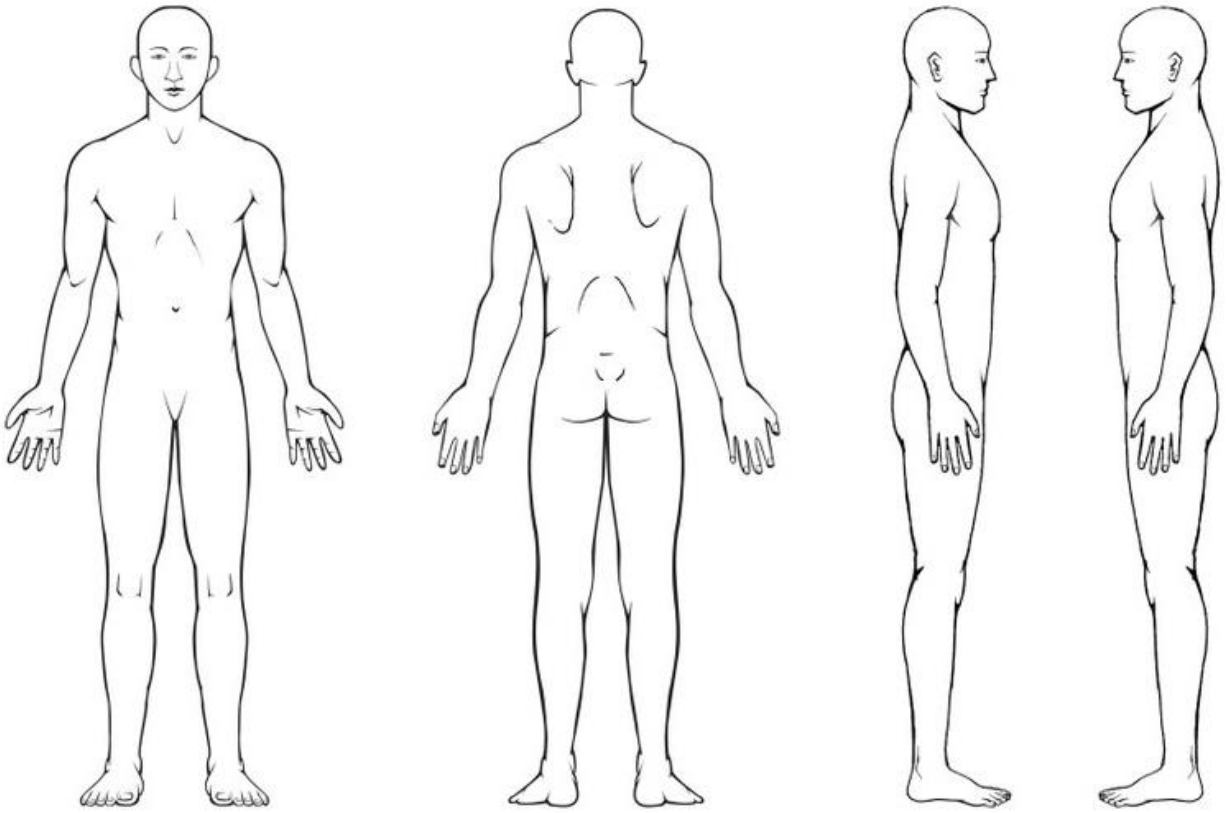
PAIN SENSATION SURVEY

On the diagram below, shade in the areas where you feel pain. If you have more than one area, circle the area that bothers you the most.



	YES	NO
Does your pain feel like pins and needles?	☐	☐
Does your pain feel hot/burning?	☐	☐
Does your pain feel numb?	☐	☐
Does the pain feel like electrical shocks?	☐	☐
Is your pain limited to your joints?	☐	☐

Please give a brief description of your pain below

CONFIDENTIAL PATIENT INFORMATION

First Name: _____ Middle Initial: ____ Last Name: _____

☐ Male ☐ Female Age: _____ Date of Birth: ____/____/____

Height: _____ Weight: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Social Security: _____ Driver's License/I. D: _____

Email Address: _____

Cell Phone: _____ Home Phone: _____

Occupation: _____ Business / Employer Name: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone Number: _____

Can the Dr. communicate with you via email & text? ☐ YES ☐ NO

How did you hear about our office? _____

YOUR GOALS

Which best describes your reason for consulting our office?

	I have a specific concern and require help only with this concern.
	I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.
	I want to be healthier in five years from now than I am today.

