ACCIDENT INFORMATION

Please PRINT clearly.

PATIENT INFORMATION

Name: (Last, First, MI) _____ **Date**: _____

ACCIDENT INFORMATION -- *Please use back of this page if needed.*

Date of accident: _____ Time of Accident: _____ Number of people in accident vehicle: _____

Location/street of Accident:_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger -- Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row

Name of Driver, *if not you* _____ Name of Driver of other Vehicle: _____

Make/Model of Vehicle you were in: _____

Is vehicle equipped with airbags? ☐ Yes ☐ No Did airbags inflate? ☐ Yes ☐ No Were you wearing a seatbelt? ☐ Yes ☐ No

Where did the impact come from? ☐ Front ☐ Rear ☐ Driver side ☐ Passenger Side

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At the base

In what direction were you headed? ☐ North ☐ South ☐ East ☐ West

In what direction was the other vehicle headed? ☐ North ☐ South ☐ East ☐ West

During impact were you facing: ☐ Forward ☐ Backward ☐ Right ☐ Left

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No (Describe):_____

_____

Were you rendered unconscious? ☐ Yes ☐ No If yes, for how long? _____

What was the approximate speed of your vehicle? _____ The other vehicle? _____

Were you ☐ Aware ☐ Surprised by the impact? What did your vehicle impact? ☐ Another vehicle ☐ Other:_____

Please list the name of the other victims in the accident, if any:_____

_____

In your own words please describe the accident in detail: _____

_____

INSURANCE INFORMATION

Your Auto Ins: _____Policy #_____ Claim#_____ Phone#_____

Address:_____

Other's Auto Ins:_____Policy #_____ Claim#_____ Phone#_____

Address:_____

MEDICAL INFORMATION

BEFORE THE ACCIDENT:

Have you had complaints in the involved area? ☐ Yes ☐ No

Were they present at the time of the accident? ☐ Yes ☐ No

Describe: _____

Were you able to work without restrictions before the accident? ☐ Yes ☐ No

AT THE TIME OF THE ACCIDENT:

Did you feel pain immediately after the accident? ☐ Yes ☐ No ☐ Later that Day ☐ Next Day ☐ When? _____

Did you go to a hospital or seen any other doctor? ☐ Yes ☐ No When did you go? ☐ Immediately ☐ Next Day ☐ Other_____

How did you get there? ☐ Ambulance ☐ Private Transportation Was medication prescribed? ☐ Yes ☐ No

Describe the treatment you received: _____

Name of hospital and/or attending doctor:_____

Was he/she a : ☐ DDS ☐ MD ☐ DC ☐ DO Were any x-rays taken? ☐ Yes ☐ No

SINCE THE ACCIDENT:

Are your symptoms: ☐ getting better ☐ getting worse ☐ staying the same

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

LEGAL INFORMATION

Did the police come to the scene of the accident? ☐ Yes ☐ No Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No Was a traffic violation issued? ☐ Yes ☐ No To whom? _____

Have you retained an attorney? ☐ Yes ☐ No If yes, whom? _____Phone:_____

Signature of Patient/Guardian _____ **Date**_____

AUTOMOBILE MEDICAL BENEFITS

A lot of people have medical benefits ("medpay" or "PIP") included in their automobile policies, and don't even realize it. Our office highly recommends that you use these benefits, if you have them, in the event that you've been injured in an automobile accident, regardless of who was at fault.

Here are several reasons why we recommend that we file your medpay or PIP.

1. **Medpay and PIP are exactly like health insurance – using either form of coverage doesn't cause your rates to increase.** If your rates increase, it's not because you filed your medpay or PIP, It's most likely because: (a) the accident was determined to be your fault by your insurance company, (b) you received a police citation or ticket, or (c) you've been involved in numerous reported auto accidents within a brief period of time, and therefore are now considered to be "high risk."

2. **Filing your medpay or PIP doesn't relieve the other party from having to pay in full for your loss.** Filing medpay/PIP doesn't relieve the other party from being responsible for payment. If the other driver's laibility insurance refused to make payment to you for whatever reason, filing your medpay/PIP will help to ensure that you are not left to pay the medical bills out of your own pocket.

