PANCHESIN CHIROPRACTIC CENTER
5311 SOUTH 12TH AVENUE
TUCSON, ARIZONA 85706
(520) 294-0400

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_____Sex_____Marital Status_____Date of Birth_____Home Phone_____
Address_____ City_____ State_____ Zip_____
Occupation_____ Who referred you to our office? _____
(Indicate if child, student, housewife, unemployed, retired)
Social Sec. #_____ Business Phone _____Company Name_____ Location_____
Spouse's First Name _____ Spouse's Soc. Sec#_____ Spouse's Employer _____Location_____
Please explain in detail how your accident happened: _____
_____
_____
_____
Insurance Co. _____ Policy No. _____Claim No._____
Driver of other vehicle (if any)
Name_____Insurance Company_____Policy No._____
Driver of vehicle in which you were injured (if applicable)
Name_____ Insurance Company_____ Policy No._____
Name of your insurance adjustor_____
Have you retained an attorney? _____ Yes _____No
If so, his name and address_____
You were heading ___North ___ East ___South ___ West on _____(street or highway)
Other vehicles were headed ___North ___East ___ South ___ West on _____(street or highway)
Were police notified ___Yes ___ No
Were you knocked unconscious ___ Yes ___ No If so, for how long? _____
You were stuck from ___ Behind ___ Front ___ Left side ___ Right side
You were __ Driver __ Passenger __ Front seat __ Back seat __ Using seat belts ___ Other protective devices
What were the time and date of present injury? _____
Where did you feel pain immediately after the accident? _____
Where were you taken after the accident? _____
What treatment was given? _____
Was any other doctor consulted after your accident? ___ Yes ___ No
If so, what was the doctor's name? _____ D.C., ___ M.D., ___ D.O., ___D.D.S.
What was the diagnosis? _____
What treatment was given? _____
How often did you see the doctor? _____
How long did you see the doctor? _____
Have you ever had any complaints in the involved area before? ___ Yes ___ No
If so, what were the complaints? _____
Before the injury were you capable of working on an equal basis with others your age? ___ Yes ___ No
Are your work activities restricted as a result of this accident? ___ Yes ___ No
Since this injury are your symptoms ___ Improving? ___ Getting worse? ___ Same?
Emergency Contact Number _____
Primary Care Physician _____
Email Address _____ Cell Phone _____

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HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes:
1-never had, 2- previously had, 3- presently have.

MUSCULO-SKELETAL SYSTEM

___ Low back problems
__Pain between shoulders
___Neck problems
___Arm problem
___Leg problem
___Swollen joints
___Painful joints
___Stiff joints
___Sore muscles
___Weak muscles
___Walking problems
___Ruptures
___Broken bones

GENITO-URINARY SYSTEM

___Bladder trouble
___Excessive urination
___Scanty urination
___Painful urination
___Discolored urine

FEMALE

___Vaginal discharge
___Vaginal bleeding
___Vaginal pain
___Breast pain
___Lumps on breast
Are you pregnant?
___yes ___no

GASTRO-INTESTINAL SYSTEM

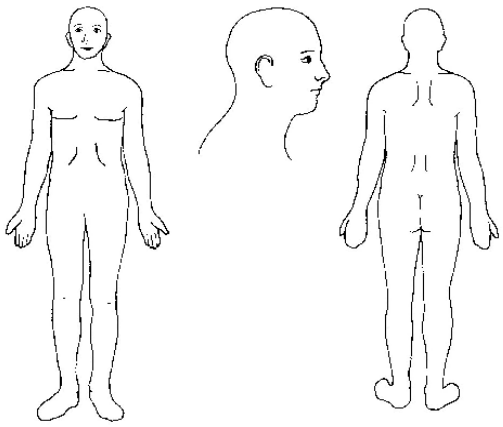
___Poor appetite
___Excessive hunger
___Difficult chewing
___Difficult swallowing
___Excessive thirst
___Nausea
___Vomiting blood
___Abdominal pain
___Diarrhea
___Constipation
___Black stool
___Bloody stool
___Hemorrhoids
___Liver trouble
___Gall bladder problems
___Weight trouble