By signing below, I certify that the preceding questions have been answered truthfully and completely to the best of my knowledge and belief. I understand that I may be examined and treated by a licensed doctor, and that the treatment I receive shall be given as outlined by the doctor in charge of my case.

Patient/Guardian Signature _____ **Date** ____/____/____

Printed Name: _____

MUSCLE THERAPY INFORMED CONSENT AGREEMENT

Check all of the following health concerns that you have experienced in the last five years.

□ High/Low Blood Pressure	□ Endocrine/Thyroid Condition	□ Immune System Disorders	□ Pins & needles in arms
□ Surgery (Recent)	□ Loss of taste	□ Pregnancy	□ Swelling
□ Loss of smell	□ Skin conditions	□ Arthritis (Rheumatoid)	□ Loss of balance
□ Fibromyalgia	□ Ulcer	□ Scoliosis	□ Infection
□ Pins &needles in legs	□ Thrombophlebitis	□ Kidney dysfunction	□ Stroke
□ Hypertension	□ Numbness in fingers	□ Burns	□ Fractures
□ Myositis Ossificans	□ Bruise easily	□ Headache	□ Muscle/Joint Pain
□ Back pain	□ Heart condition	□ Memory Loss	□ Bladder problems
□ Anemia	□ Open Wounds	□ Cold sweats	□ Hemophilia
□ Numbness in toes	□ Cancer	□ Hematoma	□ Neck Pain/Stiffness
□ Circulatory problems	□ Neck Injury	□ Cold feet	□ Sensitive to touch
□ Surgery wound	□ Cold	□ Osteomyelitis	□ Urinary Difficulty
□ Diabetes	□ Osteoporosis	□ Varicose Veins	□ Deep Vein Thrombosis

Other Medical Conditions not listed above:

Check any medications you are currently taking or recently completed:

☐Diabetic Medications ☐ Hypertension Medications ☐ Chemotherapy Medications ☐ Pain Medications ☐ Steroid Medications

I consent to soft tissue manipulation therapy through one or more of the following modalities: massage therapy, percussion therapy, and instrumented assisted soft tissue manipulation. I understand the side effects of soft tissue manipulation therapy may include temporary pain or discomfort, bruising, swelling, and a sensitivity or allergy to massage oils. I understand that the soft tissue manipulation is for the purpose of (stress reduction, pain reduction, relief from muscle tension, increasing circulation, or specific reasons stated here). If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that soft tissue manipulation practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. I understand that soft tissue manipulation therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have. Because soft tissue manipulation therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. A statement that if the client is uncomfortable for any reason, the client may ask the therapist to cease the massage and the therapist will do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Patient/Guardian Signature _____ **Date** ____/____/____

Printed Name: _____

INFORMED CONSENT FOR CUPPING THERAPY

Cupping therapy utilizes negative pressure, rather than tissue compression, for superior results in a wide array of bodywork techniques. I understand that I may also be given cupping as part of my treatment to promote circulation and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: short term bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable. By signing below, you understand the terms listed above.

Patient/Guardian Signature _____ **Date** ___/___/___

Printed Name: _____

INFORMED CONSENT FOR CRYOTHERAPY & COMPRESSION THERAPY

What is Cryotherapy?

Ice therapy also known as cryotherapy, is one of the most widely known and used treatment modalities for acute injuries. The application of ice to an injury alongside with compression, can decrease the extent of the tissue damage. It achieves this in a number of different ways: decreases the amount of inflammation called vasoconstriction, reduces pain, and reduces muscle spasm.

What is Compression Therapy?

Compression therapy is an effective method by which controlled pressure is applied to the extremities in order to increase blood flow and the efficiency of the lymphatic and venous systems. Benefits of compression therapy include increased range of motion, lessens pain sensitivity, treatment for DOMS (delayed onset muscle soreness), and decreases muscle fatigue after acute exercise.

Contraindications for Cryotherapy & Compression Therapy

Cryotherapy & compression therapy is contraindicated for patients with: acute paroxysmal cold hemoglobinuria or cryoglobulinemia, acute deep vein thrombosis, severe atherosclerosis or other ischemic vascular diseases, suspect or known acute deep vein thrombosis, severe congestive cardiac failure, existing pulmonary edema, existing pulmonary embolism, extreme deformity of the limbs, any local skin or tissue condition which the garments would interfere with such as gangrene, untreated or infected wounds, recent skin graft, and dermatitis; known presence of malignancy in the legs; limb infections, including cellulitis, that have not received antibiotic coverage; presence of Lymphangiosarcoma.

