NORTH SUBURBAN HEALTHCARE, P.A.
8770 Springbrook Dr NW Suite 100
Coon Rapids, MN 55433
Ted Harrison DC, FACO, CCST

MVC Patient Intake

Name_____ Date_____
First MI Last

Home Address _____
Street City State Zip

Phone _____ _____ _____
Cell Home Work

☐**Check here to receive text appointment reminders**. Text reminders are sent at approximately 5:00 pm the day before your appointment. **Appointment reminders are subject to your carrier's normal text messaging rates.** Reminders available for: AT&T, Boost Mobile, Cricket, MetroPCS, Nextel, Sprint, T-Mobile, US Cellular, Verizon, and Virgin Mobile.

☐ **Check here to receive e-mail appointment reminders.** E-mail reminders are sent approximately 2 hours before your scheduled appointment. Text and/or e-mail reminders may not be activated immediately.

E-Mail_____

Gender ☐M ☐F Date of Birth_____

Marital Status ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

If Married, Spouse's Name_____

Children ☐Y ☐N If yes, age of children_____

In the event of an emergency, please contact:

Name	Relationship	Phone Number

Employment Information

Employer_____

Employer's Address _____
Street City State Zip

Nature of Work_____

Authorizations

Persons you authorize the release of your health information to: Initial here if none _____

Name _____ Relationship _____ Initials _____

Name _____ Relationship _____ Initials _____

Authorization for the release of health information can be cancelled at any time by submitting cancellation in writing.

I understand that I am responsible for all charges incurred at North Suburban Healthcare, P.A., including any collection cost or attorney fees required to collect outstanding balances. Accounts greater than 60 days past due will be charged interest at a rate of 1% per month.

Signature_____ Date_____

Relationship to patient, if not self:_____ Reason unable to Sign_____

Patient Health Questionnaire I

Name_____ Date_____

Describe your symptoms_____

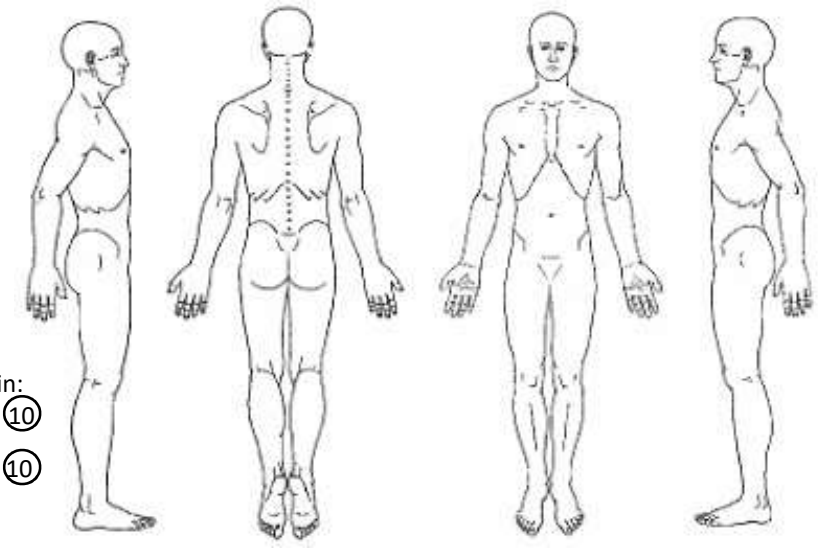
_____

When did the symptoms begin? (mm/dd/yy if possible) _____

How did the symptoms begin? _____

_____

Please indicate on the diagram where you are experiencing symptoms; Mark as:
S=Sharp D=Dull A=Aching N=Numbness T=Throbbing W=Weak O=Other



Description:
☐Sharp
☐Dull
☐Ache
☐Numb
☐Throbbing
☐Weak
☐Other: _____

Frequency:
☐Constant (76-100%)
☐Frequent (51-75%)
☐Occasional (26-50%)
☐ Intermittent (25% or less)

Average Pain intensity 0=No Pain and 10=Unbearable Pain:
Last 24 Hours: (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Past Week: (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Are your symptoms affecting your ability to be active?
☐No effect
☐Some physical restrictions (light duty tasks only)
☐Need limited assistance with everyday tasks
☐Need assistance often
☐Significant inability to function without assistance
☐Am totally disabled/impaired

