Dear Patient,

It is our desire that you have as pleasant an experience in our office as possible. Our most important concern is your health but we do need to do certain things to ensure that your personal injury bills will be taken care of. The following are a list of things all persons involved in an auto accident need to know about.

Please read the following and sign the bottom of this form.

1. *If the car is insured in MA:* YOUR insurance company is responsible for paying your bills, NOT the company of the person who hit you. If the accident was someone else's fault your insurance company will seek compensation from their insurance company. After the first $2,000.00 of total Personal Injury Protection (PIP) benefits are paid out, by law we must bill your health carrier. If your health carrier does not provide chiropractic benefit or if you do not have health insurance your PIP company will continue to pay your bills up to a total of $8,000.00.
2. *If the car is insured in NH*: you have the option of submitting bills to auto insurance, med pay or to your health insurance.
3. It is your responsibility to obtain the following information from your insurance company: Name, Address, Phone, and Fax number, as well as the claim number, name and extension of the PIP adjuster NOT the adjuster for the damage to your car.
4. Your insurance company will send you a form called a "PIP Application". This form must be filled out by you as soon as it is received. Your insurance company will not pay your bills until this form is on file with them. Failure to send in your PIP application will cause the bills to become your responsibility.
5. If you have decided to utilize the help of an attorney you and your attorney will need to sign a Lien form, which is held on file at this office. The Lien is used should you have any outstanding bills that are awaiting settlement to be paid.
6. At some point during your care your insurance company will send you to another doctor for an evaluation. This is called an IME or an Independent Medical Examination. Please inform this office immediately once you are notified of an IME.
7. Keeping your scheduled appointments is imperative, not only for your recovery but also to ensure your claims will be paid. If an insurance company sees you missing appointments or changing your treatment plan without the recommendation of your doctors, they will assume that you are recovered and no longer need care.
8. Please supply us with all of the necessary items to process your claim. See list in the form labeled "REGARDING ALL PERSONAL INJURY PATIENTS FORMS TO SUPPLY OUR OFFICE" (form attached).

"I understand the above information and agree to comply fully with the office policies of Healthcare Complete.

Signed_____ Date_____ Witness_____

Thank you for your time and cooperation.

COPY FOR PATIENT

PERSONAL INJURY INSURANCE INFORMATION

PATIENT NAME _____ DATE_____

ADDRESS_____

PHONE (H) _____ (W) _____

YOUR AUTO INSURANCE INFORMATION (Or OWNER OF VEHICLE)

NAME OF INSURED_____
(IF OTHER THAN YOURSELF)

NAME OF COMPANY_____ CLAIM # _____

ADDRESS_____

PHONE # _____ ADJUSTER _____ EXT # ____
HAVE YOU HAD OR BEEN SCHEDULED FOR AN INDEPENDENT MEDICAL EXAM (IME)? _____

OTHER DRIVER'S INFORMATION

NAME OF DRIVER _____

NAME OF COMPANY _____

ADDRESS _____ PHONE _____

NAME OF ATTORNEY_____PHONE_____

By law in Massachusetts we must bill your personal health carrier after $2,000.00 of personal injury benefits have been exhausted.
PERSONAL HEALTH INSURANCE COMPANY_____
Please provide our receptionist with a copy of your health insurance card.

I HEREBY AUTHORIZE my health carrier and/or personal injury insurance carrier listed above TO PAY HEALTHCARE COMPLETE DIRECTLY FOR MY HEALTH CARE COSTS. THIS PAYMENT WILL NOT EXCEED MY INDEBTEDNESS TO
HEALTHCARE COMPLETE AND I AGREE TO PAY ANY BALANCE OF PROFESSIONAL SERVICES OVER AND ABOVE THIS INSURANCE PAYMENT.

I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINANT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER OR ATTORNEY INVOLVED IN MY CASE.

(Please read the above paragraph carefully before signing.)