Knowing the risks involved and the contraindications related, I nevertheless chose voluntarily to request permission to participate. By signing below, you understand the terms listed above.

Patient/Guardian Signature _____ **Date** ___/___/___

Printed Name: _____

INFORMED CONSENT FOR SPINAL DECOMPRESSION

What is Spinal Decompression
Spinal distraction (spinal decompression) is used as a treatment option to relieve back pain resulting from herniated, bulging, or protruding discs associated with various spine injuries and pathologies. Stretching the spine helps reduce pressure on the intervertebral disc, relieves compression and irritation of the nerve roots and improves sagittal spine alignment.

Contraindications for Spinal Decompression
Spinal decompression therapy is contraindicated and not recommended for patients with: broken vertebrae, spinal fusions, artificial discs, implants in spine, osteoporosis, spondylolisthesis, spinal stenosis, spinal tumor, ankylosing spondylitis, any condition that may compromise the integrity of the spine, and any condition requiring the patient to take blood thinner medication.

Knowing the risks involved and the contraindications related, I nevertheless chose voluntarily to request permission to participate. By signing below, you understand the terms listed above.

Patient/Guardian Signature _____ **Date** ___/___/___

Printed Name: _____

INFORMED CONSENT FOR WINBACK (TECAR THERAPY)

What is WinBack?
Winback (tecar therapy) accelerates healing, relieves pain and improves movement naturally. It is a high-frequency, non-invasive energy which boosts your body's natural ability to repair itself. It reduces pain, restores movement and increases blood flow. Winback may be incorporated into your session and can be combined with manual therapy as well as other active rehabilitation techniques.

Contraindications for TECAR Therapy?
Tecar therapy is contraindicated for patients presenting with: pregnancy, internal or external electronic monitoring devices (such as pacemaker, insulin pump, neurostimulator), fever, infection, active cancerous lesions, blood clotting disorders (i.e. DVT, Hemophilia), insensitivity to heat or pain, and/or active growth plates.

Knowing the risks involved and the contraindications related, I nevertheless chose voluntarily to request permission to participate. By signing below, you understand the terms listed above.

Patient/Guardian Signature _____ **Date** ___/___/___

Printed Name: _____

X-RAY INFORMED CONSENT AGREEMENT

I authorize the performance of diagnostic x-ray examination of myself by Reform Chiropractic.

Patient/Guardian Signature _____ **Date** ____/____/____

Printed Name: _____

-If Patient is a Minor:

I am the parent or legal representative of _____ who is a minor of, _____ years of age. I authorize the performance of diagnostic x-ray of this minor to be done by Reform Chiropractic.

Signed: _____ **Date:** _____/_____/_____

-If Female: Regarding Possibility of Pregnancy:

This is to certify that, to the best of my knowledge, I am not pregnant, and Reform Chiropractic has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed: _____ **Date:** _____/_____/_____

By signing this form, I am acknowledging that Reform Chiropractic is not responsible for any diagnostic reading of x-rays or any written x-ray reports. Reform Chiropractic does not have any board-certified radiologist on staff. Although, if there are any substantial findings on the X-Rays taken within the office, the doctor will send your X-Rays to a board-certified radiologist for a second opinion and report.

Patient/Guardian Signature _____ **Date** ____/____/____

Printed Name: _____

INSURANCE INFORMATION

Patient Name: _____ DOB: ___/___/___

Insurance Company: _____ Type: PPO HMO EPO

ID/SS #: _____ Group #: _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR FROM HEALTH INSURANCE COMPANY

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

Reform Chiropractic
10345 Lakewood Blvd. Downey, CA 90241

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. 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 this case.

PAYMENT AGGREEMENT

I understand and agree that my co-payment, co-insurance, and deductibles are due and payable at the time of service. I understand that charges not covered by my insurance company, as well as, applicable co-payments and deductibles are my responsibility. In some special cases insurance companies will not compensate for rendered services even though you may have the appropriate benefits. In this case you would be responsible for payment of previously rendered services. By signing below, you understand the terms listed above.

Patient/Guardian Signature _____ **Date** ___/___/___

Printed Name: _____

APPOINTMENT CANCELLATION POLCIY

We strive to render excellent chiropractic care to you and the rest of our patients. In an attempt to be respectful towards all patient needs, we have an Appointment Cancellation Policy. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time can be used to treat another patient in need of care.

