AUTO INJURY HISTORY FORM

Missing / Incomplete / Inaccurate information may jeopardize your coverage by the insurance carrier or future legal documentation

ASSIGNMENT OF BENEFITS

The information on these forms is correct to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes in my medical status. I also agreed and understood all the policies written above. I, _____, hereby assign my rights, title, and interest from any and all automobile insurance policy which provides Personal Injury Protection (PIP), medical benefits, or no-fault benefits to Pangemanan Chiropractic, for services rendered to me by Pangemanan Chiropractic for the accident on _____.

Patient's Signature **X**_____

Witness_____

Date _____

INJURY HISTORY

Weather conditions at time of accident:

☐ Foggy ☐ Icy ☐ Normal ☐ Windy
☐ Raining ☐ Snowing ☐ Poor Visibility

Time of Accident: ☐ Dawn ☐ Daylight ☐ Dusk ☐ Night

Did vehicle go off the road? ☐ Yes ☐ No

Length of time in the car before accident: _____

List your body parts that were struck during collision:

_____

_____

You were: ☐ Driver ☐ Passenger Front Seat
☐ Passenger Front Middle / Right Seat
☐ Passenger Middle Left / Center / Right Seat
☐ Passenger Middle Right Seat
☐ Passenger Back Left / Middle / Right Seat

If you're not the driver, who was? _____

Your Status / Body Position Before Accident:

☐ Asleep ☐ Awake
☐ Seat/Lap Belt On ☐ Seat/Lap Belt Off
☐ Shoulder Harness On ☐ Shoulder Harness Off
☐ Reclined in Seat ☐ Rotated in Seat
☐ Both hands on steering wheel ☐ One hand on wheel
☐ Tired ☐ _____

Were brakes applied before the impact? ☐ Yes ☐ No

Your posted speed limit: _____ mph

Rate of speed before impact: _____ mph

Traffic conditions at time of accident:

☐ Congested ☐ Good ☐ Rush Hour
☐ Heavy ☐ Normal

Your vehicle was impacted on:

☐ Front Head On ☐ Front Left ☐ Front Right
☐ Rear-End ☐ Rear Left ☐ Rear Right
☐ Left Side ☐ Right Side

Type of your vehicle: _____

Make & Year: _____

Vehicle Ownership: _____

Patient's Name _____

Today's Date _____

CLAIM # _____

Insurance Co. Name + Address_____

_____

Insurance Co. Phone # _____

Date of Injury _____ Time of Injury _____AM / PM

Marital Status ☐ M ☐ S ☐ W ☐ D # Children ___

Tobacco/Smoke ☐ None Pack per day ___ #Years ____

Alcohol ☐ Never ☐ Social ☐ Rarely
☐ Recovering Alcoholic ☐ Current Abuse

At Time of Crash: ☐ Unemployed
☐ Employed by _____

Currently: ☐ Unemployed
☐ Employed by _____

Type of work: ☐ Office/clerical ☐ Light Labor
☐ Moderate Labor ☐ Heavy labor

Locations Taken / You Went to After the Accident:

☐ Home. How? _____
☐ ER, By Ambulance / By Self / By _____
☐ Hospital. By Ambulance / By Self / By _____
☐ Minor Emergency Center. By _____

Were you hospitalized? ☐ Yes ☐ No

Treatments received at the hospital / ER / minor emergency place:

_____

_____

Radiographs / X-rays? ☐ Yes ☐ No

Which body parts? _____

_____

Did you see any other health care provider(s) between the date of the accident and today's date?

1.) Dr.: _____
Office Name + City_____
Specialty: _____Date first seen_____
Referred by: _____
Treatments Received: _____
Drug Prescriptions: _____
Currently Treating? ☐ Yes ☐ No
Special Tests: _____
Did treatment(s) help? ☐ Yes ☐ No
Notes: _____

2.) Dr.: _____
Office Name + City_____
Specialty: _____Date first seen_____
Referred by: _____
Treatments Received: _____
Drug Prescriptions: _____
Currently Treating? ☐ Yes ☐ No
Special Tests: _____
Did treatment(s) help? ☐ Yes ☐ No
Notes: _____

3.) Dr.: _____
Office Name + City_____
Specialty: _____Date first seen_____
Referred by: _____
Treatments Received: _____
Drug Prescriptions: _____
Currently Treating? ☐ Yes ☐ No
Special Tests: _____
Did treatment(s) help? ☐ Yes ☐ No
Notes: _____

