



healthcarecomplete

- Individualized Family Chiropractic Care
- Customized Nutritional Counseling
- Pediatric & Perinatal Certified
- Rehabilitative Exercise

NUTRITION NEW PATIENT INFORMATION FORM

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ ZIP _____

Shipping Address (if different) _____

Home Phone (____) ____ - _____ Work Phone (____) ____ - _____

E-mail address: _____

Name of Individual with whom you authorize us to share your health information/appointment scheduling/financial information: _____

REFERRED BY: _____

Occupation _____ Employer _____

Date of Birth _____ Age ____ Sex: M/F Height ____ Weight ____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

Previous treatments for this complaint _____

Other complaints or problems: (use back if needed) _____

Current medications/drugs being taken: (use separate sheet if needed) _____

Are you currently under the care of a physician or other health care professionals?

(If yes, please give name and date of last visit): _____

Nutritional supplements you are taking: _____

How much of the following do you consume per day?

Cigarettes (packs) _____ Coffee (cups) _____ Alcohol (glasses) _____ Water (glasses) _____

1. Dietary Intake for 2 days before appointment:

Breakfast: _____ **Breakfast:** _____

Lunch: _____ **Lunch:** _____

Dinner: _____ **Dinner:** _____

Snacks: _____ **Snacks:** _____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery Broken Bones

Other (please list details) _____

Major Accidents Or Falls: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit: _____

Date of Last: Spinal X-ray _____ MRI _____ (region: _____) Physical Exam: _____

Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES or SYMPTOMS YOU HAVE HAD:

- | | | |
|--|---|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer (type: _____) | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema |

Have you been tested HIV Positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness
- Gas/Bloating After Meals
- Heartburn/Reflux
- Black/Bloody Stool
- Irritable Bowel/Colitis/Chron's

NERVOUS SYSTEM

- Weakness in arms/legs/body
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Cold or discolored extremities
- Fainting
- Convulsions or Seizures
- Tingling Extremities

GENERAL

- Fatigue

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine
- Kidney Stones

C-V-R

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems or congenital defect
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches or Infection
- Hearing Difficulty
- Stuffed Nose or Sinus Infection
- Ringing in the ears

FEMALES ONLY

When was your last period? _____

Are you Pregnant?

Yes No

MENTAL/EMOTIONAL

- Anxiety
- Psychotic episodes
- Attempted suicide in lifetime
- Anger/aggression
- Attention Deficit
- Depression

MALE/FEMALE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems

- Loss of Sleep
- Fever
- Headaches
- Allergies: List: _____

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

FAMILY HISTORY

List family members with the following illnesses:

- Heart Disease _____
- Cancer _____
- Diabetes _____
- Stroke _____
- Neurological Disorder _____
- Other _____

EXERCISE

- None
- Mild 1-2x/wk
- Moderate 3x/wk
- Daily
- Heavy (daily and intense)

HABITS

- High Stress Level
Reason _____
- Things you do to handle stress

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other _____

Any household pets or other animals you or family members are in close contact with:

What can we do to make you happier? _____

For Electronic Health Records:

- I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of care)

During the initial visit, the doctor will be evaluating your body for signs of nutritional deficiencies using the Nutrition Response Testing (NRT) technique. The doctor's analysis and recommended treatment is not intended to diagnose or treat any disease or dysfunction. During the second office visit, the doctor's findings and recommendations will be reported to you. Dietary and supplement recommendations are intended to support your body's normal physiology and biochemistry. Recommended nutritional supplementation is customized for your individual needs and should not be self-prescribed. Supplements in this office consist of high quality whole food concentrates, herbs and homeopathic remedies and require the doctor's expertise to determine their necessity. I understand the purpose of the initial visit and authorize the doctor to perform an examination and consultation utilizing the NRT technique.

