

# AUTO INJURY HISTORY FORM

Missing / Incomplete / Inaccurate information may jeopardize your coverage by the insurance carrier or future legal documentation

## ASSIGNMENT OF BENEFITS

The information on these forms is correct to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes in my medical status. I also agreed and understood all the policies written above. I, \_\_\_\_\_, hereby assign my rights, title, and interest from any and all automobile insurance policy which provides Personal Injury Protection (PIP), medical benefits, or no-fault benefits to Pangemanan Chiropractic, for services rendered to me by Pangemanan Chiropractic for the accident on \_\_\_\_\_.

Patient's Signature **X** \_\_\_\_\_  
Witness \_\_\_\_\_  
Date \_\_\_\_\_

## INJURY HISTORY

Weather conditions at time of accident:

- Foggy  Icy  Normal  Windy
- Raining  Snowing  Poor Visibility

Time of Accident:  Dawn  Daylight  
 Dusk  Night

Did vehicle go off the road?  Yes  No  
Length of time in the car before accident: \_\_\_\_\_  
List your body parts that were struck during collision:  
\_\_\_\_\_

You were:  Driver  Passenger Front Seat  
 Passenger Front Middle / Right Seat  
 Passenger Middle Left / Center / Right Seat  
 Passenger Middle Right Seat  
 Passenger Back Left / Middle / Right Seat

If you're not the driver, who was? \_\_\_\_\_  
Your Status / Body Position Before Accident:

- Asleep  Awake
- Seat/Lap Belt On  Seat/Lap Belt Off
- Shoulder Harness On  Shoulder Harness Off
- Reclined in Seat  Rotated in Seat
- Both hands on steering wheel  One hand on wheel
- Tired  \_\_\_\_\_

Were brakes applied before the impact?  Yes  No

Your posted speed limit: \_\_\_\_\_ mph  
Rate of speed before impact: \_\_\_\_\_ mph

Traffic conditions at time of accident:  
 Congested  Good  Rush Hour  
 Heavy  Normal

Your vehicle was impacted on:  
 Front Head On  Front Left  Front Right  
 Rear-End  Rear Left  Rear Right  
 Left Side  Right Side

Type of your vehicle: \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Today's Date \_\_\_\_\_

**CLAIM #** \_\_\_\_\_

Insurance Co. Name + Address \_\_\_\_\_

Insurance Co. Phone # \_\_\_\_\_

Date of Injury \_\_\_\_\_ Time of Injury \_\_\_\_\_ AM / PM

Marital Status  M  S  W  D # Children \_\_\_\_\_

Tobacco/Smoke  None Pack per day \_\_\_\_\_ #Years \_\_\_\_\_

Alcohol  Never  Social  Rarely  
 Recovering Alcoholic  Current Abuse

At Time of Crash:  Unemployed

Employed by \_\_\_\_\_

Currently:  Unemployed

Employed by \_\_\_\_\_

Type of work:  Office/clerical  Light Labor  
 Moderate Labor  Heavy labor

Locations Taken / You Went to After the Accident:

- Home. How? \_\_\_\_\_
- ER, By Ambulance / By Self / By \_\_\_\_\_
- Hospital. By Ambulance / By Self / By \_\_\_\_\_
- Minor Emergency Center. By \_\_\_\_\_

Were you hospitalized?  Yes  No

Treatments received at the hospital / ER / minor emergency place:  
\_\_\_\_\_

Radiographs / X-rays?  Yes  No

Which body parts? \_\_\_\_\_

Did you see any other health care provider(s) between the date of the accident and today's date?

1.) Dr.: \_\_\_\_\_  
Office Name + City \_\_\_\_\_  
Specialty: \_\_\_\_\_ Date first seen \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Treatments Received: \_\_\_\_\_  
Drug Prescriptions: \_\_\_\_\_  
Currently Treating?  Yes  No  
Special Tests: \_\_\_\_\_  
Did treatment(s) help?  Yes  No  
Notes: \_\_\_\_\_

2.) Dr.: \_\_\_\_\_  
Office Name + City \_\_\_\_\_  
Specialty: \_\_\_\_\_ Date first seen \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Treatments Received: \_\_\_\_\_  
Drug Prescriptions: \_\_\_\_\_  
Currently Treating?  Yes  No  
Special Tests: \_\_\_\_\_  
Did treatment(s) help?  Yes  No  
Notes: \_\_\_\_\_

