

PATIENT INTAKE FORM

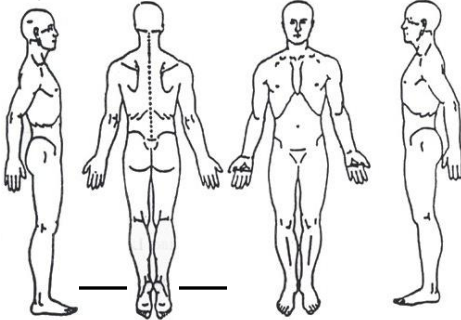
Patient Name: _____

Date: _____

1. Is today's problem caused by:

- Auto Accident Workman's Compensation Other

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Frequently (51-75%)
 Occasionally (26-50%) Intermittently (1-25%)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric-like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

OFFICE USE ONLY (This half of page):

Custom Exam Sequence
(Medical Provider) Dr. M / R

- | | |
|----|----|
| 1) | 4) |
| 2) | 5) |
| 3) | 6) |

Posture:

FHP? _____"
Shoulder R High / Low L High / Low
Pelvis R High / Low L High / Low
Pelvic Tilt ant / post
Feet Pron R / L / Bilat
Sup. R / L / Bilat

Vitals: B.P. ____/____ R / L Pulse ____
Ht. ____ft. ____in. Wgt. ____lbs

Dermatomes:

_____ levels / WNL
(Hyper ↑ / Hypo ↓)

Reflexes:

_____ C-5 Biceps L-5 Pat. _____
_____ C-6 B.R. S-1 Ach. _____
_____ C-7 Triceps

(All WNL or #)

Grip: R ____ lbs. Dominant hand: R / L
L ____ lbs.

Adsons:

+ R / L / Bilat.
WNL or Incidental _____

Max. Cerv. Comp.:

+ R / L / Bilat. Convex R / L
Concave R / L
WNL or Incidental _____

Jackson's:

+ R / L / Bilat.
Dermatome (C5-T1) _____
WNL or Incidental _____

Shoulder Depression:

+ R / L / Bilat.
Dermatome (C5-T1) _____
WNL or Incidental _____

Cervical Distraction:

+ = Decrease in px
Local / Radicular / Both
WNL or Incidental _____

Valsalva:

+ R / L / Bilat.
Dermatome (C5-T1) _____
WNL or Incidental _____

Georges Test: B.P. Both sides

R ____/____ L ____/____
WNL or Incidental _____

ABSAROKA

PAIN and REHAB

14. What alleviates your problem? (for example: ice, heat, rest, stretching, massage, pain killers, etc.)

15. What concerns you the most about your problem; what does it prevent you from doing?

16. What is your:
Height _____ Weight _____ lbs Age _____

Occupation _____

17. How would you rate your overall Health?
 Excellent Very Good Good Fair Poor

18. What type of exercise do you do?
 Strenuous Moderate Light None

19. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past/ Present	Past /Present
<input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> Neck Pain	<input type="checkbox"/> <input type="checkbox"/> Heart Attack
<input type="checkbox"/> <input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> <input type="checkbox"/> Chest Pains
<input type="checkbox"/> <input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Low Back Pain	<input type="checkbox"/> <input type="checkbox"/> Angina
<input type="checkbox"/> <input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> <input type="checkbox"/> Kidney Stones
<input type="checkbox"/> <input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/> <input type="checkbox"/> Kidney Disorders
<input type="checkbox"/> <input type="checkbox"/> Wrist Pain	<input type="checkbox"/> <input type="checkbox"/> Bladder Infection
<input type="checkbox"/> <input type="checkbox"/> Hand Pain	<input type="checkbox"/> <input type="checkbox"/> Painful Urination
<input type="checkbox"/> <input type="checkbox"/> Hip Pain	<input type="checkbox"/> <input type="checkbox"/> Loss of Bladder Control
<input type="checkbox"/> <input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/> <input type="checkbox"/> Prostate Problems
<input type="checkbox"/> <input type="checkbox"/> Knee Pain	<input type="checkbox"/> <input type="checkbox"/> Abnormal Weight Gain/Loss
<input type="checkbox"/> <input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/> <input type="checkbox"/> Loss of Appetite
<input type="checkbox"/> <input type="checkbox"/> Jaw Pain	<input type="checkbox"/> <input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> <input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/> <input type="checkbox"/> Ulcer
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Hepatitis
<input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> <input type="checkbox"/> Liver/Gall Bladder Disorder
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> General Fatigue
<input type="checkbox"/> <input type="checkbox"/> Tumor	<input type="checkbox"/> <input type="checkbox"/> Muscular Incoordination
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Visual Disturbances
<input type="checkbox"/> <input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> <input type="checkbox"/> Dizziness
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> <input type="checkbox"/> Smoking/Tobacco Use	<input type="checkbox"/> <input type="checkbox"/> Drug/Alcohol Depend.
<input type="checkbox"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> Depression
<input type="checkbox"/> <input type="checkbox"/> Systemic Lupus	<input type="checkbox"/> <input type="checkbox"/> Epilepsy
<input type="checkbox"/> <input type="checkbox"/> Dermatitis/Eczema/Rash	<input type="checkbox"/> <input type="checkbox"/> HIV/AIDS

