PWC of Elk River – Motor Vehicle Accident Patient Intake Form

Patient Name:_______________________________________ Date:________________________

Phone (cell/home):_______________________________________ Email Address:____

Address:____City:____________________ State:___ Zip Code: _____________

Sex: M F Marital Status: M S D W Date of Birth: ______________________________Social Security #:______________________

Previous Chiropractic Care? Yes No If yes, when and where?____

Insurance Comp Name:______________________________________Policy Holder Name:____________________________________

Policy Holder DOB: _____________________Your Occupation:____

Your Employer:____ Referred by:____

Auto Insurance Comp Name:____________________________________Policy Holder Name:__________________________________

Insurance Company Phone #:_____________________Claim # (Medical):____

Insurance Company Address:_____________________________________City:_________________________State:____ Zip: _________

Auto Adjuster Name:____ Direct Phone #:____________________________

Date of Injury:_________________________State of Which the Injury Occurred:____

Please Draw and Describe the accident in the box below:

Previous Interventions, treatments, medications, surgery, or care you've sought for your MVA complaint(s):

____

Since the Motor Vehicle Collision, have you experienced any of the following:

A. Loss of Range of Motion: **Yes / No**

B. Visual Disturbance: **Yes / No** Circle if "Yes":

Blurring: **L/R** ____ **% of time** Floaters: **L/R** ____ **% of time**

Vision Loss: **L/R** ____ **% of time** Hypersensitivity: **L/R** ____ **% of time**

C. Dizziness: **Yes / No** ____ **% of time** Anxiety: **Yes / No** ____ **% of time**

D. Depression: **Yes / No** ____ **% of time** Difficulty Sleeping: **Yes / No** ____ **% of time**

E. Do you have difficulty in excessive: **Standing / Walking / Riding / Bending / Twisting**

F. Do you have difficulty in excessive lifting (if Yes): **Light / Moderate / Heavy / Repetitive**

Doctor Signature: ___________________________________

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763.441.3830

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- Time of accident: ________________________ AM/PM
- Location of collision (include state): __________________________
- Please Describe how the collision happened:

  ____

  ____

  ____
- What was your position in the car? (Circle)

  Driver / Front Passenger / Left Rear / Right Rear

  If "Driver", were your hands on the steering wheel? **Both / Left / Right**
- Did the airbags deploy? **Yes / No**
- Did you strike another vehicle? **Yes / No**
- Did another vehicle strike your vehicle? **Yes / No**
- Direction of impact: **Front / Back / Left / Right / Other:** __________

  If second collision – Direction of second impact:

  Front / Back / Left / Right / Other: ___________________________
- How was your headrest set? **Low / Middle / High**
- Were you surprised by the impact? **Yes / No**

  If "No", did you brace? **With Hands / With Feet**
- Where was your head facing at the time of impact?

  Straight Ahead / Left / Right / Behind
- What type and year of vehicle were you in? ______________________
- What was the approximate speed of your vehicle when the accident occurred? __________________mph
- What type and year of vehicle struck yours? _____________________
- What was the approximate speed of the other vehicle when the accident occurred? __________________mph
- Did you strike anything in the vehicle at the time of impact? **Yes / No**

  If "Yes", specify what part of your body struck what by circling below:

  Steering Wheel / Windshield / Dashboard / Roof / Left Side Door / Right Side Door / Left Window / Right Window / Other
- Did your seat break or bend? **Yes / No**
- Were you wearing a seatbelt? **Yes / No**

  If "Yes", What Type? **Lap Belt / Shoulder Belt / Both**
- Were you leaning forward at the time of impact? **Yes/No**
- Did you feel pain immediately after the accident? **Yes / No**
- Were you rendered unconscious after the accident? **Yes / No**
- Immediately following the accident, how did you feel? (Circle all that apply): **Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other:** ____
- Was the accident reported to the police? **Yes / No**

  Do you have the report? **Yes / No**

  Were traffic citations issued? **Yes / No** If "Yes", to whom?

  ____
- Where did you go immediately after the accident?

  ____
- Did you go to the hospital? **Yes / No** If "Yes", where and when?

  ____

  If "Yes", how did you get there?

  Ambulance / Police Car / Private Transportation
- Were you admitted? **Yes / No** If "Yes", how long?