## REPORTS & CITATION

Make & Year: \_\_\_\_\_  
 Vehicle Ownership: \_\_\_\_\_  
 3.) Dr.: \_\_\_\_\_  
 Office Name + City \_\_\_\_\_  
 Specialty: \_\_\_\_\_ Date first seen \_\_\_\_\_  
 Referred by: \_\_\_\_\_  
 Treatments Received: \_\_\_\_\_  
 Drug Prescriptions: \_\_\_\_\_  
 Currently Treating?  Yes  No  
 Special Tests: \_\_\_\_\_  
 Did treatment(s) help?  Yes  No  
 Notes: \_\_\_\_\_

**BEFORE vs. AFTER THE ACCIDENT**

Conditions/illness due to the accident interfere with:

- Activities of Daily Living
- My normal/regular personal lifestyle
- My normal/regular work activities

BEFORE accident/injury, WALKING activities at home or work:

- Normal  Limited  Difficult  Painful

AFTER accident/injury, WALKING activities at home or work:

- Normal  Limited  Difficult  Painful

BEFORE accident/injury, STANDING activities at home / work:

- Normal  Limited  Difficult  Painful

AFTER accident/injury, STANDING activities at home or work:

- Normal  Limited  Difficult  Painful

BEFORE accident/injury, BENDING activities at home or work:

- Normal  Limited  Difficult  Painful

AFTER accident/injury, BENDING activities at home or work:

- Normal  Limited  Difficult  Painful

BEFORE accident/injury, SITTING activities at home or work:

- Normal  Limited  Difficult  Painful

AFTER accident/injury, SITTING activities at home or work:

- Normal  Limited  Difficult  Painful

**POST-INJURY**

Self-care activities you have been doing since the accident:

- None  Ice  Heat
- Compression  Rest  Soaking
- ACE wrap  Massage
- Over the Counter Medications \_\_\_\_\_
- Over the Counter Orthotics \_\_\_\_\_
- Over the Counter Treatments \_\_\_\_\_
- Others \_\_\_\_\_

Do you remember the impact?  Yes  None

After the accident, do you need another person / outside help to help you to get around at home or at work?  Yes  None

Lost time from work:  Yes  None  
 If yes, provide dates: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Notes: \_\_\_\_\_

Are you able to do almost any physical activity? \_\_\_\_\_

Are you able to do almost any mental activity? \_\_\_\_\_

Does it bother you to ride in a car now? \_\_\_\_\_

**Please mark the area of injury or**

To whom was citation given and for what reason?

\_\_\_\_\_

\_\_\_\_\_

Were police on-scene?  Yes  No  
 Injury/accident/police report filed?  Yes  No  
 Witness(es) of accident: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ADDITIONAL INFO:**

- Seat back adjustment altered by the crash?  Yes  No
- Was the seat broken?  Yes  No
- Lap belt:  Wearing  Not wearing  Don't Know
- Shoulder belt:  Wearing  Not wearing  Don't Know
- Your vehicle equipped with air bag?  Yes  No
- Did air bag deploy?  Yes  No
- If yes, were you struck by air bag?  Yes  No
- Did your vehicle strike any objects after crash?  Yes  No
- Did you wear hat or glasses during the crash? \_\_\_\_\_
- If yes, were they still on after crash?  Yes  No
- Did you lose consciousness?  Yes  No
- Estimated property damage to your vehicle: \$ \_\_\_\_\_
- Estimated property damage to other vehicle(s): \$ \_\_\_\_\_
- Symptoms AFTER the impact:
  - Headache  Dizziness  Nausea
  - Vomiting  Confusion / Disorientation
  - Tingling / Numbness. Where? \_\_\_\_\_
  - Pain. Where? \_\_\_\_\_
  - Pain. Where? \_\_\_\_\_
- The symptoms mentioned above appear:
  - Immediately
  - \_\_\_\_\_ hour(s) afterward. Which symptoms? \_\_\_\_\_

**Crash Diagram:** (please draw the roads, names of roads or highways, vehicles, direction of vehicles with arrows, etc.)