For Females Only:

- Past/ Present**
 Birth Control Pills
 Hormonal Replacement
 Pregnancy

Cervical ROM: D.N.P. d/+ Px
 F _____ (50°) Px _____; Ext _____ (60°) Px _____
 LLF _____ (45°) Px _____; RLF _____ (45°) Px _____
 LR _____ (80°) Px _____; RR _____ (80°) Px _____

Lumbar ROM: D.N.P. d/+ Px
 F _____ (60°) Px _____; Ext _____ (25°) Px _____
 LLF _____ (25°) Px _____; RLF _____ (25°) Px _____

Chiropractic Analysis:
 Point Tend. 0 1 2 3 4 5 6 7; 1 2 3 4 5 6 7 8 9 10 11 12;
 1 2 3 4 5; SI
 Vert. Spasm 0 1 2 3 4 5 6 7; 1 2 3 4 5 6 7 8 9 10 11 12;
 1 2 3 4 5; SI
 Fixations 0 1 2 3 4 5 6 7; 1 2 3 4 5 6 7 8 9 10 11 12;
 1 2 3 4 5; SI

Minors Sign:
 + R / L
 WNL or Incidental _____

Bechterews:
 LB px / SI px / Both
 R / L / Bilat
 WNL or Incidental _____

Kemp's Test:
 + Radicular: R / L / Bilat
 + Local: R / L / Bilat
 ON Hyperext / NO Hyperext
 WNL or Incidental _____

Straight Leg Raise:
 R _____ Px _____ degree _____
 L _____ Px _____ degree _____
 WNL or Incidental _____

Bragard's Sign: SLR w/dorsiflexion foot
 + R / L / Bilat
 WNL or Incidental _____

Goldthwaits: SLR w/ palp L5/S1
 R / L / Bilat
 Px before / after separation
 WNL or Incidental _____

Thomas Test:
 + R / L / Bilat
 WNL or Incidental _____

Patrick Fabere Test (frog leg):
 + R / L / Bilat
 WNL or Incidental _____

Ely's Test: Prone Heel to Butt
 Thigh Px: R / L / Bilat
 No Ext Px: R / L / Bilat
 WNL or Incidental _____

Soto Hall:
 Px at C1-T3? _____
 WNL or Incidental _____

Smoking Addressed: Y / N **Time Spent:** _____ min.

21. List all prescription medications you are currently taking:

22. List all of the over-the-counter medications you are currently taking:

23. List all surgical procedures you have had:

24. What activities do you do at work?

- Sit:** Most of the day Half the day A little of the day
 Stand: Most of the day Half the day A little of the day
 Computer work: Most of the day Half the day A little of the day
 On the phone: Most of the day Half of the day A little of the day

25. What activities do you do outside of work?

26. Have you ever been hospitalized? No Yes

If yes, why?

27. Have you had significant past trauma? No Yes

28. Anything else pertinent to your visit today?

Patient Signature _____

Date: _____

Additional Tests/Comments:

PATIENT REGISTRATION FORM

ABSAROKA PAIN & REHAB
1001 W Oak Street, Bldg C Ste 210
Bozeman, MT 59715
406-587-8446 phone 406-587-0898 fax

PATIENT INFORMATION

Patient (Legal) Name: _____

(Preferred Name): _____ Previous/Maiden Name(s): _____

Social Security #: _____ Birth Date: _____ Male: Female:

Mailing Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Patients Employer: _____ Work Phone #: _____

Primary Care Provider (or N/A if none): _____

Height: _____ Weight: _____

Spouse Name: _____ Spouse Social Security #: _____

Spouse Birth Date: _____ Spouse Employer: _____ Spouse Work phone #: _____

COMPLETE THIS SECTION IF PATIENT IS UNDER THE AGE OF 18 OR A STUDENT

Parent's Name: _____
Mother's Social Security #: _____ Father's Social Security #: _____
Address: _____
Mother's DOB: _____ Employer: _____ Work Phone #: _____
Father's DOB: _____ Employer: _____ Work Phone #: _____