  ____

  Name of Hospital? ____

  Attended by Dr. ____
- What treatment was given? **None / X-rays / Pain Medication / Stitches / Muscle Relaxants / Bandaged / Cervical Collar / Physical Therapy / Instructed Regarding Concussion / Instructed to call Orthopedist / Instructed Regarding Sprains & Strains / Instructed to Call a Private Physician / Referred to this Office / Other:** ___________________
- Have you seen any other physicians as a result of this injury?

  ____

Doctor Signature: ____________________________________

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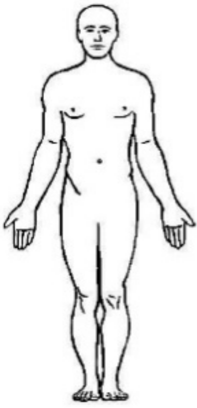
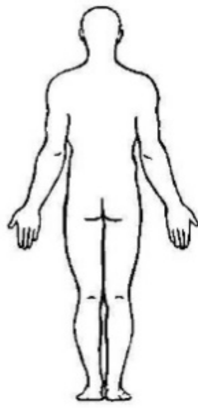

Please place an X on the body icon where you are feeling your pain and symptoms and then describe any other pertinent information on the right.

____

____

____

____

____

____

Primary Reason: ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  No Pain 0 1 2 3 4 5 6 7 8 9 10 Most Severe
- What percentage of the time do you experience the above symptom?
  0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100%
- When and how did the symptom begin? Suddenly or Gradually?
  ____
- Was this symptom a result of a motor vehicle collision? **Yes / No**
- Did you have this symptom before this motor vehicle collision?
  Yes / No If "yes", what was the intensity (1-10 w/10 the worst) and frequency?
  ____
- What makes the symptom worse? (circle all that apply):
  bending forward, bending backward, tilting to left, tilting to right, turning head to left, turning head to right, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, most movements, driving, walking, running, nothing, Other (please describe):
  ____
- What makes the symptom better? (circle all that apply): rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe):
  ____
- Describe the quality of the symptom (circle all that apply): sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, numbness, shooting, stinging, Other (please describe):
  ____
- Does the symptom radiate to another part of your body (circle one):
  yes no If yes, where? ________________________________
- Is the symptom worse at certain times of the day or night?
  (circle one): Morning Afternoon Evening Night Unaffected

Secondary Reason: ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  No Pain 0 1 2 3 4 5 6 7 8 9 10 Most Severe
- What percentage of the time do you experience the above symptom?
  0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100%
- When and how did the symptom begin? Suddenly or Gradually?
  ____
- Was this symptom a result of a motor vehicle collision? **Yes / No**
- Did you have this symptom before this motor vehicle collision?
  Yes / No If "yes", what was the intensity (1-10 w/10 the worst) and frequency?
  ____
- What makes the symptom worse? (circle all that apply):
  bending forward, bending backward, tilting to left, tilting to right, turning head to left, turning head to right, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, most movements, driving, walking, running, nothing, Other (please describe):
  ____
- What makes the symptom better? (circle all that apply): rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe):
  ____
- Describe the quality of the symptom (circle all that apply): sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, numbness, shooting, stinging, Other (please describe):
  ____
- Does the symptom radiate to another part of your body (circle one):
  yes no If yes, where? ________________________________
- Is the symptom worse at certain times of the day or night?
  (circle one): Morning Afternoon Evening Night Unaffected

Doctor Signature: ________________________________

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Third Reason: ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  No Pain 0 1 2 3 4 5 6 7 8 9 10 Most Severe
- What percentage of the time do you experience the above symptom?
  0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100%
- When and how did the symptom begin? Suddenly or Gradually?
  ____
- Was this symptom a result of a motor vehicle collision? **Yes / No**
- Did you have this symptom before this motor vehicle collision?
  Yes / No If "yes", what was the intensity (1-10 w/10 the worst) and frequency?
  ____
- What makes the symptom worse? (circle all that apply):
  bending forward, bending backward, tilting to left, tilting to right, turning head to left, turning head to right, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, most movements, driving, walking, running, nothing, Other (please describe):
  ____
- What makes the symptom better? (circle all that apply): rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe):
  ____
- Describe the quality of the symptom (circle all that apply): sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, numbness, shooting, stinging, Other (please describe):
  ____
- Does the symptom radiate to another part of your body (circle one):
  yes no If yes, where? ____________________________________
- Is the symptom worse at certain times of the day or night?
  (circle one): Morning Afternoon Evening Night Unaffected