**discomfort on the chart, using the appropriate symbols:**

Numbness	- - - -
Tingling	O O O
Burning	^ ^ ^
Aching	X X X
Stabbing	⊗ ⊗ ⊗

**WHAT are your COMPLAINTS?** \_\_\_\_\_

Have you had these problems before the accident ? (ex. 2 years ago) \_\_\_\_\_

**HOW** did this problem **started** ? (ex. Car wreck)? \_\_\_\_\_

What makes the pain **better** (sitting/standing/nothing/painkillers/rest,etc.) \_\_\_\_\_

What makes the pain **worse** (sitting/rest, etc.) \_\_\_\_\_

Does it stay in the same place/**locally** or does it **radiate**? Where to? \_\_\_\_\_

Rate **INTENSITY** of pain: (NO PAIN) → 0 1 2 3 4 5 6 7 8 9 10 → (excruciating, unbearable, 10/10 = need to go to ER immediately)

Timing of pain:  Occasional  Intermittent  Frequent  Constant  Other \_\_\_\_\_

Have you seen any other health care professionals about this? **If yes, who, where and when and what** were the results? \_\_\_\_\_

Have you ever experienced this problem **before**? When? Please explain \_\_\_\_\_

Has this problem been getting better, worse, or staying the same since it started? \_\_\_\_\_

Have you had any **X-rays or MRI** or any tests taken for this problem(s) in the last 2 years? Yes / No. If yes, where \_\_\_\_\_

*(If this form is not sufficient to document all your complaints, please use additional forms as necessary, copies, etc.)*

List the body parts that struck the following vehicle parts during the accident:

Dashboard	Windshield	Steering Wheel	Right Door	Left Door
R / L side of the head	R / L side of the head	R / L side of the head	R / L side of the head	R / L side of the head
R / L shoulder	R / L shoulder	R / L shoulder	R / L shoulder	R / L shoulder
R / L arm	R / L arm	R / L arm	R / L arm	R / L arm
R / L elbow	R / L elbow	R / L elbow	R / L elbow	R / L elbow
R / L wrist	R / L wrist	R / L wrist	R / L wrist	R / L wrist
R / L hip	R / L hip	R / L hip	R / L hip	R / L hip
R / L knee	R / L knee	R / L knee	R / L knee	R / L knee
R / L ankle	R / L ankle	R / L ankle	R / L ankle	R / L ankle

Other information: \_\_\_\_\_  
 \_\_\_\_\_

## NEW AUTO / PERSONAL INJURY PATIENT COMPLIANCE AGREEMENT FORM

We are honored that you choose Pangemanan Chiropractic to help you recover from your recent auto-accident / personal injury, however, in order to create a harmonious, ethical, win-win situation and a congruous environment in this office, we are very selective in accepting and retaining patients. Due to the strict and meticulous legal nature of auto-accident and personal injury case, and in order to prevent accepting patients who are non-compliant, we are forced to create a selective environment in selecting patients to be cared for in this office.

This Agreement Form allows *Pangemanan Chiropractic* to **retain, honor, and respect** patients (a.k.a. practice members) who are compliant and honor their privilege as patients, at the same time we reserve the right to cease care and discharge non-compliant patients and/or refer them to other chiropractic office(s) in the area at any time.