SIGNED: _____ DATE _____

CREDIT CARD PREAUTHORIZATION

Healthcare Complete
260 Merrimac Street-The Towle Building
Newburyport, MA 01950
978-499-WELL (9355)

To better serve our patients, and to give the best care to everyone, we are requiring a credit/debit card to be kept confidentially in each individual's file. Please complete the information below:

Patient Name: _____

I authorize Healthcare Complete to charge my credit card account for patient care under the following circumstances (check off each one that you authorize):

Please charge my credit card weekly in pre-payment of my appointments

Please charge my credit card after each visit

My bill is over 90 days past due, and an attempt to reach me by phone or mail has been made, without response.

My insurance didn't cover a service I received, and an attempt to reach me by phone or mail has been made, without response.

Patient Signature _____ Date _____

NAME: _____ AGE: _____ HEALTH CARE PROFESSIONAL: _____ DATE: _____

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, don't circle anything** for that symptom.

Circle the corresponding number.	
1	MILD symptom (occurs rarely)
2	MODERATE symptom (occurs several times a month)
3	SEVERE symptom (occurs almost constantly)

GROUP 1

1.	1 2 3	Acid foods upset
2.	1 2 3	Get chilled often
3.	1 2 3	"Lump" in throat
4.	1 2 3	Dry mouth, eyes, nose
5.	1 2 3	Pulse speeds after meal
6.	1 2 3	Keyed up, fail to calm
7.	1 2 3	Gag occasionally
8.	1 2 3	Unable to relax, startle easily
9.	1 2 3	Extremities cold, clammy
10.	1 2 3	Strong light irritates
11.	1 2 3	Occasionally weak urine flow
12.	1 2 3	Heart pounds after retiring
13.	1 2 3	"Nervous" stomach
14.	1 2 3	Appetite reduced occasionally
15.	1 2 3	Cold sweats often
16.	1 2 3	Get heated easily
17.	1 2 3	Nerve discomfort
18.	1 2 3	Staring, blink little
19.	1 2 3	Sour stomach frequent
_____ TOTAL 1 2 3		

GROUP 2

20.	1 2 3	Joint stiffness after arising
21.	1 2 3	Muscle, leg, toe cramps at night
22.	1 2 3	"Butterfly" stomach, cramps
23.	1 2 3	Eyes or nose watery
24.	1 2 3	Eyes blink often
25.	1 2 3	Eyelids swollen, puffy
26.	1 2 3	Indigestion soon after meals
27.	1 2 3	Always seem hungry, feel "lightheaded" often
28.	1 2 3	Digestion rapid
29.	1 2 3	Vomit occasionally
30.	1 2 3	Hoarseness frequent
31.	1 2 3	Uneven breathing
32.	1 2 3	Pulse slow
33.	1 2 3	Gagging reflex slow
34.	1 2 3	Difficulty swallowing
35.	1 2 3	Temporary constipation or diarrhea
36.	1 2 3	"Slow starter"
37.	1 2 3	Get "chilled"
38.	1 2 3	Perspire easily
39.	1 2 3	Sensitive to cold
40.	1 2 3	Upper respiratory challenges
_____ TOTAL 1 2 3		

GROUP 3

41.	1 2 3	Eat when nervous
42.	1 2 3	Excessive appetite
43.	1 2 3	Hungry between meals
44.	1 2 3	Irritable before meals

45.	1 2 3	Get "shaky" if hungry
46.	1 2 3	Fatigue, eating relieves
47.	1 2 3	"Lightheaded" if meals delayed
48.	1 2 3	Heart palpitates if meals missed or delayed
49.	1 2 3	Fatigue in afternoon
50.	1 2 3	Overeating sweets upsets
51.	1 2 3	Awaken after few hours sleep, hard to get back to sleep
52.	1 2 3	Crave candy or coffee in afternoon
53.	1 2 3	Moods of "blues" or melancholy
54.	1 2 3	Craving for sweets or snacks
_____ TOTAL 1 2 3		