3. **If you have medpay or PIP coverage and choose not to file it, then you are paying for an option, but not receiving the benefit.**

4. **We do not charge for filing your medpay or PIP!**

OUR OFFICE FINANCIAL POLICY

As long as our office is filing your PIP or Medpay, and these companies are continuing to cover your charges, we will waive collection of payment at the time of service. If we receive overpayment to your account, we will be happy to refund you the difference, provided we are not under a duty to refund the insurance company.

Next Level Chiropractic
554 W. Ralph Hall Parkway
Rockwall, TX 75032
(972) 771-3388 FAX (972) 722-3398

Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Next Level Chiropractic, a lien and assignment of any and all benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority.

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and upon violation, I further instruct my carrier to make all checks payable to Next Level Chiropractic and send to 554 W. Ralph Hall Parkway, Rockwall, TX 75032.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to: Next Level Chiropractic and send any and all checks to 554 W. Ralph Hall Parkway, Rockwall, TX 75032.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collections, including attorney fees and court costs incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf, I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disabiltiy granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

Signature of Patient and/or Responsible Parties:
I declare under penalty of perjury that the foregoing is true and correct. (CPRC: Sec. 132.001(a))

_____ Date: _____

_____ Date: _____

CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First, MI) _____ **Preferred Name**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home: _____ **Mobile**: _____ **Mobile Carrier**: _____ **Work**: _____

Email: _____ **Gender**: M / F **Marital Status**: Married / Single / Other

Best way to reach you: home / cell / work / email Date of Birth: _____ Age: _____

Preferred patient reminders: email / text Occupation: _____ Employer: _____

Who may we thank for referring you to our office? _____

CMS requires providers to report both race and ethnicity

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer **Preferred Language**: _____

Race: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Native Hawaiian or Pacific Islander Other / Decline to Answer

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____

Home: _____ **Mobile**: _____

Relationship: Child / Parent / Spouse / Other: _____

Name of Previous Chiropractor: _____

Date of Last Chiropractic Adjustment: _____

Primary Care Physician: _____

Doctor's Phone: _____

FINANCIAL INFORMATION -- ***Please allow our staff to photocopy your insurance card.***

Texas State law requires that we inform you in writing of your charges at each visit. Please initial below indicating your choice of receiving a paper receipt detailing the charges for each visit.

_____ **Yes**, I would like a printed Appointment Receipt at each visit. I understand that it is my responsibility to request this at check out.

_____ **No**, I do not wish to receive any of my printed Appointment Receipts. I understand that I may request any Appointment Receipt for any date of service at any point in the future.

List all medications, Dosage and Frequency (i.e. 5 mg once a day, etc.) *Did you bring a list? Can we make a copy?*

_____

_____

_____

Describe Major Complaint for seeking care today: _____

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

Onset of Symptoms: _____ Descrie how it began: _____

_____

Grade Intensity/Severity of Complaint: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6)
Moderate-Severe (6-8) Severe (8-10)

Is the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Numb / Other: _____

How frequent is the complaint present? Come & Go / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)* _____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both *Leg* - Hip / Thigh-Knee / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area:* _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

How does this condition affect your daily activities? *(Describe)* _____

Have you received any prior treatment for this condition?

DC / MD / PT / Massage / ER / Other: _____ Where? _____

Surgery? *(Describe)* _____

Medications? OTC / Prescriptions *(Describe)* _____

Diagnostic testing? X-rays / MRI / CT / Other: _____ When and Where? _____

❑ Acupunture ❑ Massage ❑ Other: _____

Describe any Secondary Complaints: _____

HEALTH HISTORY *(PLEASE USE REVERSE SIDE OF PAGE IF NEEDED)*

FAMILY HISTORY:

Heart Disease Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather

Stroke Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather

Cancer Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather

Type of Cancer: _____

Any other family history that might be relevant: _____

MEDICATION:

Allergies to Medications: *(List and reactions)* _____

_____

_____

Vitamins & Supplements: *(List all and frequency)* _____

_____

_____

PAST HEALTH HISTORY: *(List even if it was 20 years ago…)*

Surgeries – Date, Type and Reason: _____

_____

_____

Major Injuries/Traumas: *(List even if it was 20 years ago or more…)*

_____

_____

Major Hospitalizations including year:

_____

_____

_____

LIFESTYLE:

Lifestyle: *(Your Hobbies, Rec. Activities, Exercise, Diet, Health Goals)*

_____

_____

_____

_____

Habits:

Cigarettes – (#/day) _____

Alcohol – (amount/day) _____

Coffee/Tea – (cups/day) _____

Rec. Drugs: (list) _____

Are you *currently* experiencing any of these symptoms? (Check all that apply)
Many of the following conditions respond to Chiropractic treatment.