- (1) I agree to KEEP MY APPOINTMENTS and follow the treatment schedule prescribed by the physician(s) at *Pangemanan Chiropractic* for my own benefits. I agree to FOLLOW THE HOME / WORK CARE INSTRUCTIONS prescribed by the physician(s) at *Pangemanan Chiropractic* for my own benefit. This includes, but not limited to, icing instructions (cryotherapy) to reduce swelling and inflammation, exercises, stretches, rest, posture, etc.
- (2) In rare cases where I have to cancel my appointment, I will make every effort to change my scheduled appointment(s) AT LEAST 24 HOURS PRIOR to the scheduled appointment.
- (3) I am allotted UP TO THREE MISSED VISITS annually after the start of my care. When this is reached, *Pangemanan Chiropractic* may be forced to dismiss me from care and may refer me to another chiropractic office immediately for my own benefit.
- (4) I agree to be financially responsible for all charges incurred at this clinic should the insurance company refuse to pay for the services provided. This office has a Zero Balance Policy and reserve the right to refuse care to patients with outstanding balance at anytime as well as the right to collect the outstanding balance using various collection methods. This office does NOT and is not responsible to send bills or charges to the patients.
- (5) My full, active participation in my care at *Pangemanan Chiropractic* is crucial for my own recovery and stabilization. Following the home / workplace care instructions is imperative. Failure to perform the home / workplace care instructions (ice applications, exercises, stretches, posture, etc) will likely result in a slow recovery and possible worsening of my symptoms. *Pangemanan Chiropractic* may be forced to dismiss me from care immediately and refer me to another chiropractor for my own benefit. I will agree to hold harmless and indemnify *Pangemanan Chiropractic*, its physicians, employees, volunteers, and affiliated individuals or corporations from any and all liability in the past, present, or future, arising from my non-compliance, my own inability to keep my appointments and/or participating fully and actively in my home / workplace care instructions.
- (6) SHOULD I, (PATIENT) LOOSE MY ACCIDENT CASE, OR SETTLE IT WITHOUT NOTIFYING PANGEMANAN CHIROPRACTIC, I AM RESPONSIBLE FOR MY BILL FROM PANGEMANAN CHIROPRACTIC AND I UNDERSTAND THAT PAYMENT WILL BE DUE IN FULL IMMEDIATELY, ESPECIALLY IF SETTLEMENT IS GIVEN TO ME WITHOUT NOTIFICATION TO PANGEMANAN CHIROPRACTIC.
- (7) If I retain an attorney, I am responsible to inform Pangemanan Chiropractic of his/her name, address, phone, fax, and information. If I change attorneys, I am also responsible to inform Pangemanan Chiropractic of these changes and related changes immediately.
- (8) I WILL ALWAYS BE CONSISTENT in telling the doctors and staff at Pangemanan Chiropractic and my attorney all my complaints/symptoms and my complete physical history including any other accidents or preexisting conditions, throughout my care. IF MY CONDITION OR SYMPTOMS CHANGE, I should immediately advise this office. I understand that certain symptoms may indicate a need to be referred to another specialist—Pangemanan Chiropractic may terminate my care and refer out immediately
- (9) I will provide Pangemanan Chiropractic with names of all insurance companies with whom I have policies, and who I am involved with. If my insurance company or any other party requests an Independent Medical Examination, I should consider my legal obligation. Most insurance companies require my cooperation and their right to an I.M.E. which is used routinely if the expenses of your treatment exceed a certain amount. I clearly understand that the request for an I.M.E. does not give the insurance company the right to require me to change doctors or to select a doctor for treatment.
- (10) I understand that if I am receiving medical care as a result of injuries sustained in an accident which is covered by a liability insurance policy, Pangemanan Chiropractic will not release to me a complete itemization of charges reflecting any outstanding balance until I am released from care. I also understand that if the accident in which I was involved was covered by any medical payment provision of any applicable insurance policy, any benefits obtained through any such policy will be applied directly to the outstanding balance on my account with Pangemanan Chiropractic's office. I fully understand that I am directly and fully responsible to Pangemanan Chiropractic for all medical bills submitted by Pangemanan Chiropractic for services rendered to me and that this agreement is made solely for said doctor's additional protection. Complete satisfaction of the medical bills is not contingent on any settlement, judgment, or verdict by which I recover said fee.

I, \_\_\_\_\_, the undersigned, hereby request chiropractic care and adjunctive services at the *Pangemanan Chiropractic* at 1004 Dewey Drive, Suite C, Lawrenceburg KY 40342. I have read, understand and accept the terms in this form above and have had the opportunity to ask questions regarding anything that I do not understand.

I am looking forward to a mutual and rewarding relationship with the doctors and team members of Pangemanan Chiropractic.

Signature of Patient / Guardian (if minor) **X** \_\_\_\_\_ Date \_\_\_\_\_

## NECK Index

**Please rate the severity of your pain by circling a number:**

*No pain* 0 1 2 3 4 5 6 7 8 9 10 *Unbearable pain*

**Name** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Instructions:** Please circle the **ONE NUMBER** in each section which most closely describes your problem.

### SECTION 1-PAIN INTENSITY

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

### SECTION 2-PERSONAL CARE (Washing, Dressing, etc.)

0. I can look after myself normally, without causing extra pain.
1. I can look after myself normally, but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help, but manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I do not get dressed; I wash with difficulty and stay in bed.