GROUP 4

55.	1 2 3	Hands and feet go to sleep easily, numbness
56.	1 2 3	Sigh frequently, "air hunger"
57.	1 2 3	Aware of "breathing heavily"
58.	1 2 3	High-altitude discomfort
59.	1 2 3	Open windows in closed room
60.	1 2 3	Immune system challenges
61.	1 2 3	Afternoon "yawner"
62.	1 2 3	Get "drowsy" often
63.	1 2 3	Swollen ankles worse at night
64.	1 2 3	Muscle cramps, worse during exercise; get "charley horse"
65.	1 2 3	Difficulty catching breath, especially during exercise
66.	1 2 3	Tightness or pressure in chest, worse on exertion
67.	1 2 3	Skin discolors easily after impact
68.	1 2 3	Tendency to anemia
69.	1 2 3	Noises in head or "ringing in ears"
70.	1 2 3	Fatigue upon exertion
_____ TOTAL 1 2 3		

GROUP 5

71.	1 2 3	Dizziness
72.	1 2 3	Dry skin
73.	1 2 3	Burning feet
74.	1 2 3	Blurred vision
75.	1 2 3	Itching skin and feet
76.	1 2 3	Hair loss
77.	1 2 3	Occasional skin rashes
78.	1 2 3	Bitter, metallic taste in mouth in morning
79.	1 2 3	Occasional constipation
80.	1 2 3	Worrier, feels insecure
81.	1 2 3	Nausea occasionally after eating
82.	1 2 3	Greasy foods upset
83.	1 2 3	Stools light-colored
84.	1 2 3	Skin peels on foot soles

85.	1 2 3	Discomfort between shoulder blades
86.	1 2 3	Occasional laxative use
87.	1 2 3	Stools alternate from soft to watery
88.	1 2 3	Sneezing attacks
89.	1 2 3	Dreaming, nightmare-type bad dreams
90.	1 2 3	Bad breath (halitosis)
91.	1 2 3	Milk products cause upset
92.	1 2 3	Sensitive to hot weather
93.	1 2 3	Burning or itching anus
94.	1 2 3	Crave sweets
_____ TOTAL 1 2 3		

GROUP 6

95.	1 2 3	Loss of taste for meat
96.	1 2 3	Lower bowel gas several hours after eating
97.	1 2 3	Burning stomach sensations, eating relieves
98.	1 2 3	Coated tongue
99.	1 2 3	Pass large amounts of foul-smelling gas
100.	1 2 3	Indigestion 1/2-1 hour after eating; may be up to 3-4 hours after
101.	1 2 3	Watery or loose stool
102.	1 2 3	Gas shortly after eating
103.	1 2 3	Stomach "bloating"
_____ TOTAL 1 2 3		

GROUP 7A

104.	1 2 3	Difficulty sleeping
105.	1 2 3	On edge
106.	1 2 3	Can't gain weight
107.	1 2 3	Intolerance to heat
108.	1 2 3	Highly emotional
109.	1 2 3	Flush easily
110.	1 2 3	Night sweats
111.	1 2 3	Thin, moist skin
112.	1 2 3	Inward trembling
113.	1 2 3	Heart races
114.	1 2 3	Increased appetite without weight gain
115.	1 2 3	Pulse fast at rest
116.	1 2 3	Eyelids and face twitch
117.	1 2 3	Irritable and restless
118.	1 2 3	Can't work under pressure
_____ TOTAL 1 2 3		

GROUP 7B

- 119. 1 2 3 Increase in weight
- 120. 1 2 3 Decrease in appetite
- 121. 1 2 3 Fatigue easily
- 122. 1 2 3 Ringing in ears
- 123. 1 2 3 Sleepy during day
- 124. 1 2 3 Sensitive to cold
- 125. 1 2 3 Dry or scaly skin
- 126. 1 2 3 Temporary constipation
- 127. 1 2 3 Mental sluggishness
- 128. 1 2 3 Hair coarse, falls out
- 129. 1 2 3 Tension in head upon arising
wears off during day
- 130. 1 2 3 Slow pulse below 65
- 131. 1 2 3 Changing urinary function
- 132. 1 2 3 Sounds appear diminished
- 133. 1 2 3 Reduced initiative

