PATIENT INFORMATION

Patient Name: _____

Address: _____ Doctor: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Social Security#: _____

Sex: _____ Marital Status: _____ DOB: _____

Referring Physician/ UPIN #: _____

Employment Status: Retired ❑ Not Employed ❑ Full Time ❑ Part Time ❑

Employer Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Student Status: Full Time ❑ Part Time ❑ Non Student ❑

INSURANCE INFORMATION

Primary Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ DOB: _____ Sex: _____ Marital Status: _____

Relationship to Patient: _____ Policy or Group #: _____

Identification #: _____ Policy Type: Employer ❑ Group ❑ Non-Group ❑

Employer Name: _____ Employer Address: _____

Employer City: _____ State: _____ Zip: _____

Work Phone #: _____

Secondary Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ DOB: _____ Sex: _____ Marital Status: _____

Relationship to Patient _____ Policy or Group #: _____

Identification #: _____

Policy Type: Emp ❑ Group ❑ Non-Group ❑ Medigap ❑ Medicaid ❑ Supplement ❑ MedicareSec ❑

Employer Name: _____

Employer Address: _____

Employer City: _____ State: _____ Zip: _____

Work Phone #: _____

Please include any additional insurance information on the back of this sheet.

I authorize release of any information necessary to process my insurance claims. I assign and request payment directly to my physician(s).

Signature: _____ Date: _____

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.

Name _____ Birthday _____ Sex ☐ M ☐ F

Address _____ City _____ Zip _____

Soc. Sec. # _____ Home Phone _____ Work _____ Cell _____ E-Mail _____

Marital Status: ☐ M ☐ S ☐ D ☐ W Children, Ages _____ Spouse's Name _____

Occupation _____ Employer _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major complaint? _____

_____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine Other _____

Other doctors or therapist who have treated THIS condition _____

What do you think caused this condition? _____

List surgical operations and years: _____

_____

_____

Do you have a family physician? Name _____

Medications, dosage and frequency: _____

_____

_____

Have you been in an auto accident or had any other personal injury? ☐ Y ☐ N Describe _____

_____

Signature _____ Date _____

Parent/Guardian _____ Date _____

REVIEW OF SYSTEMS Check only the ones you now have or have had in the past.

GENERAL	NOW	PAST
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fainting	☐	☐
SKIN		
Color Changes	☐	☐
Nail Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐
Weakness	☐	☐
HEAD		
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Last Eye Exam		
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐
EARS		
Hard of Hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Room Spins	☐	☐
NOSE		
Decreased Smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post Nasal Drip	☐	☐
Deviated Septum	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐
MOUTH		
Bleeding Gums	☐	☐
Sores	☐	☐
Dental Problems	☐	☐
Bad Breath	☐	☐
Loss of Taste	☐	☐
Dry Mouth	☐	☐
Ulcers	☐	☐
Blisters	☐	☐

THROAT	NOW	PAST
Soreness	☐	☐
Bad Tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble Swallowing	☐	☐
Recurrent Infections	☐	☐
NECK		
Neck Enlargement	☐	☐
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐
BREASTS		
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple Changes	☐	☐
Skin Changes	☐	☐
Bloated	☐	☐
LUNGS		
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Short of Breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐
Inhalant Exposure	☐	☐
HEART		
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen Extremities	☐	☐
Cold Extremities	☐	☐
Chest Pain/Pressure	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Blue Extremities	☐	☐
BLOOD		
Anemia	☐	☐
Low Blood Iron	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Swollen Nodes	☐	☐
Painful Nodes	☐	☐
Sugar in Blood	☐	☐
Red Spots	☐	☐

GASTROINTESTINAL	NOW	PAST
Abdominal Pain	☐	☐
Nausea	☐	☐
Bloated	☐	☐
Belching	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irregular Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Food Intolerance	☐	☐
Bloody Stools	☐	☐
Black Stools	☐	☐
GENITOURINARY		
Urgency	☐	☐
Incontinence	☐	☐
Straining	☐	☐
Back Pain	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed Wetting	☐	☐
Small Stream	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐
Urine Color _____		
Spotting Between Periods	☐	☐
Menstrual Cramps	☐	☐
Discharge	☐	☐
Itching	☐	☐
Painful Intercourse	☐	☐
Irregular Periods	☐	☐
Hot Flashes	☐	☐