General: (constitutional)
- ❑ Recent Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ *None in this Category*

Musculoskeletal:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems _____
- ❑ Leg Problems _____
- ❑ Painful Joints
- ❑ Stiff/Swollen Joints
- ❑ Sore/Weak Muscles or Joints
- ❑ Muscle Spasms/Cramps
- ❑ Broken Bones
- ❑ Other: _____
- ❑ *None in this Category*

Neurological:
- ❑ Numbness or Tingling Sensations
- ❑ Loss of Feeling
- ❑ Dizziness or Light Headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or Seizures
- ❑ Tremors
- ❑ Stroke
- ❑ Have you ever had a head injury?
- ❑ Ever been in an auto accident?
- ❑ Other: _____
- ❑ *None in this Category*

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ Other: _____
- ❑ *None in this Category*

Genitourinary:
- ❑ Sexual Difficulty
- ❑ Kidney Stones
- ❑ Burning/Painful Urination
- ❑ Change in Force/Strain w/Urination
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Incontinence or Bed Wetting
- ❑ Other: _____
- ❑ *None in this Category*

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Blood in Stool
- ❑ Change in Bowel Movements
- ❑ Painful Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Frequent Diarrhea
- ❑ Constipation
- ❑ Other: _____
- ❑ *None in this Category*

Cardiovascular & Heart:
- ❑ Chest Pains
- ❑ Rapid or Heartbeat Changes
- ❑ Blood Pressure Problems
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ Heart Problems
- ❑ Other: _____
- ❑ *None in this Category*

Respiratory:
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Lung Problems
- ❑ Other: _____
- ❑ *None in this Category*

Eyes and Vision:
- ❑ Wear contacts/glasses
- ❑ Blurred or Double Vision
- ❑ Glaucoma
- ❑ Eye Disease or Injury
- ❑ Other: _____
- ❑ *None in this Category*

Ears, Nose and Throat:
- ❑ Bleeding gums/Mouth sores
- ❑ Bad Breath or Bad Taste
- ❑ Dental Problems
- ❑ Swollen Throat or Voice Change
- ❑ Swollen Glands in Neck
- ❑ Ringing in the Ears
- ❑ Ear-Ache/Ringing/Drainage
- ❑ Sinus/Allergy Problems
- ❑ Nose Bleeds
- ❑ Hearing Loss
- ❑ Other: _____
- ❑ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Excessive Thirst or Urination
- ❑ Cold Extremities
- ❑ Heat or cold Intolerance
- ❑ Change in hat or glove size
- ❑ Dry Skin
- ❑ Glandular or Hormone Problem
- ❑ Swollen Glands
- ❑ Anemia
- ❑ Easily Bruise or Bleed
- ❑ Phlebitis
- ❑ Transfusion
- ❑ Immune System Disorder
- ❑ Other: _____
- ❑ *None in this Category*

Skin and Breasts:
- ❑ Rash or Itching
- ❑ Change in Skin Color
- ❑ Change in Hair or Nails
- ❑ Non-healing Sores
- ❑ Change of Appearance of a Mole
- ❑ Breast Pain
- ❑ Breast Lump
- ❑ Breast Discharge
- ❑ Other: _____
- ❑ *None in this Category*

Women Only:

Are you pregnant?
- ❑ Yes-Due Date _____
- ❑ No-Last Menstrual Period _____
- ❑ Infertility
- ❑ Painful or Irregular Periods
- ❑ Vaginal Discharge
- ❑ Other: _____
- ❑ *None in this Category*

Pregnancies with Outcome & Date

_____
_____
_____
_____

Is there anything else you would like the doctor to know? _____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. 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 chiropractic care.)