____ 1 ____ 2 ____ 3 **TOTAL**

GROUP 7C

- 134. 1 2 3 Failing memory with age
- 135. 1 2 3 Increased sex drive
- 136. 1 2 3 Episodes of tension in head
- 137. 1 2 3 Decreased sugar tolerance

____ 1 ____ 2 ____ 3 **TOTAL**

GROUP 7D

- 138. 1 2 3 Abnormal thirst
- 139. 1 2 3 Bloating of abdomen
- 140. 1 2 3 Weight gain around hips or waist
- 141. 1 2 3 Sex drive reduced or lacking
- 142. 1 2 3 Tendency for stomach issues
- 143. 1 2 3 Immune system challenges
- 144. 1 2 3 Menstrual disorders

____ 1 ____ 2 ____ 3 **TOTAL**

GROUP 7E

- 145. 1 2 3 Dizziness
- 146. 1 2 3 Headaches
- 147. 1 2 3 Hot flashes
- 148. 1 2 3 Hair growth on face
or body (female)
- 149. 1 2 3 Sugar in urine (not diabetes)
- 150. 1 2 3 Masculine tendencies (female)

____ 1 ____ 2 ____ 3 **TOTAL**

GROUP 7F

- 151. 1 2 3 Weakness, dizziness
- 152. 1 2 3 Tired throughout day
- 153. 1 2 3 Nails weak, ridged
- 154. 1 2 3 Sensitive skin
- 155. 1 2 3 Stiff joints
- 156. 1 2 3 Perspiration increase
- 157. 1 2 3 Bowel discomfort
- 158. 1 2 3 Poor circulation
- 159. 1 2 3 Swollen ankles
- 160. 1 2 3 Crave salt
- 161. 1 2 3 Areas of skin darkening
- 162. 1 2 3 Upper respiratory sensitivity
- 163. 1 2 3 Tiredness
- 164. 1 2 3 Breathing challenges

____ 1 ____ 2 ____ 3 **TOTAL**

GROUP 8

- 165. 1 2 3 Muscle weakness
- 166. 1 2 3 Lack of stamina
- 167. 1 2 3 Drowsiness after eating
- 168. 1 2 3 Muscular soreness
- 169. 1 2 3 Heart races
- 170. 1 2 3 Hyperirritable
- 171. 1 2 3 Feeling of a band around head
- 172. 1 2 3 Melancholia (feeling of sadness)
- 173. 1 2 3 Swelling of ankles
- 174. 1 2 3 Change in urinary function
- 175. 1 2 3 Tendency to consume
sweets/carbohydrates
- 176. 1 2 3 Muscle spasms
- 177. 1 2 3 Blurred vision
- 178. 1 2 3 Involuntary muscle action
- 179. 1 2 3 Numbness
- 180. 1 2 3 Night sweats
- 181. 1 2 3 Rapid digestion
- 182. 1 2 3 Sensitivity to noise
- 183. 1 2 3 Redness of palms of hands and
bottom of feet
- 184. 1 2 3 Visible veins on chest and abdomen
- 185. 1 2 3 Hemorrhoids
- 186. 1 2 3 Apprehension (feeling that
something bad is going to happen)

- 187. 1 2 3 Nervousness causing
loss of appetite
- 188. 1 2 3 Nervousness with indigestion
- 189. 1 2 3 Gastritis
- 190. 1 2 3 Forgetfulness
- 191. 1 2 3 Thinning hair