NEAREST RELATIVE/FRIEND NOT LIVING WITH PATIENT

Name: _____ Relationship: _____

Address: _____ Phone #: _____

ABOUT YOUR INSURANCE – We will need a copy of all insurance cards

Primary Insurance: _____ Secondary Insurance (if applicable): _____

If Medicaid, Passport provider: _____

WORKERS COMPENSATION INJURY? Yes No Date of Injury: _____

AUTO ACCIDENT? Yes No Date of Loss: _____

IF YOU ANSWERED "YES" TO EITHER WORK COMP OR AUTO ACCIDENT PLEASE SEE THE NEXT PAGE OF THIS FORM FOR OTHER REQUIRED INFORMATION NEEDED TO PROCESS YOUR CLAIM

IMPORTANT INFORMATION (PLEASE READ)

*I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated providers.
I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered and agree that all proceeds of insurance are assigned to this office where applicable.
I understand that I am financially responsible for all charges whether or not paid by my insurance.
I understand that should I default on payment of my account and collection agency services are required, all costs of collections, up to 45% of the balance, including attorney/court costs will be added to the balance of my account.*

PATIENT OR GUARDIAN SIGNATURE: _____ DATE: _____
PATIENT OR GUARDIAN SIGNATURE: _____ DATE: _____



A B S A R O K A
PAIN *and* REHAB

Payment Policy

As a courtesy to our patients, we offer the following billing choices. Please initial the payment plan that applies to you then sign at the bottom of the page.

Although we at Absaroka Pain and Rehab (APR) will contact your insurance company to verify your benefits, we recommend that you also call in order to fully understand your plan option. If you are aware of any limitation on your insurance benefits, please notify us immediately to allow us to try to maximize your coverage.

_____ **Self Pay**

I will pay for all services as they are rendered on the date of my visit unless arrangements are made for a payment plan. I understand that I may contact APR for required documentation if I choose to submit my own insurance claims.

_____ **Insurance Submittal**

I would like to assign my insurance benefits to APR and have you submit my insurance claims for me. If applicable, I understand that I am responsible for obtaining any necessary pre-authorization from my primary care physician. I understand that I am responsible for any balance as billed to me by APR that results from co-payments, deductibles, or non-covered services. I will also sign over to APR within 5 business days any insurance checks mailed to me for services received at APR.

_____ **Auto Accident/Personal Injury Claim**

I was involved in an accident and would like to assign benefits to APR and have you submit all charges to my insurance for me. I will sign all liens necessary to protect your office. I also understand that, regardless of settlement I am personally responsible for the entire balance. If APR is not paid within 30 days of the case settlement, I will personally pay the entire overdue balance.

_____ **Worker's Compensation Claim**

I was involved in an injury at work. I will ensure that my employer files the appropriate paperwork as needed for APR to receive compensation. I understand that it is in my rights as a Montana resident to have any bills paid that are incurred as a result of a work related injury. If after 90 days of my visit to APR my claim is not paid, I understand that I am responsible for the overdue balance.

Name (please print): _____

Signature: _____ Date: _____

Absaroka Pain and Rehab

Consent to Examination and Treatment

I hereby consent to the performance of examination and treatment performed by the licensed doctors of chiropractic, medical doctors and/or licensed physical therapist who may be employed by or engaged in practice in this clinic. I have had an opportunity to discuss with the doctor or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic treatment nor medical treatment is an exact science and that my care may involve judgments based on facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctors to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which included rarely, but not limited to fractures, disc injuries, strokes and sprains/strains and am therefore willing to accept and consent to the risk associated with the care I am about to receive.

I have read the above information regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Name (printed): _____

Signature: _____ Date: _____

Consent to participate in Active Rehabilitation

The goals of the rehabilitation program include:

Determining the cause and extent of your problem.

Providing a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility and decrease your pain.

Return you to full duty, non-restricted work status and lifestyle.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company or attorney if it is applicable.

If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your providers. The team approach has the best chance of attaining your goals, so please ask as many questions as necessary for you to gain the maximum benefit from your rehabilitation program.

Since the process of strengthening and conditioning are a form of “controlled strain”, there is a chance of aggravation or injury. It is therefore imperative that you communicate to your provider any aggravation or injury that you may observe during the rehabilitation process. For example, the best exercise for you, if performed too early in your condition, may be your worst enemy if performed too soon. Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

I have read the above and understand the risks and benefits of the rehabilitation program. I agree to participate and have my rehabilitation information released to my doctor, insurance carrier and/or attorney if applicable.