CARDIO-VASCULAR-RESPIRATORY SYSTEM

___Chest pain
___Pain over heart
___Difficult breathing
___Persistent cough
___Coughing phlegm
___Coughing blood
___Rapid heartbeat
___Blood pressure
___Heart problems
___Lung problems
___Varicose veins

EYE, EAR , NOSE, & THROAT

___Eye stain
___Eye inflammation
___Vision problems
___Ear pain
___Ear noises
___Hearing loss
___Ear discharge
___Nose pain
___Nose bleeding
___Nose discharge
___Difficult breathing thru nose
___Sore gums
___Dental problems
___Sore mouth
___Sore throat
___Hoarseness
___Difficult speech



NERVOUS SYSTEM

__Numbness
__Loss of feeling
__Paralysis
__Dizziness
__Fainting
__Headaches
__Muscle jerking
__Convulsions
__Forgetfulness
__Confusion
__Depression

_____
Patient's Signature

----------DO NOT WRITE BELOW THIS LINE----------

_____
_____
_____
_____
_____

Patient accepted? ___Yes ___No Doctor's Signature_____

PANCHESIN CHIROPRACTIC CENTER
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(520) 294-0400

HEALTH HISTORY QUESTIONNAIRE

Patient Name_____ Date _____ Patient # _____

1) Please list all past injured joints in your body giving the approximate month and year, and all significant injuries:
   _____
   _____
   _____
2) Please list all past treatment for your current condition:
   _____
   _____
   _____
3) Please list all past surgeries and give approximate date:
   _____
   _____
   _____
4) Please describe any home care or treatment you have done for your current condition:
   _____
   _____
   _____
5) Please list all current medications you are taking, their purpose, dose, times per day, and length of time:
   _____
   _____
   _____
6) Please briefly describe your family health history of your mother and father:
   _____
   _____
   _____
7) Please describe your current work activities:
   _____
   _____
   _____
8) Please list any allergies you may have and treatment you received for them:
   _____
   _____
   _____

Do not write below this line:
…….

Review of Systems:

_____
_____
_____
_____

Panchesin Chiropractic Center's
Dr Thomas Panchesin, 5311 S 12th Ave.,
Tucson, Az., 85706, (520)-294-0400

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Please print your name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have fully read and understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform and x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

_____ _____
(Signature) (Date)

PANCHESIN CHIROPRACTIC CENTER
5311 SOUTH 12TH AVENUE
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(520) 294-0400
PROFESSIONAL FEE SCHEDULE

Initial Consultation. . . . . .No Charge
Chiropractic Examinations . . . . . .$55-$100
Chiropractic Office Visits (average) . . . . . .$55-$101
Chiropractic X-ray Studies (average) . . . . . .$72-$182
Doctor/Patient Conference $75
Thermoscribe $39

(All fees are standard and primarily based on our professional association's guidelines and on the fee schedule set by the Industrial Commission of Arizona).

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your Chiropractic Care at our office, and you may choose the plan which best fits your needs. Please red carefully and choose the plan which you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. If special arrangements are necessary please consult with the Doctor. Our main concern is your health and well-being, and we will to our best to help you.

PLAN #1 – INSURANCE – If you have insurance which covers Chiropractic care, we will bill your insurance directly. Please bring us an insurance claim form, on or before your second visit, with your portion completed. Until we have the completed, necessary insurance information to verity chiropractic coverage, you will be required to pay for your care. Most patients with "deductible plus 80% pay" insurances donate a nominal fee, periodically, in addition to meeting their yearly deductible. In the event the check should come to you, you are expected to bring the check to us. Reminder, insurance companies balk at "maintenance" and long term rehabilitation. Usually you will not get much help after your initial corrective care. Most ordinary "health" policies are designed and intended to only take care of acute problems so you should plan to "get off" insurance and be on your own when you get down to once a week or less (except, possible, some accident injuries). At this point refer to Health and Life Extension Plan (ask Doctor for details).