____ 1 ____ 2 ____ 3 **TOTAL**

FEMALE ONLY

- 192. 1 2 3 Very easily fatigued
- 193. 1 2 3 Premenstrual tension
- 194. 1 2 3 Menses more painful than usual
- 195. 1 2 3 Depressed feelings
before menstruation
- 196. 1 2 3 Painful breasts during menses
- 197. 1 2 3 Menstruate too frequently
- 198. 1 2 3 Hysterectomy/ovaries removed
- 199. 1 2 3 Menopausal hot flashes
- 200. 1 2 3 Menses scanty or missed
- 201. 1 2 3 Acne, worse at menses

____ 1 ____ 2 ____ 3 **TOTAL**

MALE ONLY

- 202. 1 2 3 Less involved in
exercise/social activities
- 203. 1 2 3 Difficult to postpone urination
- 204. 1 2 3 Weak urinary stream
- 205. 1 2 3 Feeling of "blues" or melancholy
- 206. 1 2 3 Feeling of incomplete
bowel evacuation
- 207. 1 2 3 Lack of energy
- 208. 1 2 3 Muscles in arms and legs seem
softer/smaller
- 209. 1 2 3 Tire too easily
- 210. 1 2 3 Avoid activity
- 211. 1 2 3 Leg nervousness at night
- 212. 1 2 3 Diminished sex drive

____ 1 ____ 2 ____ 3 **TOTAL**

IMPORTANT | Please list below the five main physical complaints you have in order of their importance.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Digestion	Large Intestine (Palpate)	Adrenals	Pass/Fail Zinc Taste Test
_____ Hydrochloric	_____ Ascending	Pass/Fail Pupil Dilation Exam	Pass/Fail Cuff Test
_____ Acid Point	_____ Transverse	Postural Hypotension	_____ Cuff Pressure
_____ Enzyme Point	_____ Descending	_____ Supine	_____ pH of Saliva
_____ Murphy's Sign		_____ Standing	_____ Pulse

BARNES THYROID TEST

The test is conducted by the patient in the morning before leaving bed, with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test such as getting up for any reason, shaking down the thermometer, etc. It is important that the test, be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES (any two days during the month)
FEMALES HAVING MENSTRUAL CYCLES (the second and third days of flow or any five days in a row)
MALES (any two days during the month)

Day 1 _____ Day 2 _____ Day 3 _____ Day 4 _____ Day 5 _____

RESTRICTIONS ON USE

The systems survey is to be used only by trained health care professionals. If you are a patient, you should not use the systems survey. If you are not a trained health care practitioner, you should not use the systems survey. Health care practitioners should only use the systems survey to provide services that are within the scope of their license or professional training. The systems survey is intended to be used as a helpful tool for health care practitioners in collecting information concerning the health and wellness of patients.

OUR MISSION

To create optimal lifelong health and well-being for families, from newborns to seniors, by caring for the unique needs of the whole person and educating our community about the body's natural ability to heal.

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff.

Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before and after work as well as during lunch. If you must miss an appointment please notify us. If you do not show up for your scheduled appointment you will be charged \$25.00 as a missed appointment fee that you must pay before you are seen or treated again. We are available to immediately see new patients the same day. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing in. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

HEALTHCARE PRIVACY NOTICE/HIPPA

I acknowledge that I have received a copy of the Notice of Privacy Practices for Protected Health Information of Healthcare Complete.

(Initial) I authorize that this office may share my health information, appointment and financial arrangements with: (List person(s)) _____

INFORMED CONSENT/NO GUARANTEE POLICY

I understand that this facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However, as with any diagnostic test procedure, examination, or doctor's care, a guarantee or promise of improvement or complete recovery cannot be made and it is even possible that no change will occur. I further understand that in the practice of chiropractic, massage therapy, rehabilitation, and nutrition counseling there are some risks including but not limited to fracture, disk injury, stroke, dislocation, sprains-strain, and/or side effects which cannot be predetermined. I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of procedure(s) which the doctor/provider feels at the time is in my best interest. In addition, because the psycho-social, spiritual, and cultural values affect a patient's response to care, patient's are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

