



**THE BACK  
ALLEY**  
CHIROPRACTIC & MASSAGE

**PERSONAL INJURY INTAKE & QUESTIONNAIRE**

*Please take the time to complete these forms to the best of your ability. If you have any questions we will be glad to help you.*

Patient Full Name \_\_\_\_\_ Gender:  Male  Female

**Home Address** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Billing Address** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email Address \_\_\_\_\_

By providing an email address, you are giving explicit consent and agree to receive communication and marketing emails (see our HIPAA notice for more details)

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Name of person, place, or physician who referred you so that we may thank them \_\_\_\_\_

*To the best of my ability, the information I have supplied is complete and truthful. At any time, I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and may be released. I grant permission to be called or emailed to confirm or reschedule an appointment and to be sent occasional cards, letters or emails as an extension of my care in this office.*

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE**

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices. I understand that this information can and will be used to:

- ◆ Conduct, plan and direct my treatment and follow-up among health care providers who may be directly and indirectly involved in providing my treatment
- ◆ Obtain payment from third party payers
- ◆ Conduct normal health care operations such as quality assessments and accreditation

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT TO TREATMENT OF A MINOR**

I, \_\_\_\_\_, hereby authorize The Back Alley Chiropractic clinic/doctor/assistants to administer chiropractic treatment as deemed necessary to my son/daughter/legal dependent \_\_\_\_\_.

This authorization shall remain effective until \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, unless sooner revoked in writing.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

COVERAGE INFORMATION

Self Pay     Health Insurance     Auto Insurance (MEDPAY)     Third Party Auto Insurance     Attorney

**Health** Insurance Company \_\_\_\_\_

Member ID # \_\_\_\_\_

Group # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Policy Holder Mailing Address \_\_\_\_\_

**Your** Auto Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_

Claim # \_\_\_\_\_

Adjustor Name \_\_\_\_\_

Phone # \_\_\_\_\_

**Third** Party Auto Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_

Claim # \_\_\_\_\_

Adjustor Name \_\_\_\_\_

Phone # \_\_\_\_\_

**Attorney** Name \_\_\_\_\_

Firm Name \_\_\_\_\_

Phone # \_\_\_\_\_

- I authorize the release of any medical or other information necessary to process my claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
- I authorize payment of medical benefits to The Back Alley Chiropractic and its physicians or supplier for services received.

Print Patient Name \_\_\_\_\_

Patient or Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatment (also known as CMT, chiropractic adjustments or chiropractic manipulative treatment) and any other associated procedures; physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedure, that there are certain complications that may arise during CMT. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner’s Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon facts known, are in my best interest. I have had the opportunity to discuss nature, purpose and risks of chiropractic treatment and other recommended procedures with the doctor and/or with office staff and/or clinic personnel.

I have read, or have had read to me, the above explanation of the CMT. I state that I have been informed and weighed the risks involved in CMT. I have decided that it is in my best interest to receive CMT. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient or Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Arizona Revised Statute §20-263

(Patient information for personal injury regarding MEDPAY use)

Arizona Revised Statutes, Title 20 Insurance, Chapter 2 Transaction of Insurance Business, Article 2 Kinds of Insurance; Reinsurance; Limits of Risk, 20-263 vehicle insurance; prohibited act by insurer; hearing; penalty:

A. No insurer shall increase the motor vehicle insurance premium of an insured as a result of an accident not caused or significantly contributed to by the actions of the insured. Any insurer which increases the premium as a result of accident involvement shall notify the insured of the reason for such increase.

B. The director, after a hearing, shall order an insurer that has raised the premium of an insured in violation of subsection A to refund the amount attributable to such premium increase and shall impose a civil penalty not to exceed three hundred dollars. In determining whether an insurer has violated subsection A, the director may conduct such investigation as he deems necessary and the costs shall be paid by the insurer pursuant to section 20-159.

## ACCIDENT INFORMATION

Date of Accident \_\_\_\_\_ Time \_\_\_\_\_ AM / PM (circle one)  
Address/Intersection \_\_\_\_\_ City, State \_\_\_\_\_  
In your own words, describe **in detail** how the accident occurred \_\_\_\_\_  
\_\_\_\_\_

Were you the  Driver  Front passenger  Rear passenger  Pedestrian  Cyclist

What direction were you traveling?  North  South  East  West

Did your vehicle hit the other vehicle?  Yes  No Did the other vehicle hit your vehicle?  Yes  No

-If yes, were you struck from  Front  Behind  Driver side  Passenger side

Were you  Aware of the approaching impact  Surprised by the impact

Is there a police/accident report?  Yes  No Were any traffic citations issued?  Yes  No