Patient or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache				Neck				Low Back		
No pain											**worst possible pain**
0	**1**	**(2)**	**3**	**4**	**(5)**	**6**	**7**	**(8)**	**9**	**10**	

---

1 – What is your pain RIGHT NOW?

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

2 – What is your TYPICAL or AVERAGE pain?

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

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

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

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

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

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) CONSENT FORM

RELEASE OF INFORMATION: Your Protected Health Information (PHI) will be used by this office and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this Consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

REQUESTING A RESTRICTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION: You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

REVOCATION OF CONSENT: You may revoke this Consent to the use and disclosure of your PHI. You must revoke this Consent in writing. Any use or disclosure that has occurred prior to the date on which your revocation of consent is received will not be affected.

CLINICAL SUMMARY REPORT (CCR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Next Level Chiropractic to save these electronically for me and not print them out after each visit. I understand that, upon my request, these reports are available to be printed or emailed to me for review.

I, _____ (print name), acknowledge that I have reviewed the above information and __ **DO** (or) __ **DO NOT** authorize this office to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for the purposes of processing my claim for benefits and payment of services rendered to me. I do understand that if I choose to refuse release of this information, my PHI will be used within the office for purposes of my care to those individuals designated by the doctor.

Signature of Patient/Guardian _____ **Date**_____

ASSIGNMENT OF BENEFITS/ASSIGNMENT OF CAUSE OF ACTION/CONTRACTUAL LIEN

Our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Your insurance should pay claims within 30 days from the date in which it was filed. In the event that your insurance company does not pay in a timely manner, you may be asked to contact your insurance carrier.

IRREVOCABLE ASSIGNMENT OF RIGHTS: I hereby assign the exclusive irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand for payment, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request. To any insurance company providing benefits or settlement of a claim, for any treatment rendered by this facility/physician within 15 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate check to pay in full all services rendered by this office.

I instruct checks to be made payable to Next Level Chiropractic, and payment to be sent to 554 W Ralph Hall Pkwy, Rockwall, TX 75032

This demand specifically conforms to Sec. 542.057 of theTexas Insurance Code and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court costs, and interest from judgment, upon violation. In the event my insurance settlement proceeds are paid directly to my attorney I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account and remit payment of all such sums directly to the above named doctor and/or treating facility upon receipt of my settlement award(s). I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by this facility/physician, in addition to reasonable cost of collection, including attorney fees and court costs incurred.

LIMITED POWER OF ATTORNEY: I hereby grant the above named facility/physician the power to endorse my name upon any checks drafts, or other negotiable instrument representing payment from any insurance company for treatment renderd by this office. I agree that any payment in excess of the charges for treatment rendered will be credited to my account or forwarded to my address.

REJECTION IN WRITING: I hereby authorize the above facility/physician to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request of the provider, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. If my carrier is uable to provide said rejections in a timely maner, I acknowledge that I am entitled to minimum levels of coverage as per section 1952.152 of the Texas Insurance Code, and further instruct my carrier to pay up to available limits directly to the facility named above.

If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

I, _____ (print name), in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to **Next Level Chiropractic**, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the above rights, power and authority.

Signature of Patient/Guardian _____ **Date**_____

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic procedures, various forms of physical therapy, physical examination, x-ray studies, and/or any clinical services that are deemed necessary in my case to be administered by the doctor and/or any support staff employed or contracted by this office or clinic. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy tecniques. The risks of complications due to chiropractic treatments have been labeled as “rare” and include, but are not limited to, muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fracture, disc injury, stroke, dislocation and sprains. I understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also be used to alleviate other symptoms through a conservative approach with hopes to avoid more invasive procedures. I further understand that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has the right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I further understand that there are other treatment options available for my condition, and that I have the right to a second opinion should I have concerns as to the nature of my symptoms and/or treatment options. If during the course of my care my insurance company requires me to take an examination from any other doctor, I will notify this facility/physician immediately. I understand that failure to do so may jeopardize my case.

I, _____ (print name), have read the above consent and I have had an opportunity to ask questions regarding its content. By signing below, I agree to the above-named procedures and intend this consent to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with this office.

Signature of Patient/Guardian _____ **Date**_____