THE BACK ALLEY
CHIROPRACTIC & MASSAGE

## PERSONAL INJURY INTAKE & QUESTIONAIRRE

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.

**First** Name _____ **Middle** Initial _____ **Last** Name _____

Gender: ☐ Male ☐ Female Do you prefer to go by a **nickname**? ☐ No ☐ Yes _____

**Home** Address _____

City _____ State _____ Zip Code _____

**Billing** Address (*if different*) _____

City _____ State _____ Zip Code _____

**Email** Address* _____

*Providing an email is explicit consent and agree to receive communication and marketing emails (see our HIPAA notice for more details)

**Cell** Phone _____ Would you like to receive text reminders? ☐ Yes ☐ No

**Home** Phone _____ **Work** Phone _____

Emergency Contact Name _____ Phone # _____

Primary Care Physician _____ Phone # _____

Date of Birth _____ / _____ / _____ Social Security Number _____ - _____ - _____

Employment Status: ☐ Employed _____ ☐ Retired ☐ Not Employed ☐ Student
(employer name)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How did you find our office? ☐ Drive-by ☐ Employer ☐ Facebook ☐ Google ☐ Insurance ☐ Nextdoor ☐ Website ☐ Yelp

☐ Doctor _____ ☐ Friend/Family _____ ☐ Other _____

## ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

You may request a copy of our HIPAA Privacy Notice to take home with you by requesting from any member of our staff.

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 Parent/Guardian Signature _____ Date _____

## CONSENT TO TREATMENT OF A MINOR

All minors must be accompanied by a parent/legal guardian for any service requiring an exam. Leave section blank if not applicable.

I, _____, hereby authorize The Back Alley Chiropractic & Massage clinic/doctors/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.

Parent/Guardian Signature _____ Date _____

## COVERAGE INFORMATION

If you are **Self Pay**, please request a copy of our updated fee schedule. If you are **Insured**, complete below, sign where indicated and provide your health *and* auto insurance card(s) to reception. Digital cards should be emailed to thebackalleychiro@yahoo.com.

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

***Health*** Insurance _____ ID # _____ Insured: ☐Self ☐Spouse ☐Parent ☐Other

Insured: Full Name _____ Phone # _____ Date of Birth ____/____/____

Social Security Number ____ - ____ - ____ Employer _____

***Your*** Auto Insurance _____ Adjuster Name _____

Phone # _____ Policy # _____ Claim # _____

***Third*** Party Auto Insurance _____ Adjuster Name _____

Phone # _____ Policy # _____ Claim # _____

***Attorney*** Name _____ Firm Name _____

Phone # _____ Address _____

## INSURANCE POLICY & PROCEDURES

All office policies and procedures are available on our website for reference at any time. Policies and procedures are updated regularly.

The Back Alley Chiropractic fully complies with all our insurance contracts. It is not our custom to balance bill amounts not allowed by your insurance policy. It is your responsibility to update us with your current insurance information. **If you fail to notify us of a change in carrier, termination of coverage, and/or exceeded benefits, you will be 100% responsible for payment per your insurance policy's allowable amount.**

The Back Alley Chiropractic strives to contract with all local insurance plans. In special cases this may not be possible. Out-of-network coverage often requires a referral or pre-authorization by a Primary Care Physician (PCP). **It is your responsibility to know if a referral or pre-authorization is required to see specialists.** If a referral is required, it is up to you to arrange the submission per your insurance carrier by your PCP. If a referral is not received, you will be 100% responsible for payment.

The Back Alley Chiropractic does its best to verify and interpret your benefits and eligibility with regard to chiropractic and therapeutic procedures. Occasionally we are given incorrect information and can make mistakes. You are responsible for balances owed if your Explanation of Benefits (EOB) shows a different amount owed from your verification. **Any questions about balances owed should be directed to your insurance carrier's member services.**

According to your insurance carrier, you are responsible for co-pays, deductibles and/or co-insurances. **Co-pays, deductibles and/or co-insurances are fees that cannot be waived or discounted.** You will be responsible for your portion of the bill, which is due at the time of service, unless other arrangements have been requested in advance.

If your insurance carrier is to be billed prior to payment collection, once we receive an EOB from your insurance carrier an itemized bill will be sent to you with any balance owed per your insurance plan.

Any insurance you may have is an agreement between you and your insurance carrier and you are financially responsible for the payment of any services rendered.

According to your insurance carrier, verification of your benefits is not a guarantee of payment and final determination will be made for payment of services ***after*** a claim is received. The Back Alley Chiropractic is committed to providing the best treatment for our patients. Our professional fees are usual and customary per local state and federal rate tables.