-If yes, citation(s) issued to  You  Driver of your vehicle  Driver of the other vehicle

Did you go to the hospital?  Yes  No -If yes, name of hospital \_\_\_\_\_

Have you lost time from work?  Yes  No -If yes, dates missed \_\_\_\_\_

Was your vehicle a rental?  Yes  No Was your vehicle a company car?  Yes  No

Make/model of your vehicle \_\_\_\_\_ Make/model of other vehicle \_\_\_\_\_

Were you wearing your seatbelt?  Yes  No Did you lose consciousness?  Yes  No

Did your head hit anything?  Yes  No -If yes, what \_\_\_\_\_

Did your neck hit anything?  Yes  No -If yes, what \_\_\_\_\_

Did your chest hit anything?  Yes  No -If yes, what \_\_\_\_\_

Did your knees hit anything?  Yes  No -If yes, what \_\_\_\_\_

Did your feet hit anything?  Yes  No -If yes, what \_\_\_\_\_

How was your head positioned during the accident? \_\_\_\_\_

How was your torso positioned during the accident? \_\_\_\_\_

How were your hands positioned during the accident? \_\_\_\_\_

Please check any symptoms you have noticed since the accident

- |  |   |   |  |   |
|--|---|---|--|---|
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Back pain      | <input type="checkbox"/> Blurred vision   | <input type="checkbox"/> Chest pain      | <input type="checkbox"/> Cold sweats      |
| <input type="checkbox"/> Depression        | <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Fainting         | <input type="checkbox"/> Fatigue         | <input type="checkbox"/> Fever            |
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Hearing loss   | <input type="checkbox"/> Irritability     | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Loss of memory   |
| <input type="checkbox"/> Loss of smell     | <input type="checkbox"/> Loss of taste  | <input type="checkbox"/> Neck Pain        | <input type="checkbox"/> Neck stiff      | <input type="checkbox"/> Nervousness      |
| <input type="checkbox"/> Numbness          | <input type="checkbox"/> Painful joints | <input type="checkbox"/> Pins and needles | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Short of breathe |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Tension        | <input type="checkbox"/> Upset stomach    |  |   |

Print Patient Name \_\_\_\_\_

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

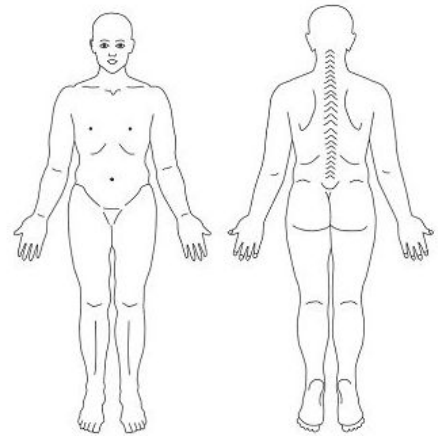
Are you pregnant?

Yes  No

Use the following abbreviations to indicate your symptoms on the illustration to the right:

- SS** = Spasms
- DP** = Dull Pain
- SH** = Shooting Pain
- NU** = Numbness

- ST** = Stiffness
- SP** = Sharp Pain
- TI** = Tingling
- O** = Other



When did you first notice your symptoms? \_\_\_\_\_

How extreme are your symptoms? (circle one)

0	1	2	3	4	5	6	7	8	9	10
Absent						Uncomfortable				Agonizing

How often are your symptoms present?

0-25%                       26-50%                       51-75%                       76-100%

What activities **worsen** the symptoms? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What tends to **lessen** the symptoms? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How does your **current condition** interfere with your:

Work career \_\_\_\_\_

\_\_\_\_\_

Recreational activities \_\_\_\_\_

\_\_\_\_\_

Household responsibilities \_\_\_\_\_

\_\_\_\_\_

Personal relationships \_\_\_\_\_

\_\_\_\_\_

Please list all prescription and over-the-counter medications you are **currently** using:

Prescription \_\_\_\_\_

Over-the-counter \_\_\_\_\_

Supplements/vitamins \_\_\_\_\_

*To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. Inaccurate information could be dangerous to my health. If there is any change in my medical status I will notify the chiropractor immediately. I authorize the chiropractor and staff to perform any necessary services needed during diagnosis and treatment.*

Print Patient Name \_\_\_\_\_

Patient or Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

## HEALTH HISTORY

### **Illnesses** Please check any illnesses that you've **had** OR currently **have**

- |   |                                    |  |   |                                       |
|---|------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Chicken pox/shingles | <input type="checkbox"/> Diabetes     |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Gout      | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke    | <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> Typhoid fever        |                                       |