Contraception Type _____
Age at First Period _____
Duration of Cycle _____
Duration of Flow _____
No. of Pregnancies _____
No. of Births _____
No. of Miscarriages _____
No. of Abortions _____
Menstrual Flow ☐ Heavy ☐ Mod ☐ Light
Last Period _____
Last Pap Smear _____
Last Vaginal Exam _____
Last Mammogram _____
Last Prostate Exam _____

NAME _____

NEUROLOGIC	NOW	PAST
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Hand Trembling	☐	☐
Loss of Sensation	☐	☐
Incoordination	☐	☐
Loss of Facial	☐	☐
Weak Grip	☐	☐
Paralysis	☐	☐
Difficulty Speech	☐	☐
Tingling	☐	☐
Loss of Memory	☐	☐
Numbness	☐	☐

ENDOCRINE		
Weight Loss	☐	☐
Weight Gain	☐	☐
Extremely Thin	☐	☐
Heat Intolerance	☐	☐
Cold Intolerance	☐	☐
Hair Changes	☐	☐
Breast Changes	☐	☐

IMMUNIZATION/VACCINATION	
DPT	☐
Mumps	☐
Smallpox	☐
Typhoid	☐
Tetanus	☐
Measles	☐
Pneumococcal	☐
Influenza	☐
Polio	☐
MMR	☐

BLOOD TYPE

A +	☐	A -	☐
B +	☐	B -	☐
AB +	☐	AB -	☐
O +	☐	O -	☐

Other _____

BLOOD TRANSFUSIONS

Date_____

Date_____

Date_____

Date_____

PSYCHIATRIC	NOW	PAST
Hyperventilation	☐	☐
Insecurity	☐	☐
Depression	☐	☐
Troubled Sleep	☐	☐
Irritable	☐	☐
Undecidedness	☐	☐
Timid	☐	☐
Hallucinations	☐	☐
Loss of Memory	☐	☐
Alcoholism	☐	☐
Drug Addiction	☐	☐
Drug Dependent	☐	☐
Suicidal Thoughts	☐	☐
Extreme Worry	☐	☐
Sexual Problems	☐	☐

MUSCULOSKELETAL	NOW	PAST
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Twitching	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐

PAST MEDICAL HISTORY. Check only the ones you have had in the past.

Hay Fever	☐	Epilepsy	☐
Mumps	☐	Paralysis	☐
Rheumatic Fever	☐	Polio	☐
Allergies	☐	Mental Illness	☐
Angina	☐	Alcoholism	☐
Cancer	☐	Depression	☐
Tumor	☐	Nervous Breakdown	☐
Blood Disease	☐	Migraine	☐
Leukemia	☐	Gout	☐
Heart Trouble	☐	Hemorrhoids	☐
Varicose Veins	☐	Prostate Problems	☐
Phlebitis	☐	Sexual Problems	☐
Hypertension	☐	Gonorrhea	☐
Stroke	☐	Syphilis	☐
Ulcers	☐	Diabetes	☐
Jaundice	☐	Bladder Trouble	☐
Skin Trouble	☐	Kidney Stones	☐
Gallstones	☐	Kidney Infections	☐
Liver Trouble	☐	Diabetes	☐
Hepatitis	☐	Bladder Trouble	☐
Parasites	☐	Dysentery	☐

Date of Last Chest X-Ray _____ ☐ Normal ☐ Abnormal

Last TB Skin Test _____ ☐ Normal ☐ Abnormal

Allergies: _____

_____

_____

_____

_____

Patient Name_____ Number _____ Date _____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Physical Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Exercise ☐ Heavy ☐ Moderate ☐ Light Hours per week _____ Type _____