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 Parent/Guardian Signature _____ Date _____

## 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 (left) ☐ Rear passenger (right) ☐ Pedestrian ☐ Cyclist

Direction of travel? ☐ North ☐ South ☐ East ☐ West

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

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

-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? ☐ No ☐ Yes

Were any citations issued? ☐ No ☐ Yes

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

Did you go to the hospital? ☐ No ☐ Yes Name of hospital _____

Did you go to the Urgent Care? ☐ No ☐ Yes Name of facility _____

Have you lost time from work? ☐ No ☐ Yes Dates missed _____

Make/model of your vehicle _____

Make/model of other driver's vehicle _____

Was your vehicle a rental car? ☐ No ☐ Yes

Was your vehicle a company car? ☐ No ☐ Yes

Were you wearing your seatbelt? ☐ No ☐ Yes

Did you lose consciousness? ☐ No ☐ Yes

Did your head hit anything? ☐ No ☐ Yes What did your head hit _____

Did your neck hit anything? ☐ No ☐ Yes What did your neck hit _____

Did your chest hit anything? ☐ No ☐ Yes What did your chest hit _____

Did your knees hit anything? ☐ No ☐ Yes What did your knees hit _____

Did your feet hit anything? ☐ No ☐ Yes What did your feet hit _____

How was your head positioned during the accident? _____

How was your torso positioned during the accident? _____

How were your hands positioned during the accident? _____

Have you treated nay where else for this accident? ☐ No ☐ Yes Name of facility _____

Print Patient Name _____

Patient or Guardian Signature _____ Date _____

## INJURY INFORMATION

List and describe your **chief complaint(s)** and answer all questions following. If you need more space, please ask for an additional page.

1)_____ When did this symptom begin _____

This occurs? ☐ seldom ☐ repeatedly ☐ frequently ☐ constant Severity: 0 1 2 3 4 5 6 7 8 9 10

How often? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100% ☐ in the afternoon ☐ in the evening Intensity: ☐ light ☐ extreme

Condition is: ***Aggravated*** by_____ ***Improved*** by_____

2)_____ When did this symptom begin _____

This occurs? ☐ seldom ☐ repeatedly ☐ frequently ☐ constant Severity: 0 1 2 3 4 5 6 7 8 9 10

How often? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100% ☐ in the afternoon ☐ in the evening Intensity: ☐ light ☐ extreme

Condition is: ***Aggravated*** by_____ ***Improved*** by_____

3)_____ When did this symptom begin _____

This occurs? ☐ seldom ☐ repeatedly ☐ frequently ☐ constant Severity: 0 1 2 3 4 5 6 7 8 9 10

How often? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100% ☐ in the afternoon ☐ in the evening Intensity: ☐ light ☐ extreme

Condition is: ***Aggravated*** by_____ ***Improved*** by_____

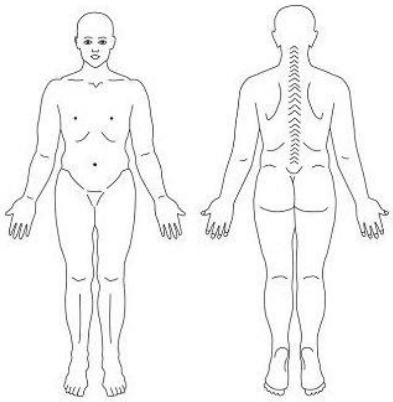
4)_____ When did this symptom begin _____

This occurs? ☐ seldom ☐ repeatedly ☐ frequently ☐ constant Severity: 0 1 2 3 4 5 6 7 8 9 10

How often? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100% ☐ in the afternoon ☐ in the evening Intensity: ☐ light ☐ extreme

Condition is: ***Aggravated*** by_____ ***Improved*** by_____

Use the abbreviations to indicate your symptoms on the illustration on the appropriate body side. If <u>both</u> sides, **circle** the abbreviation.



**BU** = Burning **DP** = Dull Pain **H** = Heavy

**HA** = Headaches **NU** = Numb **S** = Sore

**SP** = Sharp Pain **SH** = Shooting Pain **SS** = Spasm

**ST** = Stiff **TH** = Throbbing **TI** = Tingling

**O** = Other _____

## ADDITIONAL SYMPTOMS

Please check any additional symptoms not noted above that you have noticed since the accident.

| | | | | |
|---|---|---|---|---|
| ☐ Anxiety | ☐ Back pain | ☐ Blurred vision | ☐ Burning Pain | ☐ Chest pain |
| ☐ Cold sweats | ☐ Confusion | ☐ Depression | ☐ Dizziness | ☐ Extremity Pain |
| ☐ Fainting | ☐ Fatigue | ☐ Fever | ☐ Headache | ☐ Hearing loss |
| ☐ Irritability | ☐ Loss of balance | ☐ Memory Loss | ☐ Migraines | ☐ Muscle Cramps |
| ☐ Neck Pain | ☐ Numbness | ☐ Painful joints | ☐ Pins and needles | ☐ Ringing in ears |
| ☐ Shortness of breath | ☐ Sleeping problems | ☐ Tension | ☐ Tingling | ☐ Other |