### **Review of Systems** Please check any condition that you've **had** OR currently **have**

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> Angina              | <input type="checkbox"/> Anorexia          | <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Asthma             |
| <input type="checkbox"/> Back problems       | <input type="checkbox"/> Blurred vision    | <input type="checkbox"/> Chronic ear infection | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Depression         |
| <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Elbow/wrist pain      | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Excessive bruising |
| <input type="checkbox"/> Fainting            | <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Food sensitivities    | <input type="checkbox"/> Foot/ankle pain    | <input type="checkbox"/> Frequent infection |
| <input type="checkbox"/> Hair loss           | <input type="checkbox"/> Hay fever         | <input type="checkbox"/> Headache              | <input type="checkbox"/> Hearing loss       | <input type="checkbox"/> Heartburn          |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol  | <input type="checkbox"/> Hip disorders         | <input type="checkbox"/> Immune disorders   | <input type="checkbox"/> Kidney stones      |
| <input type="checkbox"/> Knee injury         | <input type="checkbox"/> Loss of smell     | <input type="checkbox"/> Loss of taste         | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Low energy         |
| <input type="checkbox"/> Neck pain           | <input type="checkbox"/> Numbness          | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Pins and needles   | <input type="checkbox"/> Pneumonia          |
| <input type="checkbox"/> Poor appetite       | <input type="checkbox"/> Poor circulation  | <input type="checkbox"/> Poor posture          | <input type="checkbox"/> Prostate issues    | <input type="checkbox"/> Ringing in ears    |
| <input type="checkbox"/> Scoliosis           | <input type="checkbox"/> Shoulder problems | <input type="checkbox"/> Skin cancer           | <input type="checkbox"/> Swollen glands     |   |
| <input type="checkbox"/> Thyroid issues      | <input type="checkbox"/> TMJ issues        |  |   |   |

### **Operations** Please check any operations that you've ever **had**

- |   |   |   |   |                                      |
|---|---|---|---|--------------------------------------|
| <input type="checkbox"/> Appendix removal | <input type="checkbox"/> Bypass surgery | <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Elective surgery | <input type="checkbox"/> Eye surgery |
| <input type="checkbox"/> Hysterectomy     | <input type="checkbox"/> Pacemaker      | <input type="checkbox"/> Spine            | <input type="checkbox"/> Tonsillectomy    |                                      |

### **Treatments** Please check the treatments you've received in the **past** OR are **currently** receiving

- |  |                                      |  |  |                                       |
|--|--------------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> Acupuncture         | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Chiropractic care   | <input type="checkbox"/> Dialysis    | <input type="checkbox"/> Dietary supplements | <input type="checkbox"/> Herbs             | <input type="checkbox"/> Homeopathy   |
| <input type="checkbox"/> Hormone replacement | <input type="checkbox"/> Inhaler     | <input type="checkbox"/> Massage therapy     | <input type="checkbox"/> Physical therapy  | <input type="checkbox"/> Other _____  |

### **Social History** Please tell the doctor about your health habits

- |                |  |                 |
|----------------|--|-----------------|
| Alcohol use    | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ |
| Coffee use     | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ |
| Exercise       | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ |
| Pain relievers | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ |
| Soft drinks    | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ |
| Tobacco use    | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ |
| Water intake   | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | How much? _____ |

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. Inaccurate information could be dangerous to my health. If there is any change in my medical status I will notify the chiropractor immediately. I authorize the chiropractor and staff to perform any necessary services needed during diagnosis and treatment.

Print Patient Name \_\_\_\_\_

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## OFFICE POLICY

### Appointments

We value the time we have set aside to see you. The Back Alley Chiropractic is a multiple provider office and we must often schedule overlapping appointments according to the service requested and depending on the treatment required.

Walk-ins are **always** welcome, however, appointments will be seen first.

If you are late for your appointment, we will do our best to accommodate you.

We strive to minimize wait time, however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

**If you have not been seen in our office in 18 months or longer, or if you have a new or different injury, a re-exam will be carried out and charged to you or your insurance carrier.** If you have not been seen in our office in 3 years or longer, you are considered a new patient.

### Self-Pay Patients

We welcome patients whose insurance companies are out-of-network, do not provide chiropractic benefits, or are uninsured.

We recommend you keep a copy of our updated fee schedule for your records. All payments are to be paid in full at the time services are rendered.

Insurance **cannot** be used when opting for a Prompt Pay Fee service discount.