BEFORE vs. AFTER THE ACCIDENT

Conditions/illness due to the accident interfere with:

- ☐ Activities of Daily Living
- ☐ My normal/regular personal lifestyle
- ☐ My normal/regular work activities

BEFORE accident/injury, WALKING activities at home or work:
☐ Normal ☐ Limited ☐ Difficult ☐ Painful
AFTER accident/injury, WALKING activities at home or work:
☐ Normal ☐ Limited ☐ Difficult ☐ Painful
BEFORE accident/injury, STANDING activities at home / work:
☐ Normal ☐ Limited ☐ Difficult ☐ Painful
AFTER accident/injury, STANDING activities at home or work:
☐ Normal ☐ Limited ☐ Difficult ☐ Painful
BEFORE accident/injury, BENDING activities at home or work:
☐ Normal ☐ Limited ☐ Difficult ☐ Painful
AFTER accident/injury, BENDING activities at home or work:
☐ Normal ☐ Limited ☐ Difficult ☐ Painful
BEFORE accident/injury, SITTING activities at home or work:
☐ Normal ☐ Limited ☐ Difficult ☐ Painful
AFTER accident/injury, SITTING activities at home or work:
☐ Normal ☐ Limited ☐ Difficult ☐ Painful

POST-INJURY

Self-care activities you have been doing since the accident:
☐ None ☐ Ice ☐ Heat
☐ Compression ☐ Rest ☐ Soaking
☐ ACE wrap ☐ Massage
☐ Over the Counter Medications _____
☐ Over the Counter Orthotics_____
☐ Over the Counter Treatments_____
☐ Others _____
Do you remember the impact? ☐ Yes ☐ None
After the accident, do you need another person / outside help
to help you to get around at home or at work? ☐ Yes ☐ None
Lost time from work: ☐ Yes ☐ None
If yes, provide dates: ____/___/____ to ___/___/____
Notes: _____

_____
Are you able to do almost any physical activity? _____
Are you able to do almost any mental activity? _____
Does it bother you to ride in a car now? _____

REPORTS & CITATION

To whom was citation given and for what reason?
_____
_____
Were police on-scene? ☐ Yes ☐ No
Injury/accident/police report filed? ☐ Yes ☐ No
Witness(es) of accident:
_____
_____
_____

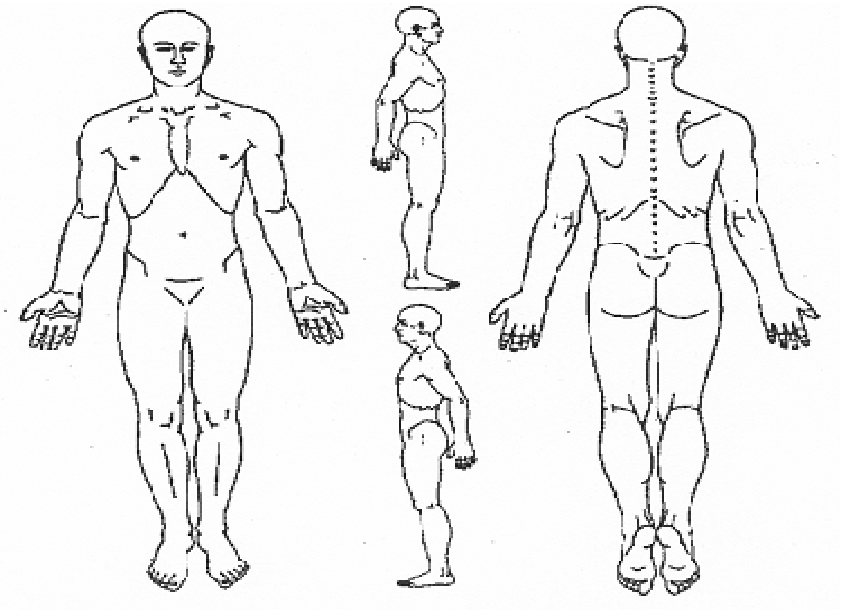
ADDITIONAL INFO:

Seat back adjustment altered by the crash? ☐ Yes ☐ No
Was the seat broken? ☐ Yes ☐ No
Lap belt: ☐ Wearing ☐ Not wearing ☐ Don't Know
Shoulder belt: ☐ Wearing ☐ Not wearing ☐ Don't Know
Your vehicle equipped with air bag? ☐ Yes ☐ No
Did air bag deploy? ☐ Yes ☐ No
If yes, were you struck by air bag? ☐ Yes ☐ No
Did your vehicle strike any objects after crash? ☐ Yes ☐ No
Did you wear hat or glasses during the crash? _____
If yes, were they still on after crash? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
Estimated property damage to your vehicle: $ _____
Estimated property damage to other vehicle(s): $ _____
Symptoms AFTER the impact:
☐ Headache ☐ Dizziness ☐ Nausea
☐ Vomiting ☐ Confusion / Disorientation
☐ Tingling / Numbness. Where?_____
☐ Pain. Where? _____
☐ Pain. Where? _____
The symptoms mentioned above appear:
☐ Immediately
☐ _____ hour(s) afterward. Which symptoms? _____

Crash Diagram: (please draw the roads, names of roads or highways, vehicles, direction of vehicles with arrows, etc.)

Please mark the area of injury or discomfort on the chart, using the appropriate <u>symbols</u>:

Numbness	- - - -
Tingling	O O O
Burning	^ ^ ^
Aching	X X X
Stabbing	⊗ ⊗ ⊗



WHAT are your **<u>COMPLAINTS ?</u>** _____

Have you had these problems before the accident ? (ex. 2 years ago)_____

HOW did this problem **started** ? (ex. Car wreck)? _____

What makes the pain **better** (sitting/standing/nothing/painkillers/rest,etc.)_____

What makes the pain **worse** (sitting/rest, etc.) _____

Does it stay in the same place/**locally** or does it **radiate**? Where to? _____

Rate **INTENSITY** of pain: (NO PAIN) → 0 1 2 3 4 5 6 7 8 9 10 → (excruciating, unbearable, 10/10 = need to go to ER immediately)

Timing of pain: ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant ☐ Other _____

Have you seen any other health care professionals about this? **If yes**, <u>who</u>, <u>where</u> and <u>when</u> and <u>what</u> were the results? _____

_____

Have you ever experienced this problem <u>before</u>? When? Please explain _____

_____

Has this problem been getting better, worse, or staying the same since it started? _____

_____

Have you had any **X-rays or MRI** or any tests taken for this problem(s) in the last 2 years? Yes / No. If yes, where _____

_____

(If this form is not sufficient to document all your complaints, please use additional forms as necessary, copies, etc.)

List the body parts that struck the following vehicle parts during the accident:

Dashboard	Windshield	Steering Wheel	Right Door	Left Door
R / L side of the head	R / L side of the head	R / L side of the head	R / L side of the head	R / L side of the head
R / L shoulder	R / L shoulder	R / L shoulder	R / L shoulder	R / L shoulder
R / L arm	R / L arm	R / L arm	R / L arm	R / L arm
R / L elbow	R / L elbow	R / L elbow	R / L elbow	R / L elbow
R / L wrist	R / L wrist	R / L wrist	R / L wrist	R / L wrist
R / L hip	R / L hip	R / L hip	R / L hip	R / L hip
R / L knee	R / L knee	R / L knee	R / L knee	R / L knee
R / L ankle	R / L ankle	R / L ankle	R / L ankle	R / L ankle

Other information: _____

_____

NEW AUTO / PERSONAL INJURY PATIENT COMPLIANCE AGREEMENT FORM

We are honored that you choose Pangemanan Chiropractic to help you recover from your recent auto-accident / personal injury, however, in order to create a harmonious, ethical, win-win situation and a congruous environment in this office, *we are very selective in accepting and retaining patients*. Due to the strict and meticulous legal nature of auto-accident and personal injury case, and in order to prevent accepting patients who are non-compliant, we are forced to create a selective environment in selecting patients to be cared for in this office. This Agreement Form allows *Pangemanan Chiropractic* to ***retain, honor, and respect*** patients (a.k.a. practice members) who are compliant and honor their privilege as patients, at the same time we reserve the right to cease care and discharge non-compliant patients and/or refer them to other chiropractic office(s) in the area at any time.