Smoking ☐ Current ☐ Previous Packs/Day _____ No. of years _____

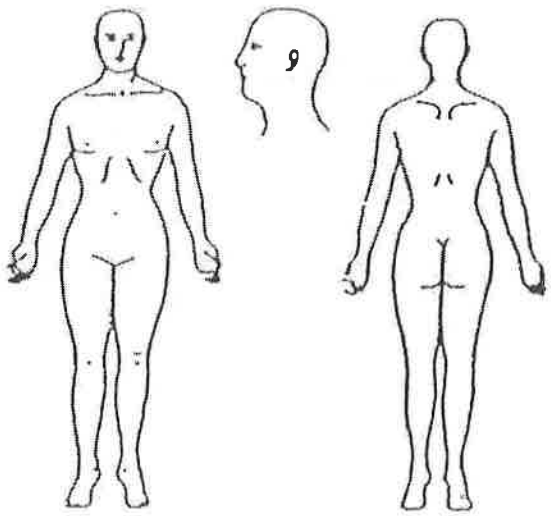
Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

Caffeine *(Coffee, Tea, Cola)* Cups/Day _____ No. of Years _____

Aspirin No./Day _____ No. of Years _____ Others _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:

Aches ^^^^ Numbness oooo Pins/Needles ···· Stabbing ////



MARK AN "X" ON THE LINES:

How bad are your symptoms now?

None Most Severe

How bad have they been in the past?

None Most Severe

Patient Name _____ Number _____ Date _____

FINANCIAL POLICY AND AGREEMENT

Valley Spine & Injury Center

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Definitions. In this Agreement, "Office" and "Clinic" shall refer to Jordan Chiropractic Center located at 411 D. Street South Charleston WV, 25303. "Financial Policy" or "Agreement" shall refer.to this document.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase, "(by [Name of Office])," shall serve as a properly authorized endorsement. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office promptly upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. I agree that any delay by the Office in making demand for payment, any delay in paying the full amount of my Charges, and any partial payments received by the Office towards my Charges, shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full promptly upon demand, and shall not constitute an "accord and satisfaction" of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments. I also agree that my account with your Office shall be construed as in "default" on the earlier of the following dates: (a) a Payer fails to pay any or all of the Charges in-full and directly to the Office upon receipt of those Charges within thirty (30) days or the period established by the earliest prompt pay deadline applicable to the Payer (whichever occurs later), (b) I do not pay any or all of the Charges in-full within fourteen (14) days of request, or (c) the Office attempts to charge my credit card in compliance with a written Payment Arrangement, but the charge is declined or not approved.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). For example (without limiting this Agreement), I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I further understand that a Payer may Deny Payment stating that the individual provider who actually renders the treatment or procedure is out-of-network. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I also understand that a Payer may require certain Charges to be pre-certified or pre-authorized. In the event that my condition arose from an accident, I further agree to the terms of the Office's Auto / Work Comp Advance Beneficiary Notices as applicable. I understand that there may be many other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I agree that if I have any questions about the Terms of Non-Coverage, I can request copies of the Office's verification (e.g., eligibility, pre-authorization) forms to gain further understanding. I agree that should the Office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or the Office may in my opinion not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office responsible or liable in any of the foregoing instances.

Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any and all Payers, including without limit in accident cases my health benefit plan, but not including Medicare. Notwithstanding the foregoing, in the event that the Office determines in its sole discretion that it has any reasonable basis for either submitting or not submitting my Charges and/or other documentation to a Payer, I hereby authorize the Office to take such action without condition or restriction. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said Payers in writing, or (b) law expressly imposes on the Office to accept (collectively, "Mandatory Fee Reductions"). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are imposed on the Office by virtue of laws which regulate or restrict "balance billing," I hereby waive the application of such laws to the extent permitted by law. In the event that no Mandatory Fee Reductions are actually imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement 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 Agreement. I agree that each and every provision of this Agreement is reasonably necessary. However, should any provision of this Agreement 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 Agreement shall, nevertheless, remain in full force and effect. This Agreement 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 Agreement, 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 Agreement. I have reviewed the Office's "Assignment & Lien", Health Insurance Election, and, if applicable, Auto / Work Comp Advance Beneficiary Notices, and further agree to the terms and definitions set forth in these documents as applicable. Said documents are incorporated herein by reference. In the event that my condition is related to an accident, including without limit automobile accident, I understand that there will be an administrative fee necessary to cover the costs of verifying multiple Payers, filing and terminating liens, and submitting notices of same to Payers.

