CASE HISTORY

Name:______________________ Age:______ Date:__________ Social Security #:______________

Date of Birth:__________ E-Mail:______________ Phone # (H): __________ (C):__________

Address:______________________ City:______________ State:______ Zip:__________

Sex: M__ F__ Marital Status: S__M__D__W__ #of Children:______ Spouse Name: ______________ Phone#:__________

Occupation:______________ Employer:______________ Work Phone:__________

Emergency Contact:______________ Relationship:__________ Phone#:__________

Past Chiropractic Care: Y_N_ When:______ Doctor's Name:__________ Results:______________

____

Chief Complaint: 1. ______________________ Duration (How long):______ Episodes:______

List Current 2.______________________ Duration (How long):______ Episodes:______

Problems: 3.______________________ Duration (How long):______ Episodes:______

Are your present problems due to an injury? No: _____ Yes: _____ On the Job: _____ Car Accident: _____ Personal Injury: _____ Other: _______

Has the accident been reported? No:_____ Yes:_____ To Employer:_____ Auto Carrier:_____ Other:__________

Are you now or have you ever been disabled? (Service or work)? No: _____ Yes:_____ When: __________ Why:__________

Have you retained an attorney? No: _____ Yes: _____ Name and Address: ______________________

Please mark the intensity of your pain today.

1 - NO PAIN

10 - MOST INTENSE EVER FELT

Example Neck

1 2 3 ④ 5 6 7 8 9 10

1. ______________

1 2 3 4 5 6 7 8 9 10

2. ______________

1 2 3 4 5 6 7 8 9 10

3. ______________

1 2 3 4 5 6 7 8 9 10

DOCTORS USE ONLY

____

____

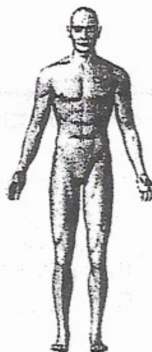
____

____

Please mark area & type of pain on the drawings using the codes listed below.

N-Numbness
T-Tingling
S-Soreness

P-Pain
A-Ache
ST-Stiffness



HABITS

- ❑ Smoking Packs/Day: _____
- ❑ Drinking Alcohol: _____
- ❑ Caffeine Cups/Day: _____

EXERCISE

- ❑ None
- ❑ Light Activity
- ❑ Moderate Activity
- ❑ Active
- ❑ Very Active
- ❑ Elite Athlete

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Other
Mother	❑	❑	❑	❑	❑______
Father	❑	❑	❑	❑	❑______
Brother,# of ___	❑	❑	❑	❑	❑______
Sister,# of ___	❑	❑	❑	❑	❑______

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

❑ 541	Appendicitis	❑ 280	Anemia	❑ 429.9	Heart Disease	❑ 716	Arthritis
❑ 480	Pneumonia	❑ 055	Measles	❑ 240	Goiter	❑ 345	Epilepsy
❑ 390	Rheumatic Fever	❑ 072	Mumps	❑ 487	Influenza	❑ 319	Mental Disorder
❑ 045	Polio	❑ 052	Chicken Pox	❑ 511	Pleurisy	❑ 724.2	Lumbago
❑ 011	Tuberculosis	❑ 250	Diabetes	❑ 303.9	Alcoholism	❑ 690	Eczema
❑ 033	Whooping Cough	❑ 239	Cancer	❑ 099	Venereal Disease	❑ 042	HIV Positive
❑ 493.9	Asthma	❑ 346.9	Migraine Headaches	❑ 054.9	Herpes	❑ 340	Multiple Sclerosis

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ☐ Never ☐ Previously ☐ Presently.