PLAN #2 – CASH – Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

PLAN #3 – WEEKLY/MONTHLY CASH AGREEMENT – For those non-transient, but active patients who qualify, we will extend knowledgeable credit through this plan; however, should you become inactive by discontinuing your care, your entire unpaid balance will be due immediately. This plan applies to all cases, except Work Injury or Auto injury claim.

PLAN #4 – CASH PREPAY – Ask Doctor for details.

PLAN #5 – INDUSTRIAL – You need to report your accident to your employer, bring in necessary insurance information, and sign industrial forms for billing by second visit. We will bill your insurance directly.

PLAN #6 – AUTO INJURY – You need to supply us with the accident report, your car insurance, health insurance, and liable parties insurance, and attorney if applicable. Until necessary insurance information is gathered and verified for chiropractic care, you will be required to pay for your care. We will bill your insurance directly after verification of coverage. In the event the check should come to you, you are expected to bring the check to us.

I QUALIFY AND UNDERSTAND PLAN # _____ REQUIREMENTS

SIGNATURE_____ DATE_____

PANCHESIN CHIROPRACTIC CENTER
5311 SOUTH 12TH AVENUE
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(520) 294-0400

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxation are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

The material risk in an adjustment: As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

The probability of those risks: Fractures are rare and can result from an underlying weakness in the bones. The other complications listed are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

Other treatment options for your condition can include: Medical care with prescription drugs, self management with over-the-counter medication, rest, and/or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self dosages and surgical risks including complications from either the procedure and the anesthesia.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x- ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____	_____
Patient Signature	Date

PANCHESIN CHIROPRACTIC CENTER
5311 SOUTH. 12TH AVENUE
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APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION (HIPAA)

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____
Patient name printed Date

_____ _____
Patient Signature Authorized provider representative

_____ _____
Personal representative Printed Personal representative signature

_____
Description of personal representative's authority to act for the patient

Panchesin Chiropractic Center
5311 South 12th Avenue
Tucson, Az 85706
(520) 294-0400

MARKETING AUTHORIZATION
(HIPAA)

From time to time our practice works with marketing organizations to make you aware of products or services that you may have an interest in purchasing. Your chiropractors and members of the practice staff may need to use your health information including your name, address, phone number, and your clinical records for the purpose of marketing products and services from _____to you. We are specifically requesting authorization to market the following products and or services to you

_____
_____.

You may restrict the individuals or organizations to which your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose on the authorization you are giving us may be subject to re-disclosure by the organization/s listed above and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do no give us permission, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you for marketing purposes at any time. (164.524). Our practice and staff will receive direct or indirect remuneration from our marketing activities.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____	_____
Patient name printed	Date
_____	_____
Patient signature	Authorized Provider Representative
_____	_____
Personal Representative Printed	Personal Representative Signature

_____
Description of personal representative's authority to act for the patient

Panchesin Chiropractic Center
5311 South 12th Avenue
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To Our Patients Regarding HIPPA Privacy and Our Office

In 1996, President Clinton enacted the Health Insurance Portability and Accountability Act. It was enacted to make selling and commercial exchange of patient's private health information illegal. In my office, we have for 20 years respected patient privacy long before a law had to be passed. Those areas that we choose to make you aware within this office are the following.

1. There are partial walls and no doors surrounding our adjusting rooms. If there is a private issue that needs to be discussed, you may request a private room, and I will come in as soon as possible to discuss any matter.
2. We place patient's names on our bulletin board when they refer a new patient into this office to say, "Thank You", for referring to our office.
3. We mail Postcards to patients whom refer others to our office to thank them for the referral.
4. We mail Postcards to our patients on their birthday.
5. We type up anonymous patient testimonials with the patient's permission only identifiable by a number, to share your success story with others, thereby enlightening them to what other ailments have been helped by chiropractic.
6. We require the signing of record release authorization forms for your insurance company or attorney to release your records in this office to them for the purpose of getting paid.
7. We occasionally take pictures of our patients to put in our scrap book in our waiting room library, or temporarily place on our walls.