I have read, understood, and agree to the terms of this Agreement.

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

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

Parent/Guardian Signature: _____ Date: ___/___/___

Valley Spine & Injury Center
411 D. Street
South Charleston, WV 25303

Health Insurance Election

(Accident and Non-Accident Cases)

How would you like for us to handle your health insurance? Please choose one:

☐ **Option 1 -- I Do Not Have Health Insurance / I Don't Want You to File My Health Insurance**

I want the services we discuss, but either I don't have health insurance or I don't want you to bill or submit paperwork to my health insurance. You may keep any health insurance which I may have and that I provide to you on file, but only for the purposes set forth in, and as consistent with, your Financial Policy. You may ask to be paid now or later as I am responsible for payment. I understand that if my claims or forms are not submitted to my health insurance in a timely manner, my payer may decline to pay on my claims and I may not be able to appeal this decision.

☐ **Option 2 -- I Want You to File My Health Insurance and Also to Help Me Verify My Benefits. To Help You Get Paid, I'll Make Partial Payments and/or Sign an Assignment & Financial Policy**

I want the services we discuss, but I also want you to bill my health insurance for an official decision on payment even if this is an accident case. Please help me verify any Terms of Non-Coverage. If I have any questions, I will verify my coverage on my own. You may ask to be paid now or later for estimated co-pays, co-insurance, deductibles and other Non-Covered amounts. I understand that these are just estimates. If my condition is due to an accident case, I would ask that you delay from collecting such amounts as described in your Financial Policy. With this in mind, I agree to the terms of the Financial Policy. In the event that my health insurance delays or Denies Payment, I will be responsible for payment as described in the Financial Policy, but I understand that I will be able to appeal to my health insurance following its directions.

☐ **Option 3 -- I Want You to File My Health Insurance, But I'll Pay in-Full at the Time of Service or Pre-Pay. If Insurance Pays, You'll Give Me a Refund**

I want the services we discuss, but I also want you to bill my health insurance for an official decision on payment. However, you may ask to be paid now. If my health insurance does pay, you will refund any payments I made to you, less co-pays, co-insurance, and deductibles, and also discounts (Mandatory Fee Reductions) as described in your Financial Policy. In the event that my health insurance Denies Payment, I can appeal to my health insurance following its directions.

Important: I understand that in certain circumstances, the Office may have a policy of not filing health insurance or law may actually control or regulate the filing of insurance. This election will remain in effect until a new election is signed with the Office's consent. This election supersedes any prior health insurance election.

Patient Signature: _____ Date: ___/___/___

ASSIGNMENT, UCC LIEN, AND AUTHORIZATION

FOR DIRECT PAYMENTS BY MY PAYERS TO Valley Spine & Injury Center

PURPOSE AND CONSIDERATION; TERMS WHICH PAYERS MAY BE REQUIRING. The purpose of this Assignment & UCC Lien is to assist the Office in obtaining Proceeds from various Payers (including without limit my Attorney) for the payment of my Charges. In consideration for receiving / continuing health care at the Office based on terms which Payers may be requiring, as well as on terms set forth in various documents of the Office, I agree to the following and direct all Payers as follows:

DEFINITIONS. In this Assignment & UCC Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to Jordan Chiropractic Center located at 411 D Street South Charleston, WV 25303 "Assignment & UCC Lien Document," "Assignment & UCC Lien," "Assignment & Lien," and other like phrases 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 expense or payments benefits ("Medpay"), personal injury protection ("PIP"), 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 & UCC Lien, any Additional Costs incurred by the Office as defined herein, 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; "Additional Costs" shall include without limit any costs incurred by the Office relating directly or indirectly to (i) the goods or services associated with my Charges, (ii) this Assignment & UCC Lien, (iii) the application or enforcement of any law relating to the issue of the Office's Charges, secured interests or its goods and services, (iv) any effort or action to collect my Charges either from me or from any Payer, or (v) any legal or medico-legal action, process, or claim of any nature against, or by, the Office or its employees for any reason relating to the foregoing items, (i)-(iv), of the previous clause ("Medico-Legal Process"). "Additional Costs shall further include without limit an hourly fee of $_____ for our Office's administrative staff time, as well as an hourly fee of $_____ for any lost-time at work by any treating or diagnosing health care provider employed by or contracted with our Office, relating to any of the foregoing items. "Medico-Legal Process" shall include without limit civil and administrative proceedings, mediation, arbitration, interpleader actions, cross-claims or counterclaims, requests for reconsideration, independent reviews, and internal appeals. Costs associated with such Medico-Legal Processes shall also include without limit any pre- and post-judgment costs, filing fees, service of process charges, and attorney's fees to an. In determining the Office's Charges, I hereby waive any defense or argument that such costs shall not apply or be awarded based on the claim that the Office's goods or services were somehow (i) not sufficiently necessary or effective, related accident, documented or otherwise warranted, or (ii) inappropriately directed, delivered, conducted or administered.

ASSIGNMENT AND UCC LIEN TERMS. (i) Assignment 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. (ii) UCC Lien Terms: I further intend for this Assignment & UCC 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 ("UCC Lien"), 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. (iii) Other Assignment and UCC Lien Terms: Consistent with the foregoing 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 & UCC 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 relating to my Claims to Proceeds, I hereby direct (and the Office hereby requests) each attorney to review the terms of this Assignment & UCC Lien, including without limit the fact that I may become responsible for various costs arising hereunder. Accordingly, I respectfully request that each attorney not unilaterally assume to arbitrate potential disputes relating to this Assignment & UCC Lien. 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 such Proceeds shall be primarily to pay my Charges. If I have a dispute with the Office, attorney, or any other party for any reason, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the Office for any portion of the Charges. 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 TO ALL PAYERS. 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 & UCC Lien, unless otherwise agreed to in writing.

MISCELLANEOUS. Except as provided in this paragraph, this Assignment & UCC 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 & UCC Lien. I agree that each and every provision of this Assignment & UCC Lien is reasonably necessary. However, should any provision of this Assignment & UCC 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 & UCC Lien shall, nevertheless, remain in full force and effect. I agree to indemnify and hold the Office harmless for Charges, including without limit any Additional Costs as defined herein. In the event that I file for bankruptcy, I waive any objection to the Office proceeding after any Payer for receiving reimbursement of the Office's Charges. This Assignment & UCC 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 & UCC 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 & UCC Lien.

I have read, understood, and agree to the terms of this Assignment & UCC 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: ___/___/_____

Valley Spine & Injury Center

CONSENT FOR TREATMENT

Doctor Name: _____

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. On me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including strokes.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a 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 treatments. I state that I have been informed and weighed the risks involved in chiropractic treatments at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

X _____ Date: _____
Print Patient's Name

X _____ _____
Sign Patients Name Other than patient, print name and relationship

X _____
Office Witness

Valley Spine & Injury Center

RELEASE OF INFORMATION

Doctor Name: _____

By signing this form, I am granting consent to Valley Spine & Injury Center as well as other health care facilities where I have been treated to use and disclose my protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Information Privacy Practices provides more detailed information about how we may use and disclose this protected health information and you have a legal right to review the notice before you sign this consent, and we encourage you to read it in full. You have the right to revoke this consent, except to the extent we already have used or disclose your protected health information in reliance on your consent.
By signing this form, I am attesting that I agree to this release of information and have read, understand, and agree to the Notice of Information Privacy Practices.