GENERAL SYMPTOMS

Never / Previously / Presently	Code	Symptom
☐ ☐ ☐	995.3	Allergy (What)________
☐ ☐ ☐	490	Bronchitis
☐ ☐ ☐	780.9	Chills
☐ ☐ ☐	780.39	Convulsions
☐ ☐ ☐	780.4	Dizziness
☐ ☐ ☐	780.2	Fainting
☐ ☐ ☐	780.79	Fatigue
☐ ☐ ☐	780.6	Fever
☐ ☐ ☐	784.0	Headache
☐ ☐ ☐	780.52	Loss of Sleep
☐ ☐ ☐	783	Loss of Weight
☐ ☐ ☐	799.2	Nervousness
☐ ☐ ☐	729.2	Neuralgia
☐ ☐ ☐	780.8	Sweats
☐ ☐ ☐	786.07	Wheezing
☐ ☐ ☐	311	Depression

GASTRO-INTESTINAL

Never / Previously / Presently	Code	Symptom
☐ ☐ ☐	787.3	Belching/Gas/Bloating
☐ ☐ ☐	789.0	Abdominal Pain
☐ ☐ ☐	564.0	Constipation
☐ ☐ ☐	787.91	Diarrhea
☐ ☐ ☐	783.6	Excessive Eating
☐ ☐ ☐	575.9	Gall Bladder Trouble
☐ ☐ ☐	455	Hemorrhoids (piles)
☐ ☐ ☐	782.4	Jaundice
☐ ☐ ☐	794.8	Liver Trouble
☐ ☐ ☐	787.02	Nausea
☐ ☐ ☐	536.9	Stomach Pain
☐ ☐ ☐	783.0	Poor Appetite
☐ ☐ ☐	536.8	Poor Digestion
☐ ☐ ☐	787.03	Vomiting
☐ ☐ ☐	578.0	Vomiting Blood
☐ ☐ ☐	783.5	Excessive Thirst
☐ ☐ ☐	536.8	Indigestion
☐ ☐ ☐	569.3	Rectal Bleeding

EYE/EAR/NOISE/THROAT

Never / Previously / Presently	Code	Symptom
☐ ☐ ☐	493.9	Asthma
☐ ☐ ☐	378.9	Crossed Eyes
☐ ☐ ☐	389.9	Deafness
☐ ☐ ☐	388.70	Earache
☐ ☐ ☐	388.60	Ear Discharge
☐ ☐ ☐	388.30	Ear Noises
☐ ☐ ☐	240.9	Enlarged Thyroid
☐ ☐ ☐	460	Frequent Colds
☐ ☐ ☐	477	Hay Fever
☐ ☐ ☐	784.49	Hoarseness
☐ ☐ ☐	478.1	Nasal Obstruction
☐ ☐ ☐	784.7	Nosebleeds
☐ ☐ ☐	379.91	Pain in Eyes
☐ ☐ ☐	368.9	Poor Vision
☐ ☐ ☐	461.9	Sinusitis
☐ ☐ ☐	462	Sore Throat
☐ ☐ ☐	463	Tonsillitis
☐ ☐ ☐	786.2	Persistent Cough
☐ ☐ ☐	787.2	Difficulty Swallowing
☐ ☐ ☐	523.8	Bleeding Gums

RESPIRATORY

Never / Previously / Presently	Code	Symptom
☐ ☐ ☐	786.50	Chest Pain
☐ ☐ ☐	786.2	Chronic Cough
☐ ☐ ☐	786.09	Difficulty Breathing
☐ ☐ ☐	786.3	Spitting Blood
☐ ☐ ☐	786.4	Spitting Phlegm

GENITO-URINARY

Never / Previously / Presently	Code	Symptom
☐ ☐ ☐	788.36	Bed Wetting
☐ ☐ ☐	599.7	Blood in Urine
☐ ☐ ☐	788.4	Frequent Urination
☐ ☐ ☐	788.3	Lack of Bladder Control
☐ ☐ ☐	590.9	Kidney Infection
☐ ☐ ☐	788.1	Painful Urination
☐ ☐ ☐	601.9	Prostate Trouble

MUSCLES/JOINTS/BONES

Never / Previously / Presently	Code	Symptom
☐ ☐ ☐	724.5	Backache
☐ ☐ ☐	719.7	Foot Trouble
☐ ☐ ☐	550	Hernia
☐ ☐ ☐	719.1	Pain Between Shoulders
☐ ☐ ☐	724.6	Painful Tail Bone
☐ ☐ ☐	723.9	Stiff Neck
☐ ☐ ☐	781.9	Spinal Curvature
☐ ☐ ☐	719.0	Swollen Joints
☐ ☐ ☐	781.0	Tremors/Twitching
☐ ☐ ☐	782	Arm Trouble