Name (printed): _____

Signature: _____ Date: _____

WORKER'S COMPENSATION

This information must be completed in order for us to bill for services. If it is not complete, the patient will be responsible for full payment at the time they are treated.

EMPLOYER AT TIME OF INFURY: _____ Phone #: _____

ADDRESS: _____
STREET ADDRESS CITY STATE ZIP

SUPERVISOR: _____ PART OF BODY INJURED: _____ L R

In detail, explain how accident/injury occurred?

DATE OF INJURY: _____ LAST WORKED DATE: _____

WORK COMP INSURANCE CARRIER: _____

WORK COMP CARRIER ADDRESS: _____
STREET ADDRESS CITY STATE ZIP

Does your work comp carrier require you to make co-payments to the Doctor? yes No

CLAIMS EXAMINER: _____ PHONE #: _____

CLAIM #: _____

HAVE YOU RETAINED AN ATTORNEY? _____ ARE YOU CURRENTLY IN LITIGATION FOR THIS INJURY? _____

ATTORNEYS NAME _____ OFFICE PHONE # _____

AUTO ACCIDENT

This information must be completed in order for us to bill for services. If it is not complete, the patient will be responsible for full payment at the time they are treated.

POLICY HOLDER: _____

CLAIM #: _____ ACCIDENT DATE _____

INSURANCE CARRIER: _____

MAILING ADDRESS: _____
STREET ADDRESS CITY STATE ZIP

ADJUSTOR: _____ PHONE # _____

HAVE YOU RETAINED AN ATTORNEY? _____ ARE YOU CURRENTLY IN LITIGATION FOR THIS INJURY? _____

ATTORNEY'S NAME _____ OFFICE PHONE # _____

OTHER INJURY

PLEASE EXPLAIN:



Media Release Form

Absaroka Pain and Rehab
1001 W. Oak St. Bldg. C Ste. 210
Bozeman, MT 59715

Permission to Use Media

I grant to Absaroka Pain and Rehab, its representatives and employees the right to take photographs &/or videos of me and my property in connection with the above-identified subject. I authorize Absaroka Pain and Rehab, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that Absaroka Pain and Rehab may use such photographs &/or videos of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and social media (Facebook) and/or Web content.

I have read and understand the above:

Signature _____

Printed name _____

Date _____

Signature, parent or guardian _____ (if under age 18)

WORKER'S COMPENSATION QUESTIONNAIRE

Please answer all questions completed and return to office.

Employee's name & address: _____

Phone number: _____

Occupation: _____

Age: _____ Sex: M F

Employer's name & address: _____

Phone number: _____

Type of business (retail, manufacturing, construction, etc.) _____

Workers Compensation Insurance Carrier: _____

On what date did your injury occur? _____ What time? _____ AM PM

What address were you at when you were injured? _____

Did you notify your employer of this injury? Yes No

Have you retained an attorney? Yes No

If Yes, please give name & address: _____

Are you currently in litigation for this injury? Yes No Maybe

Please explain how the injury or illness occurred: _____

What injuries did you suffer? _____

When was the last day you worked? _____

When did you return to work? _____

When was your first examination? _____

Who examined you? _____

Check one, if known: D.C. M.D. D.O. D.D.S.

What was doctor's diagnosis? _____

(Please complete opposite side.)

Have you received any treatments prior to visiting this office? Yes No

What treatments did you receive? _____

Have you ever injured this area before? Yes No

If Yes, when did the injury occur? _____

Did you lose time from work? Yes No

If you lost time from work with injuries prior to this injury, please list doctor or doctors consulted: _____

Do you have other injuries or illnesses that affect your employment? Yes No

If Yes. please explain: _____

In your work, do you favor one part of your body more than others? Yes No

If Yes. please explain: _____

Do you have a history of absenteeism caused from accidents on the job? Yes No

Have you ever had a Worker's Compensation claim before? Yes No

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? the same?