This is summary of our routine practices that embody the marketing release form that is in this packet. We commit to honor your privacy as we always have in the past, and now in accord with the new laws our government has established. Should you have any questions, do not hesitate to ask.

I _____, authorize Panchesin Chiropractic Center and staff to conduct the above practices with respect to my privacy, and health care.

PANCHESIN CHIROPRACTIC CENTER
5311 South. 12th Avenue
Tucson, Arizona 85706
(520) 294-0400

FINANCIAL ARRANGEMENTS – ACCIDENT

To assist our patients in determining if they has a third party responsible for their health expenses or to aid in determining if they will be reimbursed by an insurance company, we have prepared the following checklist and policy statement. Please check the applicable area.

1. WORK INJURY - I was injured in the course of employment and am eligible to have my expenses covered under Workmen's Compensation.

2. ACCIDENT (PERSONAL LIABILITY) – I was injured in an accident. I have an attorney representing my interest in an action against a negligent party and his name is _____. I understand I may possibly collect benefits from #2 in addition to benefits from other insurance.

3. ACCIDENT (COMPREHENSIVE MEDICAL PAYMENT) - I was injured in an accident and there is comprehensive Medical Payment (automobile or homeowners) insurance that is responsible for paying. The insurance company is_____. I understand that I may possibly collect benefits from #3 in addition to benefits from other insurance.

4. AUTOMOBILE ACCIDENT (NO FAULT) - I was injured in an auto accident and the driver of my car has or I have benefits in our policy. The insurance company is _____. I understand I may possibly collect benefits from #4 in addition to benefits from other insurance.

5. GROUP HEALTH AND ACCIDENT (ACCIDENTAL INJURY) – I have been injured and my group coverage has a Supplemental Accident Benefit that will pay for the initial expenses. My company is _____. I understand I may possibly collect benefits from #5 in addition to benefits from other insurance.

In that the above potential sources of payments may pay your entire bill, this office is willing to wait for the payments of its fees when the patient agrees to the following conditions.

ASSIGNMENT AUTHORIZATION, POWER OF ATTORNEY & AGREEMENT

In that the office is waiting for the payment of some or all of its fees, I agree to provide the office with information and forms regarding any potential source of fee payment, to assist in any way I can, and,

1. **I hereby assign to this office my rights to receive payments from negligent parties or form insurance companies, Payments should be payable to and mailed to:**

Name Thomas Panchesin, D.C., Panchesin Chiropractic Center
Address 5311 S. 12th Ave., Tucson, AZ., Zip 85706
Phone (520) 294-0400

If my policy prohibits assignments, then check should be payable to me and sent to the above address.

2. **I understand that if this office receives more than their fees, the office will pay any credit balances to me, the PATIENT.**
3. **I authorize the office to release any information to any insurance company, adjustor, or attorney that will assist in the payment of a claim.**
4. **I appoint this office as attorney-in-fact to correspond in my behalf with insurance companies, to negotiate any settlement and to cash any settlement draft or check. Counsel, insurance companies and negligent parties be advised that, no settlement can be effectuated without the agreement of this office or the office's release of this specific provision. Said negotiation to be for the payment of health expenses and will not release negligent party from other responsibilities. The office does not intend to "represent" me in any way, this appointment is strictly to prevent negligent parties, attorneys or insurance companies from setting any financial relations with me without fulfilling my financial responsibilities to this office first.**
5. **I fully understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance.**
6. **A photocopy of this form shall be as valid as the original.**

_____ _____
Date **Patient**

_____ _____
Information taken by **Responsible party**

PANCHESIN CHIROPRACTIC CENTER
5311 SOUTH 12TH AVENUE
TUCSON, ARIZONA 85706
(520) 294-0400

AGREEMENT TO EXECUTE SPECIAL POWER OF ATTORNEY

PATIENT: ____ DOCTOR: ____________________________________

The parties hereto agree as follows:

1. PATIENT requires professional health care services which he/she desire that DOCTOR provide.

2. PATIENT does not wish to pay for DOCTOR's services at the time they are rendered; instead PATIENT wants DOCTOR to act in PATIENT's behalf by collecting sums owed to DOCTOR from any person, corporation or insurance company which has an obligation to pay or reimburse PATIENT for his/her medical expenses.