How to cancel:

To cancel appointments, please call 562-287-8884. If you do not reach the receptionist, please leave a voicemail. If you would like to reschedule your appointment, please be sure to leave us your phone number and the best time to return your call.

You may also reply to your text reminder that you are unable to make your appointment, and someone from our team will confirm your cancelation.

Our cancellation policy is as follows:

We require that you give our office **24-hour notice** in the event that you need to reschedule your appointment. If you miss an appointment without contacting our office within the 24 hours, this will be considered a missed appointment.

Cancelation Policy for Personal Injury Patients

If you miss appointments as mentioned below

- **Three consecutive missed appointments**

OR

- **Five missed appointments in total**

Your case may be subject to review and possible discontinuation of treatment.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have. By signing below, you understand the terms and conditions listed above.

Patient/Guardian Signature _____ **Date** ____/____/____

Printed Name: _____

INFORMED CONSENT TO CHIROPRACTIC CARE

Congratulations for having chosen the safest and most natural health care program ever conceived.

This painless and effective approach to health has been serving everyday people for over 100 years. It is licensed in every state, and in many countries. Chiropractic has the least chance of side effects of any other type of health care.

Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. Mild headaches and muscles soreness/stiffness may sometimes occur. Other rare complications usually caused by an underlying existing condition may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue.

Let's look at a few statistics about possible serious side effects:

The #1 cause of death in the US is from correctly and incorrectly prescribed pharmaceutical drugs. (CDC, FDA, NIH sites, also Gary Null: Death by Medicine)

Stroke is one of the most common causes of death in the US. With people going to doctors all the time it is probable that many will have had a recent doctor visit. But causation is another matter entirely.

There is no absolutely known material risk of chiropractic care being greater than risks from medical treatment. In fact, when all the factors are taken together, deaths and injuries from a combination of medical mistakes and intentional drugs dwarf any injuries from chiropractic.

Risk of stroke from chiropractic? Virtually zero chance of stroke from chiropractic. The largest study ever done – the 2008 study in Canada – www.belleviewchiro.com/index.php?p=213660 – looking at 12 million people over 9 years, showed that 53% of strokes had visited their MD within 30 days prior, while only 4% had visited their DC. No evidence of excess risk of stroke associated with chiropractic care.

In 2001 the Canadian Medical Association Journal found there is only a one-in-5.85-million risk that a cervical manipulation from an MD, PT, or DC would be followed by a stroke. Author David Cassidy, a professor of epidemiology at the University of Toronto said patients had already damaged the artery before seeking help from either a medical doctor or a chiropractor, and then the stroke occurred after the visit speaking of risks associated with chiropractic, we should look also at the risk associated with NOT GETTING adjusted. This risk was one of the 4 components of risk in the Association of Chiropractic Colleges guidelines on informed consent in 2008. Disc degeneration, loss of mobility, loss of overall tone, decreased quality of life – these are real risks of the untreated spine as time goes by.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

Patient/Guardian Signature _____ **Date** ____/____/____

Printed Name: _____

NOTICE OF PRIVACY PRACTICES AT REFORM CHIROPRACTIC

At Reform Chiropractic, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. Please review carefully.
The law permits us to use or disclose your health information to those involved in your treatment. an example would be if a referral to a specialist word deem necessary by your physician, your file would be available for review.
We may use or disclose your house information for payment of service. An example, we may send a report of your progress to your insurance company.
We may use or disclose your health information for your normal healthcare operation. An example, one of our staff will enter your information into our computer system.
We may use your information to contact you. We will use whatever address or telephone number you prefer. We may call you to remind you of an appointment, reschedule an appointment, or request billing information. If you are not home, we may leave a message on your answering machine or with whoever answers the phone. We may also send your reminder postcards to your home.
Our facility utilizes an open sign in sheet, a thank-you referral board, and open appointment book and our computer screens are visible from the appointment window. while our examination, X-ray, and treatment rooms are private. Please be assured that our staff and the doctor will take every precaution not to disclose any confidential information. If there is more private information that you need to discuss, please request a private room.
In an emergency, we may disclose your health information to a family member or other person responsible for your care. We met release some of your health information on required by law.
If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your healthcare information without prior written authorization.
You may request in writing that we not use or disclose your health information as described above. We will let you know if we could fulfill your request.
You have the right to transfer copies of your health information to another practice. We will forward your files for you.
You have the right to see and receive a copy of your health information, with a few exceptions. Give us written request regarding information you want to see. If you want a copy of your records, we may charge you a reasonable fee.
You have the right to request an amendment or change your health information. give us your request to make a change in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but we will be happy to include your statement in your file. If we agree to amend or change, we will not remove nor alter existing documents, but we will add new information.
You have the right to receive a copy of this notice. If we change any of the details in this notice, we will notify you of the changes in writing, you may file complaint with the department of health and human services, 200 Independence Avenue S.W. Room 509 F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However before filing a complaint or for more information or assistance regarding your health information privacy, please contact our privacy office, 562-287-8884. This notice goes into effect August 1st 2018.