(1) I agree to KEEP MY APPOINTMENTS and follow the treatment schedule prescribed by the physician(s) at Pangemanan Chiropractic for my own benefits. In rare cases where I have to cancel my appointment, I will make every effort to change my scheduled appointment(s) at least 24 hours prior to the scheduled appointment. I also agree to follow the home / workplace care instructions prescribed by the chiropractic physician(s) at Pangemanan Chiropractic for my own benefit. This includes, but not limited to, icing instructions (cryotherapy) to reduce swelling and inflammation, exercises, stretches, rest, posture, etc. Failure to perform the home or workplace care instructions (ice applications, exercises, stretches, posture, etc) will likely result in a slow recovery and possible worsening or relapse of symptoms. Pangemanan Chiropractic may stop care at any time and may refer me to another chiropractor for my own benefit. All X-rays, scan and diagnostic exam results remain property of this clinic. X-rays can be checked-out 30 days at a time. I am allotted up to three missed visits annually after the start of my care. When this is reached, *Pangemanan Chiropractic* may refer me to another chiropractic office for my own benefit. I will agree to hold harmless and indemnify *Pangemanan Chiropractic*, its physicians, employees, volunteers, and affiliated individuals or corporations from any and all liability in the past, present, or future, arising from my non-compliance, my own inability to keep my appointments and/or participating fully and actively in my home / workplace care instructions.

(2) I agree to be financially responsible for all charges incurred at this clinic should the insurance company refuse to pay for the services provided. This office has a Zero Balance Policy and reserve the right to refuse care to patients with outstanding balance at anytime as well as the right to collect the outstanding balance using various collection methods. This office does NOT and is not responsible to send bills or charges to the patients. SHOULD I, (PATIENT) LOOSE MY ACCIDENT CASE, OR SETTLE IT WITHOUT NOTIFYING PANGEMANAN CHIROPRACTIC, I AM RESPONSIBLE FOR MY BILL FROM PANGEMANAN CHIROPRACTIC AND I UNDERSTAND THAT PAYMENT WILL BE DUE IN FULL IMMEDIATELY, ESPECIALLY IF SETTLEMENT IS GIVEN TO ME WITHOUT NOTIFICATION TO PANGEMANAN CHIROPRACTIC. I understand that if I am receiving medical care as a result of injuries sustained in an accident which is covered by a liability insurance policy, Pangemanan Chiropractic will not release to me a complete itemization of charges reflecting any outstanding balance until I am released from care. I also understand that if the accident in which I was involved was covered by any medical payment provision of any applicable insurance policy, any benefits obtained through any such policy will be applied directly to the outstanding balance on my account with Pangemanan Chiropractic's office. I fully understand that I am directly and fully responsible to Pangemanan Chiropractic for all medical bills submitted by Pangemanan Chiropractic for services rendered to me and that this agreement is made solely for said doctor's additional protection. Complete satisfaction of the medical bills is not contingent on any settlement, judgment, or verdict by which I recover said fee.

(3) If I retain an attorney, I am responsible to inform Pangemanan Chiropractic of his/her name, address, phone, fax, and information. If I change attorneys, I am also responsible to inform Pangemanan Chiropractic of these changes and related changes immediately.

(4) I WILL ALWAYS BE CONSISTENT in telling the doctors and staff at Pangemanan Chiropractic and my attorney all my complaints/symptoms and my complete physical history including any other accidents or preexisting conditions, throughout my care. IF MY CONDITION OR SYMPTOMS CHANGE, I should immediately advise this office. I understand that certain symptoms may indicate a need to be referred to another specialist—Pangemanan Chiropractic may terminate my care and refer out immediately

(5) I will provide Pangemanan Chiropractic with names of all insurance companies with whom I have policies, and who I am involved with. If my insurance company or any other party requests an Independent Medical Examination, I should consider my legal obligation. Most insurance companies require my cooperation and their right to an I.M.E. which is used routinely if the expenses of your treatment exceed a certain amount. I clearly understand that the request for an I.M.E. does not give the insurance company the right to require me to change doctors or to select a doctor for treatment.

CREDIT GUARANTEE - As a courtesy to you, we will bill the insurance carrier on your behalf and wait up to 6 months for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you provide a credit card to guarantee payment of your bill. Balances not paid within 6 months after conclusion of your care will be charged to your designated credit card below. You will be sent a payment voucher. Should settlement be reached prior to the 6 month grace period or should care be terminated for any reason prior to dismissal by our chiropractor all balances become due immediately, will be charged to your credit card and are subject to monthly interest charges. I agree to the above terms and authorize Pangemanan Chiropractic to bill the charge card.