_____ _____
SIGNATURE DATE

WITNESS _____

ACCIDENT HISTORY

ACCIDENT HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Name _____ **Date** _____
Address _____
City _____ **State** _____ **Zip Code** _____
DOB _____**Age**_____ **SS#** _____**Marital Status** _____
Sex ☐ Male ☐ Female **How did you hear about the office?** _____
Home Phone _____ **Work Phone** _____
Employer _____ **Occupation** _____
Have you missed any days at work? ☐ Yes ☐ No **Dates Missed:** _____
Date of Accident _____ **Time of Accident** _____**AM/PM**
Please Describe the accident in your own words:_____
_____
_____

Were you the: ☐ **Driver** ☐ **Front Passenger** ☐ **Rear Passenger** ☐ **Pedestrian**

ACCIDENT SITE

Road/Street Name _____

City/State _____

Driving Conditions: ☐ Dry ☐ Wet ☐ Icy ☐ Other

Visibility: ☐ Poor ☐ Fair ☐ Good ☐ Other_____

Was your vehicle moving? ☐ Yes ☐ No

Speed of you vehicle: _____**mph**

YOUR VEHICLE

Make and model of your car:_____

Were you wearing a seatbelt? ☐ Yes ☐ No

Were shoulder harnesses worn? ☐ Yes ☐ No

Did the airbag inflate? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest? _____

ACCIDENT

☐ Top of headrest even with **bottom** of head
☐ Top of headrest even with **top** of head
☐ Top of headrest even with **middle** of neck

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your body strike anything inside the vehicle? ☐ Yes ☐ No

Type of Impact: ☐ Front ☐ Rear ☐ Right ☐ Left ☐ Other

How were you sitting before impact?

☐ Head straight forward ☐ Body Straight
☐ Head up/down ☐ Body Rotated
☐ Head turned right/left ☐ Other

Did you see the accident coming? ☐ Yes ☐ No

Did you brace for impact? ☐ Yes ☐ No

Was your car braking? ☐ Yes ☐ No

OTHER VEHICLE

Make and model other vehicle

_____

Speed of other vehicle_____**mph**

PATIENT CONDITON

Were you unconscious after the accident? ☐ Yes ☐ No **If yes, for how long?**

_____

Could you move all parts of your body? ☐ Yes ☐ No **If no, which parts couldn't you move and why?**_____

Were you able to get out of the car and walk unaided? ☐ Yes ☐ No, why not?

_____

Did you get any bleeding cuts? ☐ Yes ☐ No **If yes, where?**_____

Did you get any bruises? ☐ Yes ☐ No **If yes, where?** _____

Please describe how you felt, 1) immediately after the accident?

_____

2) Later that day?_____

3) The next day?_____

TREATMENT

Did you go to the hospital immediately after the accident? ☐ Yes ☐ No

How did you get there? ☐ ambulance ☐ police ☐ someone else drove me ☐ drove own car

When did you go? ☐ Immediately after the accident ☐ Next day ☐ 2 days or more after

Hospital Name: _____ **Name of Doctor :** _____

Treatment received: _____

Medications given: _____

X-rays taken: _____

Did you seek any additional treatment? ☐ Yes ☐ No **If yes, who did you see?**

_____

Date of visit?_____ **Treatment received:** _____

SYMPTOMS

If you have had any of the following symptoms since the accident, please check off:

Rate each symptom with a number on a scale of 0-10 with 10 being the worst.

☐ **Arm/Shoulder pain**	☐ **Foot/toe numbness**	☐ **Dizziness**
☐ **Low back pain**	☐ **Neck stiffness**	☐ **Ear ringing**
☐ **Neck pain**	☐ **Headaches**	☐ **Memory Loss**
☐ **Upper back pain**	☐ **Irritability**	☐ **Jaw problems**
☐ **Chest pain**	☐ **Nausea**	☐ **Sleep difficulty**
☐ **Leg pain**	☐ **Stomach upset**	☐ **Blurred vision**
☐ **Hand/finger numbness**	☐ **Chest pain**	☐ **Shortness of breath**

Past health history: Place an x if it applies and describe:

☐ None related to current complaints ☐ Hospitalized ☐ Surgery

☐ Other auto accident(s) ☐ Work Accident ☐ Illness

Describe condition and treatment:_____

_____

_____

Confidential Patient Health Record

"GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST"

Instructions: Please circle the correct response.