CARDIO-VASCULAR

Never / Previously / Presently	Code	Symptom
☐ ☐ ☐	401.9	High Blood Pressure
☐ ☐ ☐	458.9	Low Blood Pressure
☐ ☐ ☐	786.51	Pain Over Heart
☐ ☐ ☐	785.9	Poor Circulation
☐ ☐ ☐	438	Previous Heart Trouble
☐ ☐ ☐	785.0	Rapid Heart
☐ ☐ ☐	427.89	Slow Heart
☐ ☐ ☐	436	Strokes
☐ ☐ ☐	719.7	Swelling Ankles
☐ ☐ ☐	454	Varicose Veins

SKIN OR ALLERGIES

Never / Previously / Presently	Code	Symptom
☐ ☐ ☐	680.9	Boils
☐ ☐ ☐	924.9	Bruising Easily
☐ ☐ ☐	701.1	Dryness
☐ ☐ ☐	691.8	Eczema
☐ ☐ ☐	708.9	Hives or Allergy
☐ ☐ ☐	698.9	Itching
☐ ☐ ☐	782.0	Sensitive Skin
☐ ☐ ☐	782.1	Skin Eruptions

FOR WOMEN ONLY

Never / Previously / Presently	Code	Symptom
☐ ☐ ☐	625.3	Cramps or Backaches
☐ ☐ ☐	626.2	Excessive Flow
☐ ☐ ☐	627.2	Hot Flashes
☐ ☐ ☐	626.4	Irregular Cycle
☐ ☐ ☐	634.9	Miscarriage
☐ ☐ ☐	625.3	Painful Periods
☐ ☐ ☐	623.5	Vaginal Discharge
☐ ☐ ☐	611.79	Lump in Breast

☐ Yes ☐ No Pregnant at this time?

☐ Yes ☐ No Have you had a mammogram?

__________ Last Pap Date

__________ By Whom

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
__________	Vaccinations	__________	Tubes in Ears	__________	Sinus
__________	Tonsillectomy	__________	Appendectomy	__________	Hernia
__________	Gall Bladder	__________	Female Organs	__________	Thyroid
__________	Back Operation	__________	Rectal Surgery	__________	Stomach
__________	Other: __________	__________	Other: __________	__________	Other: __________

☐ I have never had any operations / surgeries

List any accidents or falls and dates: ☐ Car:__________ ☐ Recreation: __________

☐ Sports:__________ ☐ School:__________ ☐ Other: __________

List any broken bones (fractures) or dislocations:__________

Ever on crutches? ☐ Yes ☐ No Why?__________

Have you ever had any spinal taps or spinal injections? ☐ Yes ☐ No Were you ever knocked unconscious? ☐ Yes ☐ No

Have you ever had a lapse of memory? ☐ Yes ☐ No

Have you ever had X-rays taken? ☐ Yes ☐ No When?__________ By Whom? __________

For what ailments were these X-rays made? __________

Do you suffer from any condition other than that for which you are now consulting us? __________

Are you presently taking any medication - prescription or over-the -counter? ☐ Yes ☐ No What drugs? __________

____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection form the in insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian's Signature: X__________ Date:__________

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME ______________________________ DATE __________

For any YES answer, please include details.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: ______________________________

2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: ______________________________

3. Do your hands or arms fall asleep regularly? NO YES
   Comment: ______________________________

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: ______________________________

5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: ______________________________

6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: ______________________________

7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: ______________________________

8. Do our legs or feet fall asleep regularly? NO YES
   Comment: ______________________________

9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: ______________________________

10. Do you suffer from cold hands or feet? NO YES
    Comment: ______________________________

11. Do have frequent falls or find that you trip over your feet while walking? NO YES
    Comment: ______________________________

12. Do you suffer from headaches? If yes, how often, how severe, what has been tried? NO YES
    Comment: ______________________________

13. Have you tried any medications such as anti-inflammatory? NO YES
    If yes, what kind of medication?
    ____

14. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
    If yes: When? For how long? What kind?
    ____

15. Have you had an MRI? NO YES
    If yes: When? Who ordered it? What was it ordered for?
    ____

16. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If yes: When? What kind? Who ordered it?
    ____

17. If you have tried any treatment or medications, did this make your problem better? NO YES
    Comment: ______________________________

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name ______________________________ Date ______________________

