Paternal Grandmother			
Maternal Grandmother			
Maternal Grandfather			
Son			
Daughter			
Brother			
Sister			

SOCIAL AND WORK HISTORY:

This section will identify key factors in your lifestyle that may impact or contribute to your current health condition. Please check all that apply.

HABITS:	NONE	LIGHT	HEAVY
Alcohol			
Coffee			
Tobacco			
Drugs			
Exercise			
Sleep			
Appetite			
Soft Drinks			
Sugar Substitutes			
Sugar Food			
Salty Food			

What was the highest level of education you attained?_____

Please describe your conditions effect on your activities of daily living (ADL):

Caring for family:	____No effect	____Painful but I do it	____Painful and I'm limited	____Unable to Perform
Carry Groceries:	____No effect	____Painful but I do it	____Painful and I'm limited	____Unable to Perform
Changing Position:	____No effect	____Painful but I do it	____Painful and I'm limited	____Unable to Perform
Climbing Stairs:	____No effect	____Painful but I do it	____Painful and I'm limited	____Unable to Perform
Daily Pet Care:	____No effect	____Painful but I do it	____Painful and I'm limited	____Unable to Perform

Driving: ____No effect ____Painful but I do it ____Painful and I'm limited ____Unable to Perform
Computer Use: ____No effect ____Painful but I do it ____Painful and I'm limited ____Unable to Perform
House Chores: ____No effect ____Painful but I do it ____Painful and I'm limited ____Unable to Perform
Lifting Children: ____No effect ____Painful but I do it ____Painful and I'm limited ____Unable to Perform
Bathing Self: ____No effect ____Painful but I do it ____Painful and I'm limited ____Unable to Perform
Dressing Self: ____No effect ____Painful but I do it ____Painful and I'm limited ____Unable to Perform
Sexual Activity: ____No effect ____Painful but I do it ____Painful and I'm limited ____Unable to Perform
Sleeping: ____No effect ____Painful but I do it ____Painful and I'm limited ____Unable to Perform
Sitting: ____No effect ____Painful but I do it ____Painful and I'm limited ____Unable to Perform
Standing: ____No effect ____Painful but I do it ____Painful and I'm limited ____Unable to Perform
Walking: ____No effect ____Painful but I do it ____Painful and I'm limited ____Unable to Perform
Yard Work: ____No effect ____Painful but I do it ____Painful and I'm limited ____Unable to Perform
Others Not Listed:_____

Are you ___Student (Full/Part time) ___Unemployed ___Retired ___Homemaker ___Employeed (Full/Part)
If you work, do you lift at your job? ___Yes ___No If yes, approx how many lbs?_____

As a result of the accident have you lost any days of work? _____Yes ___No When?_____

Have you been in contact with your insurance adjustor? ____Yes/No Name:_____
Claim Number:_____Insurance Company_____
Policy Number:_____Telephone Number_____

Do you have an attorney representing you in this case? _____Yes/No
If yes, whom?_____Telephone Number:_____

Is there any other information that you feel would be relevant to your current condition that was not covered? Please explain in the following section any information that you feel would be helpful to the doctor in reviewing your case:_____

We welcome you to our clinic and we want to provide you with the best care possible. We will conduct a thorough history and physical examination to determine if we can assist you. If we do not believe that your condition will improve with chiropractic care we will refer you to the appropriate healthcare provider. If you are a candidate for chiropractic care, a treatment plan will be recommended to fit your individual needs.

Patient Name:_____Patient Signature:_____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her own hand)*:

Name *(PRINT or TYPE)*	Signature	Date
Daniel L. Kirschner, DC.		

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

ASSIGNMENT, LIEN AND AUTHORIZATION

For direct payments by my payers to:

Arcadia Chiropractic Clinic, Inc. & Kirschner Chiropractic & Wellness Centre, Inc.

Purpose: The purpose of this Assignment & Lien is to assist the office in obtaining proceeds 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 Arcadia Chiropractic Clinic, Inc and Kirschner Chiropractic & Wellness Centre, Inc located in DeSoto County, Florida at 936 North Mills Avenue, Arcadia Florida 34266 and 12687 SW CR 769 #3A Lake Suzy, Florida 34269. "Assignment" & "Lien Document" shall refer to this document while "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 review or review entity for at-fault party, individual, or any other entity which may elect or be obligated to pay or disburse proceeds, either now or in the future, of which may be involved directly or indirectly in determining obligation to pay or disburse proceeds. "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" 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, Medicaid, workers compensation, disability, liability, uninsured and under insured motorist, no fault medical payment benefits, personal injury protection, lost wages, lost services, property damage, errors and omissions and malpractice. "Charges" shall include without limit the full fees for the office goods and services (including without limit to treatment, diagnostic service, medical equipment, supplies, supplements, narrative reports, diagnostic reports, production of records, photocopies, pre-authorization requests, no-shows, depositions and testimony, whether rendered before or after the date of this assignment and lien and shall include any collection costs incurred by this office, delinquency penalties and interest to the maximum extent permitted under law or at the annual rate of 18% eighteen percent, whichever is greater, and any other charges incurred by me at the offices. "Collection Costs" shall include without limit any pre and post judgment court costs, filing fees, service of process charges, attorney fees, fees or costs association with requests for consideration, independent reviews, appeals, mediation, arbitration, and any other costs of collection incurred by the office in any effort or action to collect for my charges from me or any of my payers.

Assignment & 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 or intangibles, and remedies that I might have against with respect to any payer now or in the future as well as the right to prosecute, seek, settle or otherwise resolve such claims to proceeds either in my name or in the office's name 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. I further authorize the office to file the forms normally filed with the secretary of state or other agency relating to such security interests and to make such filings in all relevant jurisdictions as the office sees fit in it's discretion. I agree that once payment in-full has been made towards all outstanding charges to the full extent permitted by law as defined in my agreement with the office such security interests shall be removed or terminated solely upon my written request sent through the USPS 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 and 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 Directions to any Attorney I Retain, Such as in an Accident Case: In the event that I retain one or more attorneys who receive proceeds from one or more payers I hereby direct and the office hereby requests that each and every attorney 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 dispute regarding such 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 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 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 the condition. "Pertinent Information" shall also include without limit copies of 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 wether 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 charges, as well as a decision to refer the charges to an independent review , audit, utilization review or independent 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 and 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 necessary. However, should any provision of this assignment and 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 and lien shall, nevertheless, remain in full and effect. This assignment & lien shall be governed under the laws of the state where the office is located (Florida) and is performable in the county where the office is located (DeSoto). In any action based upon the 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 or limitations which may apply.

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

Patient Name
(Printed)_____Date_____
Patient Name
(Signature)_____

Custodial Parent or Legal Guardian of the Patient (Please Print)_____
Custodial Parent or Legal Guardian of the Patient (Please Sign)_____