Historical Information

- Have you ever been diagnosed or told you have any of the following?

1. High Blood Pressure (hypertension) ☐ Yes ☐ No
2. Hardening of the arteries (arteriosclerosis) ☐ Yes ☐ No
3. Diabetes ☐ Yes ☐ No
4. Heart or blood vessel diseases ☐ Yes ☐ No
5. Bone spurs on the neck bones (cervical spondylosis) ☐ Yes ☐ No
6. Whiplash injury (flexion-extension injury) (cervical spine) ☐ Yes ☐ No
7. Have any of your relatives suffered a stroke? ☐ Yes ☐ No
8. Were you ever a smoker? If yes, from _____ to _____ ☐ Yes ☐ No
9. Do you take any medications on a regular basis? ☐ Yes ☐ No
   - If yes, what? (Coumadin, Heparin, Aspirin, Anti-hypertensive medicine, etc.)
     _____
10. (Women Only) Have you ever taken oral Contraceptives? ☐ Yes ☐ No
    - If yes, from _____ to _____

- Have you ever had any of the following, even short, temporary attacks, in the last year?

1. Blurred Vision ☐ Yes ☐ No
2. Double Vision ☐ Yes ☐ No
3. Diminished or partial loss of vision in one or both eyes? ☐ Yes ☐ No
4. Complete loss of vision in one or both eyes? ☐ Yes ☐ No
5. Ringing, buzzing or any noise in the ear(s)? ☐ Yes ☐ No
6. Hearing loss in one or both ears? ☐ Yes ☐ No
7. Slurred speech or other speech problems? ☐ Yes ☐ No
8. Difficulty swallowing? ☐ Yes ☐ No
9. Dizziness? ☐ Yes ☐ No
10. Temporary lack of understanding? ☐ Yes ☐ No
11. Loss on consciousness, even momentary blackouts? ☐ Yes ☐ No
12. Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body? ☐ Yes ☐ No
13. Any other abnormal sensations in any part of your body? ☐ Yes ☐ No
14. Weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs? ☐ Yes ☐ No
15. Sudden collapse without loss of consciousness? ☐ Yes ☐ No

Patient Signature _____ Date _____

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)

Healthcare Complete

Dr. Jennah Dieter, D.C., C.A.C.C.P.
260 Merrimac St.
Newburyport, MA 01950
978-499-WELL (9355)

Release of Patient Information

Patient Name (print) _____ Date of Birth: _____

Authorized Release of Records to Primary Care Physician

I hereby authorize Healthcare Complete to release health care information regarding my treatment to the PCP listed below. I understand that records may be released while I am under care per my request to my PCP.

Primary Care Provider Information

Doctor Name/Practice Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Patient Signature_____

Authorized Release of Medical Records from other Providers

I hereby authorize Healthcare Complete to obtain any of the following medical records from my previous or concurrent medical providers: X-ray, MRI, CT films and reports, SOAP notes, prescriptions, lab tests and any other necessary medical records.

I hereby authorize the following medical facilities to release medical information pertinent to the management of my health.

Doctor Name/Facility Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Patient Signature_____

Integrated Family Wellness PC

Jennah Dieter, D.C., C.A.C.C.P.
260 Merrimac St.
Newburyport, MA 01950
508-254-1858

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize _____ Insurance Company to pay by check made out and mailed directly to:

Healthcare Complete
260 Merrimac St
Newburyport, MA 01950

the medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay in a current manner any balance of said Professional Service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby authorize you to make the check to me and mail it as follows:

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case.