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

____
Examiner

OTHER COMMENTS: ____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short -form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name ______________________________ Date ____________________

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

____
Examiner

OTHER COMMENTS: ______________________________

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

General Consent for Care and Treatment

Korey Kothmann, DC, PA Clayton Roberts, DO Amy Hopkins, FNP
Shonda Chancey, MSN, FNP-BC< RN Cassie Patzig, MOT, OTR
Bret Hoffman, DC Cale Hoffman, DC

TO THE PATIENT: ***You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, chiropractic or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation ne3cessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, chiropractor and/or mid level provider (Nurse Practitioner, Physician Assistant or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________	______________________________
Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	**Employee Job Title**
Signature of Witness	**Date**

PRIVACY NOTICE ACKNOWLEDGEMENT

I have received or been offered a copy of the Notice of Privacy Practice from the office.

Signature: ______________________________ Date: ______________________________

Lubbock Advanced Physical Medicine / Korey Kothmann, DC, PA
2230 Indiana Avenue
Lubbock TX 79410-2192

Phone: (806) 791-3399 Fax: (806) 791-3934

ASSIGNMENT, LIEN, AND AUTHORIZATION
FOR DIRECT PAYMENTS BY MY PAYERS TO *Korey Kothmann, D.C., PA*

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 **Korey Kothmann, D.C., PA** located at **2230 Indiana Avenue Lubbock TX 79410;** "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, attorneys fees, fees or costs associated with requests for reconsideration, independent reviews, appeals, mediation, arbitration, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Assignment and Lien Terms. I hereby assign to the Office to the extent permitted by law, but only to the extent of my Charges, all of my claims to, rights to, and interests in, Proceeds, whether resolved or unresolved, including without limit ownership rights, which I may have now or in the future relating directly or indirectly to my Charges, condition, or causes of my condition ("Claims to Proceeds"), including without limit any and all causes of action, receivables, payment intangibles, and remedies that I might have against or with respect to any Payer now or in the future, and the right to prosecute, seek, settle, or otherwise resolve such Claims to Proceeds either in my name or in the Office's name and as the Office otherwise sees fit. I agree that this assignment shall be effective as of the date and time the initial cause of my condition occurred. I further intend for this Assignment & Lien to create a security interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to the Office a primary, non-contingent security interest in all of my Claims to Proceeds to the extent permitted by law for the purpose of securing payment of my Charges, the attachment and perfection of which shall relate back to, and be effective as of, the date and time that the initial cause of my condition occurred. I further authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency relating to such security interests, and to make such filings in all relevant jurisdictions as the Office sees fit in its sole discretion. I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my agreement with the Office, such security interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Service Certified Mail. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the full extent of my Charges. To the extent that any law, including without limit a lien statute, purports to limit, reduce, or modify the distribution of Proceeds in any manner inconsistent with this Assignment & Lien including without limit through the reservation of a portion of the Proceeds exclusively to me, I hereby waive such limits, reductions, or modifications. Such waiver shall not adversely affect or prejudice any rights which the Office may have and elect to exercise under said law.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys who receive(s) Proceeds from one or more Payers, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding such Proceeds, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of such Proceeds shall be primarily to pay my Charges. If I have a dispute regarding the Charges, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the Office. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney's fees and costs, or other expenses of obtaining Proceeds.

Disclosure Directives. I hereby direct each and every Payer to immediately release to the Office any Pertinent Information relating to (a) any coverage I may have and (b) any Proceeds Determination by the Payer relating to the Office's Charges. "Pertinent Information" shall include without limit the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information" shall also include without limit copies of all documents, records, and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny, or delay payment of any Proceeds relating to the Office's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or for me by the Office to all Payers, including without limit a copy of my Charges and a copy of this Assignment & Lien, unless otherwise agreed to in writing.

Miscellaneous. Except as provided in this paragraph, this Assignment & Lien shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment & Lien. I agree that each and every provision of this Assignment & Lien is reasonably necessary. However, should any provision of this Assignment & Lien be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment & Lien shall, nevertheless, remain in full force and effect. This Assignment & Lien shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment & Lien, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment & Lien.

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

Patient Name (print): ______________________ Patient Signature: ______________________ Date: ___/___/___

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

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