Your Symptoms Are: ☐Decreasing ☐Not Changing ☐Getting Worse
Symptoms Are Worse: ☐Morning ☐Afternoon ☐Night ☐Increases During Day ☐Same All Day
What makes symptoms better? ☐Nothing ☐Lying Down ☐Walking ☐Standing ☐Sitting ☐Movement/Exercise ☐Inactivity
What makes symptoms worse? ☐Nothing ☐Lying Down ☐Walking ☐Standing ☐Sitting ☐Movement/Exercise ☐Inactivity

Have you been treated for *this* episode? ☐Y ☐N If so, by whom? ☐Chiropractor ☐MD ☐Physical Therapist
☐Other_____ When?_____
What treatment did you receive?_____

Have you been treated for something similar in the past? ☐Y ☐N If so, by whom? ☐Chiropractor ☐MD ☐Physical Therapist
☐Other_____ When?_____
What treatment did you receive?_____

What is your current work status, if employed? ☐FT ☐PT ☐Other _____
Physical activity at work: ☐Sitting more than 50% of the time ☐Light manual labor ☐Heavy manual labor ☐Repeated motion
Has your work status changed because of current symptoms? ☐Y ☐N If so, how? _____

Signature_____ Date_____

Relationship to patient, if not self:_____ Reason unable to Sign_____

Patient Health Questionnaire II

Name_____ Date_____

If you have ever had a listed condition in the past, please check it in the Past column. If you are presently troubled by a condition, check it in the Present column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

Past	Present	
☐	☐	Neck Pain
☐	☐	Shoulder Pain
☐	☐	Upper Arm or Elbow Pain
☐	☐	Hand Pain
☐	☐	Wrist Pain
☐	☐	Upper Back Pain
☐	☐	Lower Back Pain
☐	☐	Upper Leg or Hip Pain
☐	☐	Lower Leg or Knee Pain
☐	☐	Ankle or Foot Pain
☐	☐	Jaw Pain
☐	☐	Swelling/Stiffness of Joint(s)
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscular Incoordination
☐	☐	Tinnitus (Noises in Ear)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Abnormal Weight ☐Gain ☐ Loss
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/Irregular bowel habits
☐	☐	Difficulty Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Depression
☐	☐	Alcohol/Drug Dependence
☐	☐	Caffeine
How Much/Often? _____		
☐	☐	Tobacco
How Much/Often? _____		
☐	☐	Alcohol
How Much/Often? _____		

Past	Present	
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Prostate Problems
☐	☐	Blood Disorder
☐	☐	Emphysema
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Ulcer
☐	☐	Liver/Gallbladder problems
☐	☐	Kidney Stones
☐	☐	Hepatitis
☐	☐	Bladder Infection
☐	☐	Kidney Disorders
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS
☐	☐	Systemic Lupus
☐	☐	Other_____

For Females: Date of last menstrual period _____

☐	☐	Pregnancies How Many? _____ Currently? ☐ Yes ☐ No ☐ Unsure
☐	☐	Birth Control Pills/IUD/Implant/Other_____
☐	☐	Hormonal/Estrogen Replacement
☐	☐	PMS
☐	☐	Profuse Menstrual Flow
☐	☐	Irregular Menstrual Flow
☐	☐	Endometriosis
☐	☐	Breast Soreness/Lumps

Please indicate if a family member has had any of the following conditions:

- ☐ Cancer
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ High Blood Pressure
- ☐ Epilepsy
- ☐ Chronic Back Problems
- ☐ Chronic Headaches
- ☐ Lupus
- ☐ Other _____

Current:

Height _____ (ft/in)

Weight _____ (lbs.)

Please list any hospitalizations or surgical procedures:_____

_____

Please list any medications and/or supplements you are currently taking: _____

_____

Is there anything else you wish your doctor to know? _____

_____

Signature_____ Date_____

Relationship to patient, if not self:_____ Reason unable to Sign_____

Doctor's Comments_____

_____

_____

_____

Motor Vehicle Collision Questionnaire

Name_____ Date_____

Did the collision occur while on the job? ☐Yes ☐No

You were: ☐Driver ☐Front seat passenger ☐Rear seat passenger
☐Motorcycle Operator ☐Motorcycle passenger
☐Other_____