Date _____

_____
Signature of Policyholder

Integrated Family Wellness PC

Jennah Dieter, D.C., C.A.C.C.P.
260 Merrimac St.
Newburyport, MA 01950
508-254-1858

DURABLE POWER OF ATTORNEY TO ENDORSE CHECKS ONLY

KNOW ALL MEN BY THESE PRESENT: That the undersigned has made, constituted and appointed, and by these present does hereby make, constitute and appoint **Healthcare Complete** to be the undersigned's true and lawful Attorney for all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said **Healthcare Complete** which checks, drafts or money orders are to pay for services rendered at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft, or money order.

The undersigned by these presents does thus give and grant unto the said **Healthcare Complete** as attorney the full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in and about the premises as fully to all personally present insofar as the endorsing and cashing of said checks are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power of attorney and which the said attorney shall do or cause to be done by virtue of these presents.

THIS IS A DURABLE POWER OF ATTORNEY AND SHALL NOT BE AFFECTED BY SUBSEQUENT DISABILITY OR INCAPACITY OF THE PRINCIPAL as provided in Chapter 201B, M.G.L.A.

IN WITNESS HEREOF the undersigned here hereunto set their hands, this

_____ Day of _____, 20 _____

_____ _____

Witness of Patient's Signature

Patient's Full Name (Printed)

_____

Signature of Patient

I HAVE READ THE ABOVE AND FULLY UNDERSTAND WHAT I HAVE READ

Integrated Family Wellness PC

Jennah Dieter, D.C., C.A.C.C.P.
260 Merrimac St.
Newburyport, MA 01950
508-254-1858

GROUP HEALTH AFFIDAVIT

I am not now eligible under any group health, sickness or disability insurance of my own or through any member of my family. If I become eligible during the two years following the date of accident, I will notify:

_____

(PIP insurance company)

"Any person who knowingly and with intent to defraud any insurance company or other person, files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a crime and may be subject to criminal prosecution and civil penalties."

POLICYHOLDER
(Full Signature) _____

ON THIS _____ DAY OF _____ 20_____ BEFORE

ME PERSONALLY CAME _____ TO ME

KNOWN TO BE THE PERSON WHO ANSWERED THIS AFFIDAVIT

NOTARY PUBLIC _____
MY COMMISSION EXPIRES _____

ATTENDING PHYSICIAN'S REPORT

DATE	POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ASSIST US IN DETERMINING BENEFITS DUE UNDER THE MASSACHUSETTS PERSONAL INJURY PROTECTION LAW THE ATTENDING PHYSICIAN MUST COMPLETE THIS REPORT AND RETURN

PATIENT SIGNATURE

1. PATIENTS NAME AND ADDRESS

2. AGE	3. SEX	4. OCCUPATION

5. HISTORY OF OCCURANCE AS DESCRIBED BY PATIENT

6. DIAGNOSIS AND CONCURRENT CONDITIONS

7. WHEN DID THE SYMPTOMS FIRST APPEAR? DATE:	8. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE:

9. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?
YES ☐ NO ☐ IF "YES" STATE WHEN AND DESCRIBE

10. IS THE CONDITION SOLELY A RESULT OF THIS ACCIDENT?
YES ☐ NO ☐ IF "NO" EXPLAIN

11. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?
YES ☐ NO ☐

12. WILL INJURY RESULT IN PERMANENT DISFIGUREMENT OR DEFECT?
YES ☐ NO ☐

13. PATIENT WAS DISABLED (Unable to work)		14. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN
FROM:	THROUGH:	TO WORK ON DATE:

15. REPORT OF SERVICES

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	CHARGES
			$
		PLEASE SEE BILLS	$
			$
		TOTAL CHARGES TO DATE	$

16. IS PATIENT STILL UNDER CARE FOR THIS CONDITION? YES ☐ NO ☐	ESTIMATED FUTURE CHARGES $

26-4829938

DATE	PHYSICIAN' NAME (PRINT)	PHYSICIAN'S SIGNATURE	IRS/TAX IDENTIFICATION

Integrated Family Wellness PC

Jennah Dieter, D.C., C.A.C.C.P.
260 Merrimac St.
Newburyport, MA 01950
508-254-1858

NOTICE OF IRREVOCABLE LIEN AND ASSIGNMENT OF BENEFITS
AUTHORIZATION FOR RELEASE OF TREATMENT RECORDS
PROVIDER'S LEGAL & EQUITABLE LIEN-ATTORNEY'S ACCEPTANCE

Patient Name & Address:_____
_____
Name of Insured (PIP): _____Name of Insured (BI)_____
DateofInjury/Illness:_____
Name of Insurer(s) (PIP): _____Name of Insurer(s) (BI) _____
Name of Law Office & Attorney: _____

In consideration of the agreement of the Provider named above to provide me with injury treatment services, I hereby to the extent of my treatment bills irrevocably assign to my Provider all my right, title and interest to and in all applicable insurance and indemnification reimbursement benefits of applicable insurance companies including but not limited to: automobile PIP (Personal Injury Protection) coverage; Medical Payment Coverage and health care coverage to which I may be entitled to pay my Provider for services rendered to treat me on and after the above date in connection with my injury or illness.

I further grant to my Provider an irrevocable Equitable Lien and an Official Legal Lien as set forth in Ch111§70A through Ch111§70D Mass. General Laws to and in any insurance benefits that may be due me and I furthermore authorize my Provider to provide my attorney and any applicable insurance companies involved with a full report concerning my condition and treatment, including but not limited to office notes, dates of visits, and charges incurred.

I hereby authorize and direct any and all applicable insurance companies to make immediate payment directly to my said Provider for all benefits and sums due me that may be due him or her upon receipt by you of my Provider's itemized statement for treatment services rendered to me.

It is further agreed that payment by any insurance company involved as herein directed to my Provider of any itemized statement shall be considered the same as if paid by the insurer directly to me.

I am aware that I remain personally responsible to my Provider for the full amount of my unpaid treatment bills and further direct any Attorney representing me to withhold from the proceeds upon any final settlement or final disposition of my case an amount equal to that to pay any outstanding unpaid balance of my bills. This includes any balance due as a result of an independent medical exam that discontinued my personal injury protection benefits and/or my medical payments benefit.

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

AGREEMENT OF ATTORNEY

I hereby agree to honor the above irrevocable Lien and Assignment and pay the Provider all sums received by me from insurers attributable to the Provider's bills and also agree to pay the Provider any lawful balance due from the proceeds of any settlement or recovery.

Attorney's Signature_____ Date: _____

A photocopy of this form can be accepted with the same authority as the original.

REGARDING ALL PERSONAL INJURY PATIENTS
FORMS TO SUPPLY OUR OFFICE

It is to my knowledge and understanding that I must furnish **Healthcare Complete** with the proper insurance information to process my claim. Assignment will be accepted on Personal Injury Protection benefits only when the following has been satisfied:

The information that must be supplied to us includes:

- ❑ Name and address of the correct insurance company for the bodily injury claim with adjusters name and claim number
- ❑ Name and address of the insured (if not the patient)
- ❑ A copy of automobile insurance declaration page or Coverage Selection page has been provided for the vehicle you were in at the time of the accident.
- ❑ A copy of your health insurance card (both sides) has been provided if applicable.
- ❑ Signed an irrevocable lien by you and your attorney (if one has been assigned)
- ❑ Your PIP application must be returned to the PIP Carrier.

"I understand the above information and agree to comply fully with the office policies of Healthcare Complete."

Signed_____ Date_____ Witness_____

COPY THIS FORM FOR THE PATIENT TO TAKE HOME

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: _____