### SECTION 3-LIFTING

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it gives extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

### SECTION 4-READING

0. I can read as much as I want to, with no pain in my neck.
1. I can read as much as I want to, with slight pain in my neck.
2. I can read as much as I want to, with moderate pain in my neck.
3. I can't read as much as I want, because of moderate pain in my neck.
4. I can hardly read at all, because of severe pain in my neck.
5. I cannot read at all.

### SECTION 5-HEADACHES

0. I have no headaches at all.
1. I have slight headaches that come infrequently.
2. I have moderate headaches that come infrequently.
3. I have moderate headaches that come frequently.
4. I have severe headaches that come frequently.
5. I have headaches almost all the time.

### SECTION 6-CONCENTRATION

0. I can concentrate fully when I want to, with no difficulty.
1. I can concentrate fully when I want to, with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

### SECTION 7-WORK

0. I can do as much work as I want to.
1. I can do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I can't do any work at all.

### SECTION 8-DRIVING

0. I can drive my car without any neck pain.
1. I can drive my car as long as I want, with slight pain in my neck.
2. I can drive my car as long as I want, with moderate pain in my neck.
3. I can't drive my car as long as I want, because of moderate pain in my neck.
4. I can hardly drive at all, because of severe pain in my neck.
5. I can't drive my car at all.

### SECTION 9-SLEEPING

0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hr sleepless).
2. My sleep is mildly disturbed (1-2 hrs sleepless).
3. My sleep is moderately disturbed (2-3 hrs sleepless).
4. My sleep is greatly disturbed (3-5 hrs sleepless).
5. My sleep is completely disturbed (5-7 hrs sleepless).

### SECTION 10-RECREATION

0. I am able to engage in all my recreation activities, with no neck pain at all.
1. I am able to engage in all my recreation activities, with some neck pain at all.
2. I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
3. I am able to engage in few of my recreation activities, because of pain in my neck.
4. I can hardly do any recreation activities, because of pain in my neck.
5. I can't do any recreation activities at all.

**TOTAL** \_\_\_\_ / 50 = \_\_\_\_ %

## LOW BACK Index

**Please rate the severity of your pain by circling a number below:**

*No pain* 0 1 2 3 4 5 6 7 8 9 10 *Unbearable pain*

**Name** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Instructions:** Please circle the **ONE NUMBER** in each section which most closely describes your problem.

### Section 1 – Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

### Section 2 – Personal Care (Washing, Dressing, etc.)

0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

### Section 3 – Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

### Section 4 – Walking Section

0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

### Section 5 – Sitting

0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

### Section 6 – Standing

0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 min. without increasing pain.
5. I avoid standing because it increases the pain immediately.

### Section 7 – Sleeping

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

### Section 8 – Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

### 9 – Traveling

0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

### Section 10 – Changing Degree of Pain

0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

**TOTAL** \_\_\_\_ / 50 = \_\_\_\_%

**PANGEMANAN Chiropractic**

1004 Dewey Dr, Suite C, Lawrenceburg, KY 40342

P:(502) 839-7171 F:(502)839-4441 E: hello@pangemananchiropractic.com

*(This form is not necessary unless you are hiring or have hired an attorney for this personal injury / motor vehicle accident case, then this Provider's Lien form must be signed by your attorney immediately and must be returned to Pangemanan Chiropractic ASAP)*

**PROVIDER'S LIEN**

TO: Attorney \_\_\_\_\_  
\_\_\_\_\_

Re: Reports and Provider's Lien

I, \_\_\_\_\_, do hereby authorize the above health provider to furnish you, my attorney, with a full report of this examination, diagnosis, treatment, prognosis, etc of myself in regards to the accident in which I was involved.

I, \_\_\_\_\_, do hereby authorize and direct you, my attorney, to pay directly to Pangemanan Chiropractic, such sums as may be due and owing them for chiropractic services rendered me both by reason of this accident and by reason of any other bills that are due their office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said company. And I hereby further give a lien on my case to said company against any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said company for all chiropractic bills submitted by them for services rendered to me and that this agreement is made solely for said company's additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Patient's Signature: \_\_\_\_\_ Date : \_\_\_\_\_

Patient's Name: \_\_\_\_\_

***The undersigned being attorneys of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said company above named.***

Attorney's Signature: \_\_\_\_\_ Dated: \_\_\_\_\_

Please date, sign and return one copy to doctor's office. Keep a copy for your records. A photo copy of this form shall be considered as valid as the original.