DEBIT / CREDIT CARD: ☐ AMEX ☐ VISA ☐ MC ☐ DISCOVER

CARDHOLDER NAME: _____ CARD # _____ EXP. DATE _____

I, ……, the undersigned, hereby request chiropractic care and adjunctive services at the *Pangemanan Chiropractic* at 1028 Eagle Lake Dr, Lawrenceburg KY 40342. I have read, understand and accept the terms in this form twelve (12) Compliance Policies above and have had the opportunity to ask questions regarding anything that I do not understand. I am looking forward to a mutual and rewarding relationship with the doctors and team members of Pangemanan Chiropractic.

Signature of Patient / Guardian (if minor) X _____ *Date* _____

NECK Index

Please rate the severity of your pain by circling a number:

No pain 0 1 2 3 4 5 6 7 8 9 10 ***Unbearable pain***

Name _____ **Date** ____/___/_____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

SECTION 1-**PAIN INTENSITY**

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

SECTION 2-**PERSONAL CARE** (Washing, Dressing, etc.)

0. I can look after myself normally, without causing extra pain.
1. I can look after myself normally, but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help, but manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3-**LIFTING**

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it gives extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

SECTION 4-**READING**

0. I can read as much as I want to, with no pain in my neck.
1. I can read as much as I want to, with slight pain in my neck.
2. I can read as much as I want to, with moderate pain in my neck.
3. I can't read as much as I want, because of moderate pain in my neck.
4. I can hardly read at all, because of severe pain in my neck.
5. I cannot read at all.

SECTION 5-**HEADACHES**

0. I have no headaches at all.
1. I have slight headaches that come infrequently.
2. I have moderate headaches that come infrequently.
3. I have moderate headaches that come frequently.
4. I have severe headaches that come frequently.
5. I have headaches almost all the time.

TOTAL _____/ 50 = _____%

SECTION 6-**CONCENTRATION**

0. I can concentrate fully when I want to, with no difficulty.
1. I can concentrate fully when I want to, with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

SECTION 7-**WORK**

0. I can do as much work as I want to.
1. I can do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I can't do any work at all.

SECTION 8-**DRIVING**

0. I can drive my car without any neck pain.
1. I can drive my car as long as I want, with slight pain in my neck.
2. I can drive my car as long as I want, with moderate pain in my neck.
3. I can't drive my car as long as I want, because of moderate pain in my neck.
4. I can hardly drive at all, because of severe pain in my neck.
5. I can't drive my car at all.

SECTION 9-**SLEEPING**

0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hr sleepless).
2. My sleep is mildly disturbed (1-2 hrs sleepless).
3. My sleep is moderately disturbed (2-3 hrs sleepless).
4. My sleep is greatly disturbed (3-5 hrs sleepless).
5. My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-**RECREATION**

0. I am able to engage in all my recreation activities, with no neck pain at all.
1. I am able to engage in all my recreation activities, with some neck pain at all.
2. I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
3. I am able to engage in few of my recreation activities, because of pain in my neck.
4. I can hardly do any recreation activities, because of pain in my neck.
5. I can't do any recreation activities at all.

LOW BACK Index

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 ***Unbearable pain***

Name _____ **Date** ____/___/_____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking Section
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 min. without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____/ 50 = _____%

Drs. Arthur & Rebecca Pangemanan

PANGEMANAN Chiropractic
1028 Eagle Lake Dr, Lawrenceburg, KY 40342
(502) 839-7171, (502)839-4441

(This form is not necessary unless you are hiring or have hired an attorney for this personal injury / motor vehicle accident case, then this Provider's Lien form must be signed by your attorney immediately and must be returned to Pangemanan Chiropractic)

PROVIDER'S LIEN

TO: Attorney _____
_____
_____

Re: Reports and Provider's Lien

I, _____, do hereby authorize the above health provider to furnish you, my attorney, with a full report of this examination, diagnosis, treatment, prognosis, etc of myself in regards to the accident in which I was involved.

I,_____, do hereby authorize and direct you, my attorney, to pay directly to Pangemanan Chiropractic, such sums as may be due and owing them for chiropractic services rendered me both by reason of this accident and by reason of any other bills that are due their office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said company. And I hereby further give a lien on my case to said company against any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said company for all chiropractic bills submitted by them for services rendered me and that this agreement is made solely for said company's additional protection and in consideration of their 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.

Patient's Signature: _____ Date : _____

Patient's Name: _____

The undersigned being attorneys 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 company above named.

Attorney's Signature: _____ Dated: _____

Please date, sign and return one copy to doctor's office. Keep a copy for your records. A photo copy of this form shall be considered as valid as the original.