MOTOR VEHICLE COLLISION/PERSONAL INJURY QUESTIONNAIRE

Please answer all questions completely:

1. Your name and address:

2. Phone Number: _____

3. Please describe the collision in your own words:

4. Where did the collision occur? City/Town: _____ State: _____

5. Date of collision: _____ Time: _____ AM PM

6. Were you the: driver passenger pedestrian

7. If passenger, were you in the front seat right rear seat left rear seat

8. What type of vehicle were you in? _____

9. What type was the other vehicle? _____

10. Did your vehicle strike the other vehicle? yes no

11. Was your car struck by the other vehicle? yes no

12. What direction was your vehicle going? _____

13. What direction was the other vehicle going? _____

14. Was the impact from: the front the rear the left side the right side

15. What was the approximate speed at the time of the impact?

Your vehicle _____ mph Other vehicle _____ mph

16. What was the weather at the time of the collision? dry wet icy

17. Was your vehicle in: park neutral in gear moving stopped

18. Were your brakes being applied? yes no

19. Was your vehicle shoved: forward backward sideways

20. Were you shoved: forward whipped backward

21. Did your seat have a head restraint (headrest?) yes no

22. If yes, what was the position low midposition high
23. Did your head ride over the headrest? yes no
24. Did your hat/glasses end up in the back seat or rear window? yes no
25. Did any other part of your body hit the interior of the vehicle? yes no
26. If yes, please specify: seatbelt restraints steering wheel dashboard
 windshield side door side window other _____
27. Which part of your body? chest head chin face R L knee
 R L shoulder R L hand other _____
28. Were you holding on to the steering wheel? yes no
29. Did you brace your arms against the dash? yes no
30. Did you brace your legs against the floorboard? yes no
31. Was your ankle turned? yes no
32. Did the vehicle go into a spin or roll as a result of the impact? yes no
33. If yes, explain: _____
34. How much damage was there to the outside of the vehicle? none some a lot
35. How much damage was there to the inside of the vehicle? none some a lot
36. At the point of impact, where did you experience pain? Be specific:

37. Immediately after the accident were you: conscious dazed unconscious
38. If you lost consciousness, how long? _____
39. Were you wearing a seat belt? yes no
40. Did the belt have a shoulder harness? yes no
41. If yes, did it contribute to the pain you are experiencing? yes no
42. At the time of impact were you: looking straight ahead looking to the right
 looking to the left looking down looking up
43. Did the seat break as a result of the impact? yes no
44. Were you braced for the impact? yes no
45. Were you surprised by the impact? yes no
46. Did you go to the hospital? yes no
47. If yes, when? right after the accident next day other _____

48. If yes, how did you get there? ambulance other: _____

49. If by ambulance, did the ambulance attendants place you in a: neck brace

back brace other _____

50. Any medication or medical supplies given? _____

51. Did you have x-rays taken at the hospital? yes no

If you went to the hospital, please answer the following:

Name of hospital _____

Name of doctor _____

Diagnosis _____

Treatment Received _____

52. Have you had any similar problems before? yes no

53. If yes, explain: _____

54. Are you diabetic? yes no

55. Do you have high blood pressure? yes no

56. Do you have low blood pressure? yes no

57. Do you have arthritis or degenerative joint disease? yes no

58. What type of work do you do? _____

59. What are your job requirements? _____

60. Have you lost any days of work from this injury? yes no

61. If yes, give dates: _____

Patient Signature _____ Date _____

Witness _____ Date _____

Print Name _____

PERSONAL INJURY INSURANCE COVERAGE

Date _____ Spoke With _____ Number _____

Patient Name _____

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Date of Accident _____

Claim Number _____

Policy Number _____

Has the accident been reported? yes no

Name of adjuster handling claim _____

Will company accept assignment of benefits? yes no

If not, will they make checks payable to patient and our office? yes no

Limits: How much? \$ _____ What's left? _____

GROUP HEALTH INSURANCE

Medical benefits under auto insurance? yes no

Insurance Company _____

Address _____

Phone Number _____

Insured Name _____

Agent _____ Policy# _____ Phone _____

Name and address of other party or parties involved in collision:

ATTORNEY INFORMATION

Date _____ Spoke With _____ Number _____

Patient Name _____

Attorney Name _____

Address _____

Phone Number _____

Does attorney need copies of bills? yes no

In the event of settlement, will they protect any unpaid balance? yes no

Do they have PIP? yes no Do we file? yes no

Do they have insurance? yes no Do we file? yes no

Can we file liability? yes no

PATIENT RECORDS AND DOCTOR'S LIEN

TO: ATTORNEY/INSURANCE CARRIER

I do hereby authorize the above provider to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my injury/illness which occurred/began on:

I hereby give a lien to said provider on any settlement, judgment, or verdict as a result of said injury/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said provider such sums as may be due and owing him/her for services rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said provider adequately.

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

I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment of my account. Also, that in the event of noncompliance to payment agreement I understand the amount of balance due will be subject to a 1% per month service charge.

Patient's Signature: _____ Dated: _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the above named provider.

Attorney's Signature: _____ Dated: _____

Please sign, retain a copy for your records, and return this copy to us promptly.