Vehicle Year/Make/Model: _____

Other vehicle: ☐Sedan ☐Compact Car ☐SUV ☐Truck ☐Other_____

Estimated speed at impact:_____

Were you: ☐Stopped ☐Slowing ☐Accelerating
Road Conditions: ☐Dry ☐Damp ☐Wet ☐Snow ☐Ice

Date of Accident: _____

Time of Day: _____ Was it: ☐Light ☐Dark ☐Dawn ☐Dusk

Lap Belt: ☐Yes ☐No Shoulder Belt: ☐Yes ☐No

Did airbags deploy? ☐Yes ☐No If yes, which airbag(s)?_____
Were you struck by the deployed airbag? ☐Yes ☐No

Was the seat back position altered by the collision? ☐Yes ☐No Was seat broken? ☐Yes ☐No

Body position: ☐Straight ☐Leaning: ☐Forward ☐To the left ☐To the right Head position: ☐Good ☐Forward ☐Left ☐Right
Hands: ☐One hand on wheel ☐Two hands on wheel ☐N/A ☐Up ☐Down

Were you aware the collision was about to occur? ☐Yes ☐No

Did your body or head strike any parts of the vehicle? ☐No ☐Yes:_____

Did you lose consciousness? ☐Yes ☐No ☐Unsure If yes, how long?_____

Were you wearing glasses/hat at the time of the collision? ☐Hat ☐Glasses *Type*: ☐Prescription ☐Sun ☐Prescription/Sun ☐Other

Crash Diagram:

Estimated damage done to vehicle: ☐None
☐Minimal ☐Moderate ☐Major

Estimate (if known) $_____

Were police on scene? ☐Yes ☐No
Was a police report made? ☐Yes ☐No

After the crash

How quickly were symptoms felt?_____

☐ Neck Pain ☐Back pain ☐Headache ☐Dizziness ☐Nausea ☐Confusion/disorientation ☐Arms/Shoulders Pain ☐Legs/Hips Pain

Where did you go following the collision? ☐Home ☐Work ☐Urgent Care ☐Hospital ☐Other:_____

Mode of transportation from the scene:_____

Was your vehicle towed from the scene of the collision? ☐Yes ☐No

Have you ever had a similar injury before? ☐Yes ☐No If so, when? ____

Have you consulted with any other doctors/health care professionals for these injuries? ☐Yes ☐No

Emergency Department/Urgent Care? ☐Yes ☐No Where? ____

X-rays or other imaging? ☐Yes ☐No Body Part: ____

Medications/Follow Up Instructions ____

Other Doctors:

Healthcare Provider/Facility: ____

Specialty____ First Date Seen for this injury: ______________________________

How often are/were you being treated? ____

Describe Treatments: ____

____

Has treatment helped? ☐Yes ☐No Are you still being treated by this provider? ☐Yes ☐No

Healthcare Provider/Facility: ____

Specialty____ First Date Seen for this injury: ______________________________

How often are/were you being treated? ____

Describe Treatments: ____

____

Has treatment helped? ☐Yes ☐No Are you still being treated by this provider? ☐Yes ☐No

Healthcare Provider/Facility: ____

Specialty____ First Date Seen for this injury: ______________________________

How often are/were you being treated? ____

Describe Treatments: ____

____

Has treatment helped? ☐Yes ☐No Are you still being treated by this provider? ☐Yes ☐No

Have you been deemed temporarily or permanently disabled? ☐Yes ☐No If yes, describe disability: _________________________

____

Please share any other details you would like your doctor to be aware of:____

____

____

Signature____ Date__________________________

Relationship to patient, if not self:________________________________ Reason unable to Sign________________________________

Accident and Injury Questionnaire

Name_____ Date_____

Please check any of the problems below which you are currently experiencing

Cognitive (Thinking) Problems

- ☐ Attention or concentration (mind wanders, easily distracted, difficulty maintaining focus)
- ☐ Short-term memory loss, forgetfulness, problems learning new things
- ☐ Problems finding words when talking or problems articulating thoughts
- ☐ Trouble understanding what is said, problems following or tracking conversation
- ☐ Difficulties making decisions and/or solving problems
- ☐ Trouble staying organized or planning
- ☐ Making more mistakes than usual or not catching one's mistakes
- ☐ Slowed thinking, feeling dazed or "fuzzy", being easily confused
- ☐ Getting lost, misplacing personal items (keys, cell phone, etc.)
- ☐ Problems alternating attention or "juggling" things
- ☐ Becoming easily overwhelmed