Fourth Reason: ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  No Pain 0 1 2 3 4 5 6 7 8 9 10 Most Severe
- What percentage of the time do you experience the above symptom?
  0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100%
- When and how did the symptom begin? Suddenly or Gradually?
  ____
- Was this symptom a result of a motor vehicle collision? **Yes / No**
- Did you have this symptom before this motor vehicle collision?
  Yes / No If "yes", what was the intensity (1-10 w/10 the worst) and frequency?
  ____
- What makes the symptom worse? (circle all that apply):
  bending forward, bending backward, tilting to left, tilting to right, turning head to left, turning head to right, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, most movements, driving, walking, running, nothing, Other (please describe):
  ____
- What makes the symptom better? (circle all that apply): rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe):
  ____
- Describe the quality of the symptom (circle all that apply): sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, numbness, shooting, stinging, Other (please describe):
  ____
- Does the symptom radiate to another part of your body (circle one):
  yes no If yes, where? ____________________________________
- Is the symptom worse at certain times of the day or night?
  (circle one): Morning Afternoon Evening Night Unaffected

Doctor Signature: ___________________________________

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Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s): ______________________

Medications/Supplements: ______________________

Past Surgeries/Pregnancies and Outcomes/Allergies: ______________________

Recreational Activities and Lifestyle (hobbies, alcohol, tobacco and drug use, diet): ______________________

Previous Injury or Trauma: ______________________

Please indicate if you have a <u>family history</u> of the following conditions or symptoms:

□ Cancer	□ Strokes/TIAs	□ Headaches	□ Cardiac Disease
□ Adopted/Unknown	□ Cardiac Disease below age 40	□ Psychiatric Disorder	□ Neurological Disease
□ Diabetes	□ Other: ______________________	□ None of the above	

Please indicate if <u>you have</u> a history of any of the following conditions or symptoms:

General

□ Cancer: ______________________	□ Diabetes	□ Thyroid Disease	□ AIDS/HIV Positive
□ Fatigue	□ Unexplained Weight Loss	□ Decreased Energy	□ Loss of Appetite
□ Night Sweats	□ Excessive Thirst	□ Fever/Chills	□ Skin Ulcers/Rashes
□ Memory Loss	□ Other: ______________________	□ None of the Above	

Neuromuscular

□ Headaches	□ History of Seizures	□ Stroke/TIAs	□ Arthritis (Unknown)
□ Inflammatory Arthritis: __________	□ Scoliosis	□ Gout	□ Osteoporosis
□ Paralysis	□ Broken Bones: ________________	□ Dislocations	□ Difficulty Walking
□ Change in Vision/Smell/Hearing or Taste		□ Other: ______________________	□ None of the Above

Cardiovascular

□ Heart Attack/MI	□ Pacemaker/Defibrillator	□ Chest Pain/Angina	□ Heart Surgeries
□ Congestive Heart Failure	□ Irregular Heartbeat	□ Peripheral Vascular Disease	□ Shortness of Breath
□ Murmurs or valvular disease	□ Redness or Swelling of Limb	□ Anemia	□ Sickle Cell Anemia
□ High Blood Pressure/Hypertension	□ Regular Aspirin Use	□ Other: ______________________	□ None of the Above

Respiratory

□ Asthma	□ COPD	□ Wheezing	□ Emphysema
□ Cough/Difficulty Breathing	□ Blood in Sputum	□ Other: ______________________	□ None of the Above

Gastroenterology

□ Nausea/Vomiting	□ Pain or Difficulty Swallowing	□ Constipation	□ Diarrhea
□ Heartburn/GERD	□ Stomach Pain	□ Hepatitis/Liver Disease	□ Appendectomy
□ Irritable Bowel/Colitis	□ Pancreatitis	□ Gall Stones	□ Ulcers
□ Bloating/Excessive Gas	□ Bloody or Black Tarry Stools	□ Other: ______________________	□ None of the Above

Genitourinary

□ Kidney Disease/Dialysis	□ Kidney Stones	□ Prostate Enlargement	□ Blood in Urine/Hematuria
□ Burning/Difficulty with Urination	□ Loss of Bladder or Bowel Control	□ Other: ______________________	□ None of the Above

Psychiatric

□ Anxiety	□ Depression	□ Suicidal Ideations	□ Bipolar Disorder
□ Homicidal Ideations	□ Schizophrenia	□ Change in Mood or Behavior	
□ Other: ______________________	□ None of the Above		

_______ Initial here if **<u>none</u>** of the listed symptoms or conditions apply to you.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this chiropractic clinic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Power Within Chiropractic of Elk River, P.A. for services performed.