## FINANCIAL POLICY

**Payment** We accept cash, check, and debit, Visa, MasterCard and Discover. There is a minimum fee of \$25 charged for returned checks.

**Insured** By request, as a courtesy to our patients, we will submit your medical claim to your insurance carrier. Patient balances are billed immediately upon receipt of your carriers EOB. Your remittance is due immediately upon receipt of our bill.

**Self-Pay** We offer a Prompt Pay fee discount for all patients by request. If you fail to provide payment at the time services are rendered, you will be responsible for and billed for 100% of the professional fee. You can request a copy of our updated fee schedule at any time.

**Delinquent Accounts** Unpaid balances are past due at 30 days. Balances left unpaid may receive a second and third notice prior to final notice, mailed at 30-day intervals. The Back Alley utilizes an outside collection agency. Balances over 120 days past due may be submitted to our collection agency.

**Medicare** We accept Medicare assignment. As a Medicare patient you are responsible for your deductible and co-insurance. If you have secondary or supplemental insurance we will bill it for you. Medicare non-covered services are due at the time of service.

**Workers Compensation** If you are here as a result of a work related injury; we will require information regarding your health insurance and your employers Workers Compensation insurance.

**Personal Injury Claims** We bill third party insurance carriers **only** on a lien basis. Please notify our staff of your personal injury immediately. You will be asked to complete forms specific to personal injury as well as a consent and notice for medical lien.

## INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatment (also known as CMT, chiropractic adjustments or chiropractic manipulative treatment) and any other associated procedures; physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedure, that there are certain complications that may arise during CMT. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon facts known, are in my best interest. I have had the opportunity to discuss nature, purpose and risks of chiropractic treatment and other recommended procedures with the doctor and/or with office staff and/or clinic personnel.

I have read, or have had read to me, the above explanation of the CMT. I state that I have been informed and weighed the risks involved in CMT. I have decided that it is in my best interest to receive CMT. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

I have read and understand the above policies and agree to accept responsibility for any and all payment(s) due as outlined.

Print Patient Name \_\_\_\_\_

Patient or Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



**THE BACK  
ALLEY**  
CHIROPRACTIC & MASSAGE

**PATIENT CONSENT FOR NOTICE AND CLAIM OF MEDICAL LIEN**

Patient Full Name \_\_\_\_\_

Date of Accident \_\_\_\_\_ Claim # \_\_\_\_\_

State of Accident \_\_\_\_\_ Provider \_\_\_\_\_

I, \_\_\_\_\_ (Patient), the undersigned, hereby consent to examination, treatment, procedures, and services performed by any and all providers at The Back Alley Chiropractic and Massage (Provider), including emergency treatment.

Patient hereby authorizes, \_\_\_\_\_ (Attorney), (if applicable) to keep Provider advised of the progress of Patient's court case at reasonable intervals. Patient further authorizes and directs Attorney to pay Provider directly any sums due for medical services rendered to Patient. Patient directs Attorney to withhold such funds from any settlement, claim, judgment, verdict or result of said claim. Patient hereby notifies Attorney that Patient is giving Provider a lien on these benefits or settlement proceeds.

Patient understands that a copy of the Notice and Claim of Medical Lien will be filed with the Pima County recorder Office pursuant to A.R.S. §33-932. In consideration for Provider having agreed to treat me without payment at the time of service, this lien is irrevocable and can only be satisfied by full payment of all sums due for medical services rendered. Patient authorizes Provider to notify Attorney of this lien at Provider's discretion. Patient understands that any settlement, claim, judgment or verdict proceeds cannot be disbursed to Patient without first satisfying this lien.

Should a dispute arise regarding payment of Provider's charges, Patient authorizes and directs Attorney to hold in escrow all monies sufficient to satisfy this lien until the dispute can be resolved. Patient acknowledges that it would be a violation of Attorney's ethical duties to disburse the disputed funds prior to resolution of the lien dispute.

Patient understands and agrees that even though this lien has been given, Patient remains personally responsible for payment in full of Provider's fees for all services rendered. Patient is solely responsible to make appropriate arrangements for payment of such fees, including but not limited to insurance benefits. Patient acknowledges that this obligation to pay Provider's fees is not dependent on the outcome of Patient's court case.

I, the undersigned, understand that if the settlement, claim, judgment, or verdict does not cover my entire bill at The Back Alley Chiropractic and Massage, I am still responsible for the remainder and payment of the charges. The bill is not contingent on any settlement, claim or judgment which I may eventually recover.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

----- Attorney's Acceptance of Provider's Lien -----

Being the attorney of record or authorized representative, I acknowledge receipt of my client's consent to Notice and Claim of Medical Lien and agree to honor the same.