I understand that I have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with the prescribed treatment your provider will discuss the associated risks. The patient agrees to be compliant with the agreed upon treatment recommendations and treatment schedules and to maintain open communication with the doctor in regards to any misunderstandings involved with their care in the office. The Patient understands that lack of cooperation, failure to keep appointments; failure to follow exercise and other recommendations, engaging in activities identified by the Office as potentially injurious or traumatic to the body may necessitate additional treatments and therefore result in additional costs.

I may discontinue care and terminate the care plan at any time by written notice to that effect delivered in person, by fax, or by mail, to the Office. Such "notice of termination" shall discharge the Office from all further obligations and/or duty to render care.

The care the Patient is to receive will be outlined in a treatment plan and will be determined based upon the Patient's present condition. If a new injury or condition arises during the course of treatment provided for hereby, then, and in that event, care to be provided under the current treatment plan will be suspended until such time as the subsequent problem has resolved, or maximum medical improvement has been obtained. In the event that there is some type of insurance coverage available for the subsequent event such as a Worker's Compensation, Homeowner's, Automobile Medical- Payments or other insurance benefits relating to personal injury, then, and in that event, the Office shall have the option to bill said insurances for the care related to the subsequent injury or condition.

ASSIGNMENT OF BENEFITS/AUTHORIZATION & LIEN

I, the assignee, being the patient or the legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee, further authorizes any and all insurance company(s), attorney, and any third party payer to pay the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or third party benefits.

Assignee agrees that this facility & staff may deliver medical records, consultations, depositions, and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney, or legal service bureau to facilitate collections under the terms of this document. Assignee grants this Facility a full power of attorney to endorse any checks for payments to this office for any indebtedness owed to this office for services rendered to the patient.

INSURANCE BENEFITS/CREDIT POLICIES/DISCOUNTS/PAYMENT TERMS/REFUND TERMS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us, but some third party payers misquote benefits, coverage, and liability. Our Facility & staff are not responsible for what a third party payer and/or a representative may tell us. Any contractual, written, verbal, or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person. Our Facility will file initial insurance claims for you.

Co pays, deductibles, and all non-covered service charges are due the day the service is rendered. For your convenience we accept cash, check, debit and credit cards. For patients who have insurance plans for which we are out-of-network, you are responsible for charges on all service(s) and/or product(s) which insurance reimbursement is lower than our billed amount.

All account balances, including automobile and or work injury claims must be paid in full within 90 days of the release of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover the said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90 day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products, and services rendered to the patient or minor shown below. This office requires a credit card to be kept in our secure files. If charges are over 90 days past due or in the unlikely event insurance does not cover services rendered, Healthcare Complete will contact the assignee to utilize the credit card on file to pay for balances owed.

A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered or before they are rendered. The "TOS" is only offered on the day of service or before the day of service. This discount does not apply to supports, orthotics, physical therapy equipment, supplements or other retail items.

A service charge is computed by a "periodic rate" of 1.5 % per month-18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collections related expenses, attorney fees, court & filing fee's. Returned checks, debits & credit charges made payable to this Facility for insufficient funds, stop payments, or other of non-payment will be assessed a \$30.00 charge.

If a patient decides to terminate a pre-paid care plan prior to the termination date or visit limit, the patient shall be entitled to a refund. The refund shall equal the lump-sum amount(s) paid less any and all sums due for the services actually performed, including adjustments or other treatments, and examinations, re-examinations and consultations. Refund requests must be made in writing to the office and funds will be paid to the patient within 30 days of the termination by either party.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or staff of this Facility to use and share your confidential health information with others in order to treat you and/or to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities.

Patient Signature: _____ Printed Name: _____ Date: _____

Doctor Signature: _____ Printed Name: _____ Date: _____