Additional Comments regarding additional symptoms: _____

_____

_____

Print Patient Name _____

Patient or Parent/Guardian Signature _____ Date _____

## PATIENT HEALTH HISTORY

Height _____ft _____ in  Weight _____ lb _____ oz  Are you pregnant? ☐ No ☐ Yes

Check any conditions you have suffered from:

| | | | | |
|---|---|---|---|---|
| ☐ Alcoholism | ☐ Allergies | ☐ Anemia | ☐ Anxiety | ☐ Arm Pain |
| ☐ Arrhythmia | ☐ Arteriosclerosis | ☐ Arthritis | ☐ Asthma | ☐ Back Pain |
| ☐ Bronchitis | ☐ Bruise Easily | ☐ Cancer | ☐ Cold Extremities | ☐ Depression |
| ☐ Diabetes | ☐ Digestion Problems | ☐ Dizziness | ☐ Ears Ringing | ☐ Emphysema |
| ☐ Epilepsy | ☐ Fainting | ☐ Fatigue | ☐ Fibromyalgia | ☐ Foot Pain |
| ☐ Gout | ☐ Headaches | ☐ Heart Attack | ☐ Heart Disease | ☐ High Blood Pressure |
| ☐ Hip Pain | ☐ HIV Positive | ☐ Insomnia | ☐ Kidney Infection | ☐ Kidney Stones |
| ☐ Knee Pain | ☐ Leg Pain | ☐ Loss of Balance | ☐ Loss of Memory | ☐ Loss of Smell |
| ☐ Low Back Pain | ☐ Migraines | ☐ Neck Pain | ☐ Nosebleeds | ☐ Osteoarthritis |
| ☐ Osteopenia | ☐ Osteoporosis | ☐ Polio | ☐ Poor Circulation | ☐ Poor Posture |
| ☐ Rheumatoid Arthritis | ☐ Sciatica | ☐ Shoulder Pain | ☐ Sinus Infection | ☐ Spinal Curvature |
| ☐ Stroke | ☐ Swollen Joints | ☐ Thyroid Condition | ☐ TMJ | ☐ Tuberculosis |
| ☐ Tumor | ☐ Ulcers | ☐ Upper Back Pain | ☐ Varicose Viens | ☐ Other |

Additional Comments: _____

_____

## MEDICAL HISTORY

Check any trauma, injury, procedure, surgery you have experienced:

| | | | | |
|---|---|---|---|---|
| ☐ Appendectomy | ☐ Back Surgery | ☐ Broken Bone | ☐ Car Accident | ☐ Chemotherapy |
| ☐ Cosmetic Surgery | ☐ Dislocation | ☐ Fracture | ☐ Gastric Bypass | ☐ Heart Bypass |
| ☐ Hysterectomy | ☐ Joint Replacement | ☐ Knocked Unconscious | ☐ Neck Surgery | ☐ Nerve Injury |
| ☐ Pacemaker | ☐ Radiation Therapy | ☐ Spinal Fusion | ☐ Spine Injury | ☐ Spine Surgery |
| ☐ Surgery | ☐ Traumatic Brain Injury | ☐ Tonsillectomy | ☐ Trauma | ☐ Other |

Additional Comments: _____

_____

## MEDICATIONS

List any prescribed or over the counter medications, vitamins, and supplements: _____

_____

_____

## SOCIAL HISTORY

| | | | | |
|---|---|---|---|---|
| Smoking Use: | ☐ Never | ☐ Former | ☐ Current | If current smoker, how much daily? _____ |
| Alcohol use: | ☐ Never | ☐ Daily | ☐ Weekends | ☐ Occasional |
| Recreational Drug use: | ☐ Never | ☐ Daily | ☐ Weekends | ☐ Occasional |

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 Parent/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.

OFFICE POLICY

**Appointments** 1) 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. 2) Walk-ins are ***always*** welcome; however, appointments will be seen first. 3) If you are late for your appointment, we will do our best to accommodate you. 4) We strive to minimize wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding. 5) **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.** If you have not been seen in our office in 3 years or more, you are considered a new patient.

**Self-Pay Patients** 1) We welcome patients whose insurance companies are out-of-network, do not provide chiropractic benefits, or are uninsured. 2) 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. 3) 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 because of a work related injury; we will require information regarding your health insurance *and* your employers Workers Compensation policy. Providing your social security number is *required* to bill Workers Compensation.

**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.

Print Patient Name _____

Patient or 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.

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 Signature _____ Date _____


# 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: _____

THE BACK ALLEY
CHIROPRACTIC & MASSAGE

# 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.

**Donald K. Shiflet, DC**

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