Acknowledgement

I have received a copy of the Reform Chiropractic notice of privacy practices.

Patient/Guardian Signature _____ **Date** ____/____/____

Printed Name: _____

ACCIDENT / INJURY DETAILS

What type of injury did you sustain? □ Auto Accident □ Slip and Fall □ Pedestrian Hit by a Car
□ Bicycle Hit by a Car □ Other _____

If auto accident, who was determined to be at-fault? □ I was at-fault □ The other driver was at-fault

YOUR AUTOMOBILE INSURANCE INFORMATION

Insurance Company: _____ Claim# _____

Claims Adjuster Name: _____ Phone: _____

Your Agent's Name: _____ Phone: _____

Do you have Medical Payments on your policy? □ Yes □ No □ Not sure

If yes, what are the limits of coverage for medical payments? □ $1,000 □ $5,000 □ Other:

YOUR ATTORNEY'S INFORMATION

Attorney's Name: _____ Phone: _____

Case Manager's Name: _____ Phone: _____

□ I do not have an attorney, but would like a referral to one who can help me!

□ I do not have an attorney and would prefer not to work with one.

OTHER PARTY'S AUTOMOBILE INSURANCE INFORMATION

Insurance Company: _____ Claim# _____

Claims Adjuster Name: Phone:

DETAILS OF THE ACCIDENT / INJURY

1) Date injury occurred: _____ □ Morning □ Afternoon □ Evening

2) I was the □ Driver □ Front Seat Passenger □ Rear Seat Passenger □ Pedestrian □ Bicycle Rider

3) How many other people were in your vehicle? _____

4) Were you wearing a seat belt? □ Yes □ No

5) Did your airbags deploy? □ Yes □ No

6) I was struck from: □ Behind □ Front □ Right Side □ Left Side

7) My vehicle was: □ Stopped □ Turning □ Slowing Down □ Starting to Move

8) Did you lose consciousness? □ Yes □ No If Yes, for how long? _____

9) Were the Police notified? □ Yes □ No

10) Were you taken to the hospital or Urgent Care immediately following the accident? □ Yes □ No

NATURE OF YOUR INJURIES

11) In your own words, please describe the accident:

12) Did you have any physical complaints BEFORE the accident? □ Yes □ No

13) If Yes, please describe: _____

14) What did you feel immediately following the accident?

Please check all symptoms that you have experienced AFTER the accident:

□ Anxiety	□ Depression	□ Immune System Disorders	□ Numbness/tingling
□ Arthritis	□ Diarrhea	□ Infertility	□ Pins & needles
□ Asthma	□ Digestive problems	□ Kidney disease	□ Ringing in ears
□ Back pain	□ Dizziness	□ Loss of balance	□ Sensitivity to light
□ Bladder problems	□ Fainting	□ Loss of smell	□ Sinus trouble
□ Buzzing in ears	□ Fatigue	□ Loss of taste	□ Skin conditions
□ Cancer	□ Headaches	□ Menstrual cramps	□ Sleeping problems
□ Cold feet	□ Heartburn/Acid reflux	□ Menstrual Irregularity	□ Stomach upset
□ Cold hands	□ Heart condition	□ Mood Swings	□Tension
□ Cold sweats	□ Hot Flashes	□ Neck Pain/Stiffness	□ Ulcers
□ Constipation	□ Irritability	□ Nervousness	□ Urinary difficulty
□ Other:			

HOW ARE YOUR INJURIES AFFECTING YOUR DAILY LIFE?