Attorney Name \_\_\_\_\_

Attorney Signature \_\_\_\_\_ Date \_\_\_\_\_

Firm Name \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Mailing Address \_\_\_\_\_



# THE BACK ALLEY

CHIROPRACTIC & MASSAGE

## Authorization to Use or Disclose Protected Health Information

You have a right to receive a completed copy of this form. Photocopy/fax copy may be used as original. **Note to patient:** A FEE may apply to this request for records. Arizona law states we must process requests for records within 30 days of the request.

### PATIENT INFORMATION:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Phone # \_\_\_\_\_

### FACILITY RELEASING INFORMATION:

Name: The Back Alley Chiropractic & Massage  
Address: 2060 E Tangerine Rd Ste 182  
Oro Valley, AZ 85755-6251  
Fax: 520-877-9183 Phone: 520-877-2666

### TO WHOM INFORMATION IS BEING DISCLOSED:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

### RECORDS BEING REQUESTED:

Medical Records Dates From/To: \_\_\_\_\_  Radiology Reports  Billing Records  
 LMT Records & Billing  Other \_\_\_\_\_

### PURPOSE OF THE DISCLOSURE OF INFORMATION:

Self  Continuing care  Insurance claim  Other \_\_\_\_\_

An authorization to disclose PHI (Protected Health Information) is voluntary. Treatment, payment or eligibility for benefits will not be affected if you do not sign this authorization. Re-disclosure of a patient's PHI is prohibited without the specific written authorization of that person or as otherwise permitted by state or federal law. Information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by state or federal law. This authorization pertains to the dates specified on this authorization. Unless you revoke this authorization earlier, it will expire 12 months from the date signed. You may revoke this authorization at any time by sending a written notice to the custodian of records.

Signature \_\_\_\_\_ Date: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

### FOR OFFICE USE ONLY

Employee who reviewed/completed form with patient: \_\_\_\_\_  
Date received: \_\_\_\_\_ Date completed: \_\_\_\_\_ Emp initials: \_\_\_\_\_  
Comments: \_\_\_\_\_  
Records picked up by: \_\_\_\_\_ Date: \_\_\_\_\_



**DOCTOR'S LIEN AND INSTRUCTIONS TO COUNSEL**

I, the undersigned, understand that all past, present, and future bills incurred at the Doctor/Clinic noted below, are my responsibility for payment. I hereby ratify my agreement to pay all bills incurred during my health care at this Clinic.

In consideration for the below named Doctor/Clinic having agreed to treat me without payment at the time of service and enabling me to obtain treatment for my accident/injury/illness, without financial hardship, I give you a lien on any settlement, claim, judgment, verdict or result of said accident/injury/illness and I agree to irrevocably instruct my attorney to pay you in full from any proceeds of settlement, claim or judgment related to this accident/injury/illness.

I also understand that if the settlement does not cover my entire bill at this Clinic, I am still responsible for the remainder and the payment by me of this bill is not contingent on any settlement, claim or judgment which I may eventually recover.

Furthermore, in consideration for the below named Doctor/Clinic refraining from attempting to collect immediate payment for services rendered for my accident/injury/illness, I do hereby waive and toll any applicable statute of limitations on the collection of my account until I notify the Doctor/Clinic of the conclusion of my efforts to obtain a settlement or judgment through the assistance of my attorney and for a period of three (3) months thereafter.

<b>Donald K. Shiflet, DC</b>
Back Benders, Inc dba The Back Alley Chiropractic & Massage 2060 E Tangerine Rd Ste 182 Oro Valley, AZ 85755

Doctor/Clinic Name and Address

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\* \* \* \* \*

**INSTRUCTIONS TO COUNSEL**

I do hereby irrevocably instruct you, my Attorney, named below, to pay Doctor/Clinic named above in full for services to me for my accident/injury/illness from any proceeds of settlement, claim or judgment regarding said accident/injury/illness. You are to pay the Doctor/Clinic prior to distributing any proceeds to me and I instruct you not to attempt to reduce by means of negotiation my doctor's bill for the services that have been provided to me for the accident/injury/illness which I have agreed to pay in full.

\_\_\_\_\_  
Firm Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Attorney Name

\_\_\_\_\_  
Date

\* \* \* \* \*

**ATTORNEY'S ACCEPTANCE OF LIEN**

Being the attorney of record or authorized representative, I acknowledge receipt of my client's instructions to Counsel and Lien and agree to honor the same.

\_\_\_\_\_  
Firm Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Attorney Name

\_\_\_\_\_  
Date