X _____ Date: _____
Print Patient's Name

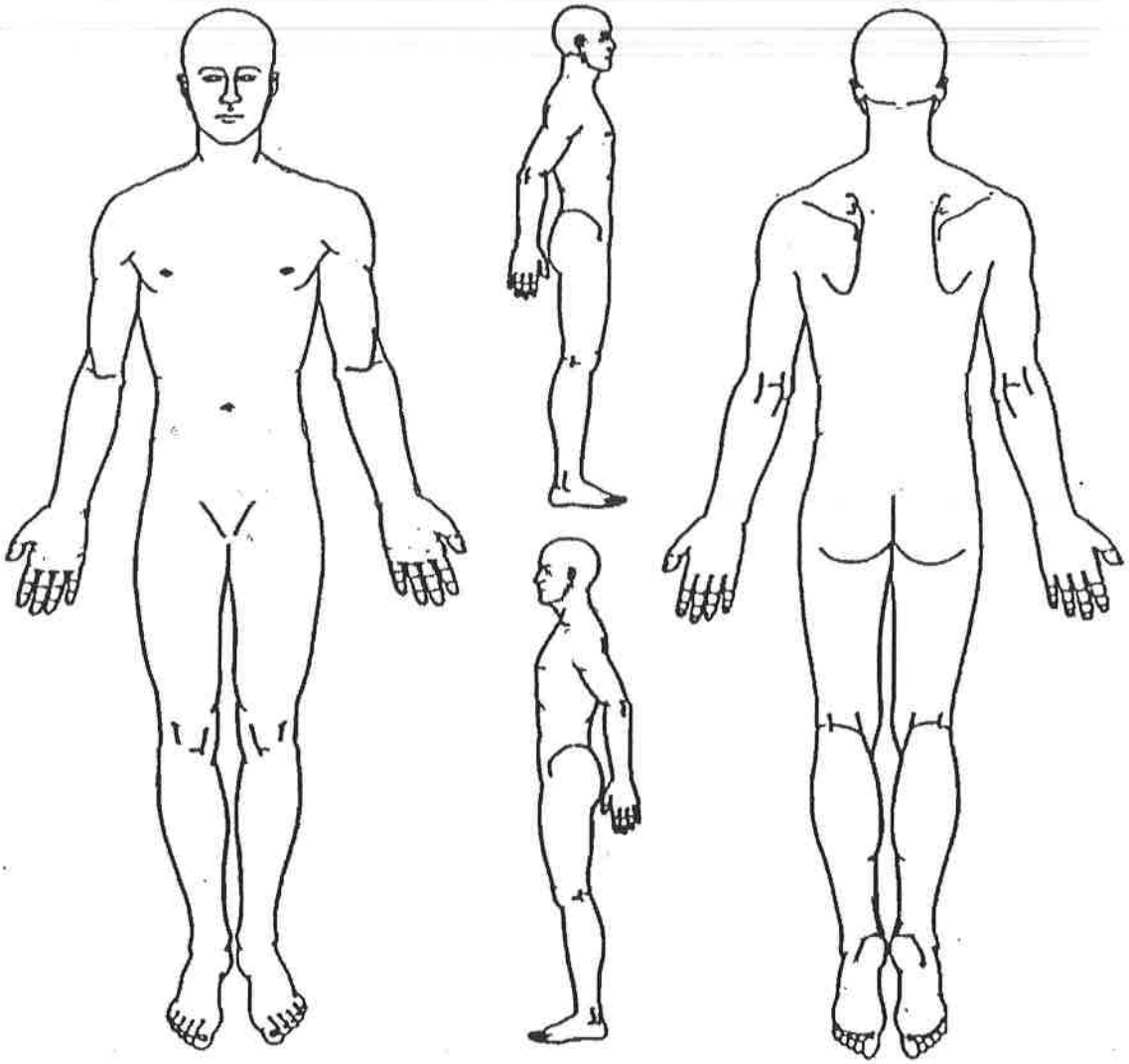
X _____ _____
Sign Patients Name Other than patient, print name and relationship

X _____
Office Witness

Where is your pain? How does it feel? Draw your pain using the following key.