15) Have you missed work or school as a result of the accident? □ Yes □ No

16) Do you notice any physical restrictions since the accident? □ Yes □ No

17) If Yes, please describe: _____

18) List any physical or mental activities that have been affected negatively since the accident:

SENSATION SURVEY

1. How frequently do you get headaches?

☐ Never ☐ 1x/month ☐ 1x/week ☐ 1x/day ☐ Many times a day ☐ Other:

On a scale of 0-10 how painful are your headaches?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Very Painful

2. How often do you have pain, stiffness or soreness in your neck?

☐ Never ☐ 1x/month ☐ 1x/week ☐ 1x/day ☐ Many times a day ☐ Other:

On a scale of 0-10 how bad is the discomfort?

No Discomfort 0 1 2 3 4 5 6 7 8 9 10 Serious Discomfort

3. Do you ever get any numbness/tingle/pain in your arms/hands?

☐ Never ☐ 1x/month ☐ 1x/week ☐ 1x/day ☐ Many times a day ☐ Other:

4. How often do you have pain, stiffness or soreness in your mid to upper back?

☐ Never ☐ 1x/month ☐ 1x/week ☐ 1x/day ☐ Many times a day ☐ Other:

On a scale of 0-10 how bad is the discomfort?

No Discomfort 0 1 2 3 4 5 6 7 8 9 10 Serious Discomfort

5. Do you ever get any numbness/tingle/pain in your ribs or chest?

☐ Never ☐ 1x/month ☐ 1x/week ☐ 1x/day ☐ Many times a day ☐ Other:

On a scale of 0-10 how bad is the discomfort?

No Discomfort 0 1 2 3 4 5 6 7 8 9 10 Serious Discomfort

6. How often do you have pain, stiffness or soreness in your low back?

☐ Never ☐ 1x/month ☐ 1x/week ☐ 1x/day ☐ Many times a day ☐ Other:

On a scale of 0-10 how bad is the discomfort?

No Discomfort 0 1 2 3 4 5 6 7 8 9 10 Serious Discomfort

7. Do you ever get any numbness/tingle/pain in your legs/feet?

☐ Never ☐ 1x/month ☐ 1x/week ☐ 1x/day ☐ Many times a day ☐ Other:

On a scale of 0-10 how bad is the discomfort?

No Discomfort 0 1 2 3 4 5 6 7 8 9 10 Serious Discomfort

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me (or my minor child-under 18) for further evaluation:

Patient/Guardian Signature _____ **Date** ____/____/____

Printed Name: _____

Doctor's Lien

Authorization and Agreement to Pay Physician's Fees
once proceeds are released from insurance company to patient

Patient Name: _____ Date of Injury: _____

I hereby authorize and direct you, or the attorney, and any subsequent attorney, to pay promptly Reform Chiropractic from my portion of the proceeds out of any recovery which may be paid to me, as a result of the professional services rendered up to the time of settlement or recovery as well as those appearances on my behalf.

I fully understand that I am directly and fully responsible to Reform Chiropractic for all medical bills submitted by Reform Chiropractic for service rendered to me and that this agreement is made solely for Reform Chiropractic's protection and in consideration of Reform Chiropractic awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. If the case is dropped, denied, no recovery or settled without satisfying the present lien I will be fully responsible for my medical cost for service performed by Reform Chiropractic.

In the event Reform Chiropractic shall have to bring legal action to enforce the terms hereof, Reform Chiropractic shall be entitled to recover court costs and all reasonable attorney's fees. In the event said doctor is called upon by me or any attorney to testify in court, arbitration hearing, deposition any dull constitutional tribunal as a result of legal action from the injuries sustained on the date indicated above further understand and agree that I will be responsible for a fee payable in advance. The said fee will apply for opinion, reading medical records or interpretation of medical record or for any other purpose. I further authorize said doctor to furnish additional reports. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date: _____ Signed: _____
(Patient Name)

For Attorney Only: Please sign below and return one copy to Reform Chiropractic. The following information is required prior to your receipt of a narrative report and itemized statement.

Defendant's Insurance Company: _____

Address & Phone # _____

_____

Adjuster & Claim # _____

The undersigned, being the attorney of record on his behalf and on behalf of any other attorney or attorneys which have been associated with the undersigned or who are substituted in his stead for the above patient does hereby acknowledge receipt of a copy of this assignment and lien, and agrees to withhold such sums from the patient's share of any settlement, judgment or verdict as may be necessary to adequately protect said doctor.

Date: _____ Attorney: _____

Signature: _____