3. DOCTOR agrees to treat PATIENT on this basis only if PATIENT executes a Special Power of Attorney to permit DOCTOR to act exclusively on PATIENT's behalf in collecting medical expenses as described I paragraph 2, above. The Special Power of Attorney shall be irrevocable by PATIENT until DOCTOR has been fully paid for all charges in connection with the health care services provided by DOCTOR to PATIENT. Any attempt by PATIENT to revoke the Special Power of Attorney prior to the payment-in-full of DOCTOR's charges shall be null and void and of no effect whatsoever.

4. PATIENT agrees to execute that SPECIAL POWER OF ATTORNEY in the form prescribed by DOCTOR, a copy of which has been read and understood by PATIENT prior to signing this Agreement.

5. The Special Power of Attorney executed concurrently with this Agreement confers only a very limited power on DOCTOR. DOCTOR will not under any circumstances act as PATIENT's attorney-at-law. DOCTOR will act as PATIENT's attorney-in-fact only for the limited purpose ad in the manner described in this Agreement and in the Special Power of Attorney.

6. PATIENT acknowledges personal responsibility for health care charges and understands that this Agreement is only an inducement for DOCTOR to extend credit to patient.

- -

SPECIAL POWER OF ATTORNEY

PATIENT:_____________________ ___________________________ DOCTOR: _______________________________________
_____________________________ herby constitutes and appoints ____
as Attorney-in-fact to act in the place of the PATIENT in the manner, and to the extent, described hereafter.

The attorney-in-fact named above shall have full and exclusive power to settle any claim that PATIENT might have against any other person, corporation or insurance company to the extent of PATIENT's claim for medical expenses representing services rendered by DOCTOR.

The power conferred hereunder shall not include the power to settle claims for other than medical expenses for services rendered by DOCTOR. Specifically, DOCTOR is not authorized to settle PATIENT's claims for damage to property, loss of income, pain and suffering or other such claims, if any.

The power conferred hereunder shall include the power to require that all drafts and checks issued in settlement of PATIENT's claims for medical expenses are made payable solely to DOCTOR or his designated agent or representative.

This Special Power of Attorney is irrevocable by PATIENT until all of PATIENT's charges with DOCTOR have been fully paid.
This Special Power of Attorney shall not be affected by the disability or incompetence of the PATIENT.
A photocopy of this Special Power of Attorney shall be as valid as the original.

Dated ____

Witness ____ Patient ____

Doctor's Name ____

Address ____

Witness ____ City/State/Zip ____

Phone # ____

PANCHESIN CHIROPRACTIC CENTER
5311 South 12th Avenue
Tucson, Arizona 85706
(520)294-0400

CHIROPRACTIC REPORTS AND DOCTOR'S LIEN

I do hereby authorize this doctor's office to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due on owing him for chiropractic service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewithin.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by said doctor for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of the doctor's awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to pay on my account and keep it on a current basis.

Dated _____ Patient's signature_____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named.

Dated _____ Attorney's signature _____

Please date, sign and return one copy to doctor's office.

Keep a copy for your records.

A photocopy of this form shall be considered as valid as the original.

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5311 South 12th Avenue
Tucson, Arizona 85706
(520)294-0400

CHIROPRACTIC REPORTS AND DOCTOR'S LIEN

I do hereby authorize this doctor's office to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due on owing him for chiropractic service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewithin.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by said doctor for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of the doctor's awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to pay on my account and keep it on a current basis.

Dated _____ Patient's signature_____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named.

Dated _____ Attorney's signature _____

Please date, sign and return one copy to doctor's office.

Keep a copy for your records.

A photocopy of this form shall be considered as valid as the original.