KEY

/ / / Stabbing	X X X Burning	000 Pins and Needles	▲▲▲ Aching, Throbbing	= = = Numbness	• • • Other



Signature _____ Date _____

Valley Spine
&
Injury Center

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by Indicating the overs//Impact of pain In your life, not Just when the pain Is at Its worst

For each of the six categories of dally living listed. PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities In which you would normally be Involved have been totally disrupted or prevented by your pain.

1. ***Family/Home Responsibilities.*** This category refers to activities related to the home or family. It Includes chores and duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g., driving the children to school).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

2. ***Recreation.*** This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

3. ***Social Activity.*** This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out. and other social functions.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

4. ***Occupation.*** This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a homemaker or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

5. ***Self Care.*** This category includes activities, which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed, etc.).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

6. ***Life-Support Activity***. This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

TOTAL SCORE: _____ SIGNATURE: _____ DATE: _____

For re-ordering information, contact:
Activator Methods International. Ltd. 3714 E. Indian School Road Phoenix, AZ 85018
Phone: (800) 598-0224 · (602) 224-0230 · Fax: (602) 224-0230 E-mail: sales@activator.com

REVISED MARCH 15.1993

Valley Spine
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NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire Is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE, WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. Tho pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care

A. I can look after myself normally without causing extra pain.
B. I can look after myself normally, but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need come help, but manage most of my personal care.
E. I need help every day In most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay In bed.

SECTION 3 - Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor, but I can manage If they are conveniently positioned, e.g., on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights If they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 - Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want to with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot reaad as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5 - Headaches

A. I have no headaches at all.
B. I have slight headaches, which come infrequently.
C. I have moderate headaches, which come infrequently.
D. I have moderate headaches, which come frequently.
E. I have severe headaches, which come frequently.
F. I have headaches almost all the time.

SECTION 6 - Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty In concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7 - Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8 - Driving

A. I can drive my car without any neck pain.
B. I can drive my car as long as I want slight pain in my neck.
C. I can drive my'car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9 - Sleeping

A. I have no trouble sleeping.
B. My sleep if slightly disturbed (less than 1 hour sleepless).
C. My sleep mildly disturbed (1-2 hours sleepless).
D. My sleep Is moderately disturbed (2-9 hours sleepless).
E. My sleep Is greatly disturbed (3-5 houts sleepless).
F. My sleep Is completely disturbed (6-7 hours sleepless).

SECTION 10 - Recreation

A. I am able to engage In all of my recreational activities, with no neck pain at all.
B. I am able to engage In all of my recreational activities, with some pain In my neck.
C. I am able to engage in most, but not all of my usual recreational activities because of pain In my neck.
D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all.

After Vernon & Mior. 1991
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REVISED 1/1/95

Comments: _____

Patient's Signature: _____ Date: _____

Valley Spine
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REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire Is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE, WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain Is mild and does not vary much.
C. The pain comes and goes and Is moderate.
D. The pain Is moderate and does not vary much.
E. The pain comes and goes and Is severe.
F. The pain is severe and does not vary much.

SECTION 2 - Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though It causes some pain.
C. Washing and dressing Increases the pain, but I manage not to change my way of doing It
D. Washing and dressing increases the pain and I find It necessary to change my way of doing It
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 - Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but K causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage If they are conveniently positioned, e.g.,on a table.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 - Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than1/2 mile.
D. Pain prevents me from walking more than 1/4i mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet

SECTION 5 - Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than 1/2 how.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 - Standing

A. I can stand as long as I want without pain.
B. I have some pain while standing, but K does not Increase with time
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than % hour without Increasing pain.
E. I cannot stand for longer than ten minutes without increasing pain.
F. avoid standing, because It increases the pain straight away.

SECTION 7 - Sleeping

A. I get no pain In bed.
B. I get pain In bed, but It does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8 - Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but Increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic Interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

SECTION 9 - Traveling

A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I got extra pain while traveling, which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989

REVISED 9/11/92

Comments: _____

Patient's Signature: _____ Date: _____