Physical Symptoms

- ☐ Headache
- ☐ Dizziness
- ☐ Fatigue
- ☐ Problems with coordination, dropping things, bumping into things, losing balance
- ☐ Stuttering or slurring words
- ☐ Change in sensitivity of hearing, smell, and/or taste
- ☐ Tingling/numbness in hands, arms, legs, toes, etc.
- ☐ Ringing in ears
- ☐ Increased sensitivity to light or sound
- ☐ Blurred or double vision
- ☐ "Black-outs" or seizures

Emotional Symptoms

- ☐ Feelings of sadness or depression
- ☐ Crying spells or weepiness
- ☐ Suicidal thoughts or ideas
- ☐ Mood swings
- ☐ Difficulties sleeping
- ☐ Irritability, "little things" getting under one's skin
- ☐ Easily frustrated
- ☐ Decreased sex drive
- ☐ Decreased or increased appetite
- ☐ Loss of interest in being around people and socializing
- ☐ Loss of interest in hobbies and activities

Signature_____ Date_____

Relationship to patient, if not self:_____ Reason unable to Sign_____

NORTH SUBURBAN HEALTHCARE, P.A.
8770 Springbrook Dr NW Suite 100
Coon Rapids, MN 55433
Ted Harrison DC, FACO, CCST

Patient Protected Health Information Consent

We want you to know how your Protected Health Information (PHI) is going to be used in this office, along with your rights concerning those records. Before we will begin any health care operations, we require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient (and/or their legal guardian) understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health, Auto, or Worker's Compensation Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum necessary for what the insurance companies require for payment.
2. The patient has a right to examine and obtain a patient copy of his or her own health records at any time and to request corrections. The patient may request to know what disclosures have been made and to submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained ONE TIME for all subsequent care given to the patient at this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for care given prior to the written request for revocation, but would apply to any care given after the written request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, we have the right to refuse to provide care.

I, the undersigned, have read and understand these consents and I agree to these policies and procedures.

Printed Name_____

Signature_____ Date_____

Relationship to patient, if not self:_____ Reason unable to Sign_____

NORTH SUBURBAN HEALTHCARE, P.A.
8770 Springbrook Dr NW Suite 100
Coon Rapids, MN 55433
Ted Harrison DC, FACO, CCST

Informed Consent

Patient Name: _____ Date:_____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

Please initial each section as you understand it.

_____ The nature of the chiropractic adjustment

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctors in this clinic will use that procedure to treat you. They may use their hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you may have experienced when you "crack" your knuckles. You may feel a sense of movement.

_____ Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

Spinal manipulative therapy, Palpation, Vital signs, Range of motion testing, Orthopedic testing, Basic neurological testing, Muscle strength testing, Postural analysis testing, Radiographic studies, Therapeutic exercises, Manual muscle stimulation, Inter-segmental traction therapy, Ultrasound, Hot/cold therapies, EMS, and other procedures as your doctor may deem necessary in their best professional judgement.

You have the right to refuse any of these procedures at time of treatment.

You may request another staff member to be present at any time during your appointment.

_____ The risks inherent in chiropractic adjustment & the probability of those risks occurring

As with any healthcare procedure, there are certain complications that may arise during chiropractic manipulation and therapy. The complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, and burns. 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. Some patients will feel some stiffness and soreness following the first few days of treatment. The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the doctor's attention it is your responsibility to inform the doctor.

Fractures are rare occurrences and generally result from an underlying weakness of the bone which we check for during the taking of your history and through the examination. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on this topic is inconclusive as to a specific incident of this complication occurring. If there is a casual relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of an arterial stroke.

_____ **The availability & nature of other treatment options, and the risks & dangers of remaining untreated**

Other treatment options for your condition may include self-administered, over the counter analgesics and rest; medical care and prescription drugs such as muscle relaxants; hospitalization; surgery. If you choose one of the "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

By signing below, you state that you understand the above explanation of the chiropractic adjustment and related treatment. You have weighed the risks involved in undergoing treatment and have decided that it is in your best interest to undergo the treatment recommended.