Patient or Guardian Signature ____ Date_________________________

Doctor Signature: ____________________________________

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Power Within Chiropractic of Elk River Motor Vehicle Accident Patient Intake Form

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) for other purposes that are permitted or required by law. “Protected Health Information” is information about you, including demographic information that may identify you and that is related to your past, present, or future physical/mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For instance, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Alternatively, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, fund-raising activities, and conduction or arranging for other business activities. For instance, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations may include, as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. For required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

______________________________ ______________________________ ______________________

Patient’s Name - Printed | Patient’s Signature | Date

Doctor Signature: ______________________________

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INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including examination tests, diagnostic x-rays, physiotherapy, manual/physical techniques, and any supportive therapies performed on me (or on the patient named below for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working or associated with, or serving as an agent of Power Within Chiropractic of Elk River, including those staff members employed at the clinic or office listed below or any affiliated office or clinic.

I understand that chiropractic adjustments and supportive treatments are designed to reduce muscle tension, joint restrictions, and improve function allowing the body to return to optimal health. However, as with all healthcare treatments, results are not guaranteed and there is no promise to "cure".

I understand that, as with any health care procedure, there are certain complications that may arise during a chiropractic treatment. Those complications include but are not limited to: fractures, disc injuries, dislocations, and muscle sprains and strains. Although rare, some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) in which the doctor believes, based upon the facts known at the time, are in my best interests.

I understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and pain killers; physical therapy; steroid injections; bracing; and surgery.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature, purpose, and risks of chiropractic adjustments and other procedures and have had my questions answered to my satisfaction.

If there is any dispute about my care, I agree to resolution by binding arbitration according to the American Arbitration Association guidelines. I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended.

Having been informed of the risks, I hereby give my consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

______________________	______________________	______________
Patient's Name - Printed	Patient's Signature	Date

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Power Within Chiropractic of Elk River to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: ____________________________. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examinations at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

______________________	______________________	______________
Patient's Name - Printed	Patient's Signature	Date

Doctor Signature: ____________________________

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ASSIGNMENT, LIEN, AND AUTHORIZATION
FOR DIRECT PAYMENTS BY MY PAYERS TO POWER WITHIN CHIROPRACTIC OF ELK RIVER

Purpose. The purpose of this Assignment & Lien is to assist the Office in collecting from various Payers who may be responsible for paying on 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 Power Within Chiropractic of Elk River located at 804 Freeport Ave NW Suite A, Elk River, Minnesota 55330; "Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, 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; "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/or "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 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 services (including without limit treatment, agnostic services, medical equipment, supplies, supplements, narrative reports, photocopies, 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 rights, remedies, and benefits relating to any Payer, including without limit a primary, non-contingent right to receive Proceeds from any Payer now or in the future, and any and all causes of action that I might have against any Payer now or in the future, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I agree that this assignment shall be effective as of the date and time my condition first arose. I further intend for this Assignment & Lien to create a secured interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to the Office a primary, non-contingent secured interest in all Proceeds to the extent permitted by law for the purpose of securing payment of my Charges, which secured interest shall attach and also be automatically perfected effective as of the date and time that my condition first arose. I further authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency relating to such secured 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 secured 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 to assist me in collecting any Proceeds, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, 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 any Proceeds received by the attorney 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 reduce its Charges or balance by a proportionate or weighted share of my attorney's fees, costs, and other expenses of pursuing collection of my claims, including the Office's Charges.

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 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.

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 for the protection of the rights and interests of the Office and myself. 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's Name - Printed	Patient's Signature	Date
______________________________	______________________________	____________________
Guardian's Name On Patient's Behalf - Printed	Patient's Signature	Date

Doctor Signature: ______________________________

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