Signature_____ Date_____

Relationship to patient, if not self:_____ Reason unable to Sign_____

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Patient Rights and Responsibilities

Each patient at North Suburban Healthcare has the right to:

- Considerate, respectful, and impartial care in a safe setting.
- Reasonable access to care with effective communication, including the ability to have support persons present and the ability to receive assistance with physical limitations.
- Make informed decisions in advance of and during care, be involved in care planning & treatment, and to be informed of both expected and possible unanticipated outcomes of care.
- Be able to refuse care and receive information regarding the possible consequences of refusal.
- Expect all communications and records to be private and confidential, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law.
- Access to information contained in his/her personal clinical records within a reasonable timeframe upon written request and authorization.
- Be informed of charges for services and payment methods available.
- Freely voice complaints without being subject to discrimination, coercion, or reprisal, and to receive a prompt review of and resolution to a complaint.
- Receive a copy of these Patient Rights & Responsibilities. These shall also be posted in patient areas that are easily accessible for review by the public.

Each patient and/or guardian at North Suburban Healthcare is responsible for:

- Providing, to the best of his/her knowledge, accurate and complete information about matters relating to the patient's health
- Following the treatment plan as discussed and agreed with the health care provider
- The patient's actions and outcomes if he/she refuses treatment or fails to follow the care plan
- Being considerate and respectful of staff and other patient's persons, property, and this facility
- Providing all needed information for insurance processing and for ensuring that the financial obligations of his/her care is fulfilled
- Asking questions when he/she does not understand the information given
- Reporting episodes of pain and the effectiveness or lack of response to treatment
- Reporting perceived risks and/or unexpected change in condition during the course of care
- Following all facility rules and regulations.

Following these guidelines helps us ensure you receive the best care available.
All staff is educated annually regarding Patient's Rights & Responsibilities, and copies of this information is available to all staff.

Thank you for your cooperation.

By signing below, I hereby acknowledge that I have read and understand these Rights and Responsibilities.

Signature_____ Date_____

Relationship to patient, if not self:_____ Reason unable to Sign_____

NORTH SUBURBAN HEALTHCARE, P.A.
8770 Springbrook Dr NW Suite 100
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Insurance Authorization and Release of Records

I. I authorize payments of benefits and the release of any necessary medical information to process my claims with North Suburban Healthcare, P.A. I also request payment of government benefits to myself or to North Suburban Healthcare, P.A. located at 8770 Springbrook Drive Northwest, Suite 100, Coon Rapids, MN 55433.

II. I understand that an insurance policy is an agreement between my insurance carrier and myself, and that I am responsible for any and all charges incurred at North Suburban Healthcare, P.A., including deductible, coinsurance, and co-payment fees, and any collection costs and/or attorney's fees required to collect outstanding balances. Accounts greater than 60 days past due will be charged at an interest rate of 1% per month.

Subscriber on Policy _____
(The subscriber of the policy is the main policyholder)

Subscriber's Date of Birth _____

Subscriber's Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Other: _____

Print Patient's Name_____

Signature_____ Date_____

Relationship to patient, if not self:_____ Reason unable to Sign_____

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*If this information is not immediately available, please be aware that it must be provided as soon as possible so that we may bill your insurance. You will be billed directly until we receive this information.

Motor Vehicle Collision Claims*:

Insurance Company: _____ Claim Number: _____

Adjuster: _____ Adjuster's Phone Number: _____

Worker's Compensation Claims*:

Insurance Company: _____ Claim Number: _____

Adjuster: _____ Adjuster's Phone Number: _____

Legal Representation, if any:

Lawyer/Office: _____ Phone: _____

ASSIGNMENT, LIEN, AND AUTHORIZATION
FOR DIRECT PAYMENTS BY MY PAYERS TO NORTH SUBURBAN HEALTHCARE. P.A.

PURPOSE. The purpose of the 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 North Suburban Healthcare, P.A. located at 8770 Springbrook Drive NW, Coon Rapids, MN 55433; "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, judgement, 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 and 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, diagnostic 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 judgement 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 an effort or action to collect my Charges either from me or from any Payer whether based on the Assignment & Lien or other legal basis.

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 cases 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 and 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, purpose to limit, reduce, or modify the distribution of Proceeds in any matter 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.

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 an 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, audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or about 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 the 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 the Assignment & Lien be found 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.

Print Patient Name_____

Signature_____Date_____

Relationship to patient, if not self:_____ Reason unable to Sign_____