Patient Name:				Date:
Address:		City:	State:	Zip Code:
	Work Ph			
	tal Status: M S D W		<u>.</u>	Age:
Social Security #:				
Occupation:		Employer:		
Employer Adress:				
Spouse Information:				
Name:		Birth	Date://	_ SSN
Phone:	Occupation:		Employer:	
Emergency Contact:	Name:		Phone Numbe	er:
Have you ever receiv	ed Chiropractic Care	? Yes No	If yes, when?	
Past Chiropractor (pa	ame address nhone	number).		
rase crimopractor (ne	ine, address, priorie			
2. Since the Motor \	/ehicle Collision, hav	e you experienced a		ng:
	nge of Motion: ye			
	hat body parts:			
C. Dizziness:	yes/no H	ow often:		
D. Anxiety:	yes/no H	ow often:		
E. Depression	ı: yes/no H	ow often:		
F. Difficulty S	leeping: yes/no	How often:		
3. Past Health Histo	ry:			
A. Please indi	icate if you have a histo	ory of any of the follow	ving:	
☐Anticoagulant use	☐ Heart problems/hig	gh blood pressure/chest p	ain Bleeding	problems
Lung problems/shor	tness of breath $\square$ Ca	ncer Diabetes	☐ Psychiatric dis	
☐ Bipolar disorder	☐ Major depression	•	□Stroke/TIA's	
☐ None of the above	Other			

	-Have you ever broken any bones? Which?
c	C. Allergies:
D	D. Medications:
	Medication: Reason for taking:
_	
_	
-	
E	Surgeries:
	Date: Type of Surgery:
_	
_	
-	
_	
•	Females/ Pregnancies and outcomes:  Outcome:
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- - - - -amily	Pregnancies/Date of Delivery:  Outcome:  Health History:
- - - - -amily	Pregnancies/Date of Delivery:  Outcome:  Health History:  O you have a family history of? (Please indicate all that apply)
- - - - -amily	Pregnancies/Date of Delivery:  Outcome:  Health History:  Outcome:  Health History:  Cancer Strokes/TIA's Headaches Cardiac disease Neurological diseases
- - - - -amily	Pregnancies/Date of Delivery:  Outcome:  Health History:  O you have a family history of? (Please indicate all that apply)  Cancer Strokes/TIA's Headaches Cardiac disease Neurological diseases  Adopted/Unknown Cardiac disease below age 40 Psychiatric disease
- - - - -amily	Pregnancies/Date of Delivery:  Outcome:  Health History:  Oo you have a family history of? (Please indicate all that apply)  Cancer Strokes/TIA's Headaches Cardiac disease Neurological diseases  Adopted/Unknown Cardiac disease below age 40 Psychiatric disease
- - - - - amily	Pregnancies/Date of Delivery:  Outcome:  Health History:  O you have a family history of? (Please indicate all that apply)  Cancer Strokes/TIA's Headaches Cardiac disease Neurological diseases  Adopted/Unknown Cardiac disease below age 40 Psychiatric disease
- - - - Family D	Pregnancies/Date of Delivery:  Outcome:  Health History:  Oo you have a family history of? (Please indicate all that apply)  Cancer Strokes/TIA's Headaches Cardiac disease Neurological diseases  Adopted/Unknown Cardiac disease below age 40 Psychiatric disease  Diabetes Other Mone of the above
- - - - Family D	Pregnancies/Date of Delivery:  Outcome:  Health History:  Oo you have a family history of? (Please indicate all that apply)  Cancer Strokes/TIA's Headaches Cardiac disease Neurological disease:  Adopted/Unknown Cardiac disease below age 40 Psychiatric disease  Diabetes Other Mone of the above
Family  Social	Pregnancies/Date of Delivery:  Outcome:  Health History:  Oo you have a family history of? (Please indicate all that apply)  Cancer Strokes/TIA's Headaches Cardiac disease Neurological diseases  Adopted/Unknown Cardiac disease below age 40 Psychiatric disease  Diabetes Other Mone of the above
Social A. Jo	Pregnancies/Date of Delivery:  Outcome:  Health History:  Cardiac disease   Neurological disease:  Adopted/Unknown   Cardiac disease below age 40   Psychiatric disease:  Diabetes   Other   None of the above:  And Occupational History:  Outcome:  No you have a family history:  Adopted/Unknown   Cardiac disease below age 40   None of the above:  And Occupational History:  Outcome:
Social A. Jo	Pregnancies/Date of Delivery:  Outcome:  Health History:  Oo you have a family history of? (Please indicate all that apply)  Cancer   Strokes/TIA's   Headaches   Cardiac disease   Neurological disease   Adopted/Unknown   Cardiac disease below age 40   Psychiatric disease   Diabetes   Other   None of the above   And Occupational History:  ob description:

#### **Review of Systems**

Have you had any of the following pulmonary (lung-related) issues?
☐ Asthma/difficulty breathing ☐ COPD ☐ Emphysema ☐ Other ☐ None of the above
Have you had any of the following cardiovascular (heart-related) issues or procedures?  Heart surgeries Congestive heart failure Murmurs or valvular disease Heart attacks/MIs Hypertension Heart disease/problems Pacemaker Angina/chest pain Irregular heartbeat Other None of the above
Have you had any of the following neurological (nerve-related) issues?  Visual changes/loss of vision  One-sided weakness of face or body  History of seizures  One-sided decreased feeling in the face or body  Headaches  Memory loss  Tremors  Vertigo  Loss of sense of smell Strokes/TIAs Other  None of the above
Have you had any of the following endocrine (glandular/hormonal) related issues or procedures?  Thyroid disease Hormone replacement therapy Injectable steroid replacements Diabetes  Other None of the above
Have you had any of the following renal (kidney-related) issues or procedures?  Renal calculi/stones Hematuria (blood in the urine) Incontinence (can't control) Bladder Infections  Difficulty urinating Kidney disease Dialysis Other None of the above
Have you had any of the following gastroenterological (stomach-related) issues?  ☐ Nausea ☐ Difficulty swallowing ☐ Ulcerative disease ☐ Frequent abdominal pain ☐ Hiatal hernia ☐ Constipation ☐ Pancreatic disease ☐ Irritable bowel/colitis ☐ Hepatitis or liver disease ☐ Bloody or black tarry stools ☐ Vomiting blood ☐ Bowel incontinence ☐ Gastroesophageal reflux/heartburn ☐ Other ☐ None of the above
Have you had any of the following hematological (blood-related) issues?  Anemia Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) HIV positive Abnormal bleeding/bruising Sickle-cell anemia Enlarged lymph nodes Hemophilia Hypercoagulation or deep venous thrombosis/history of blood clots Anticoagulant therapy Regular aspirin use Other None of the above
Have you had any of the following dermatological (skin-related) issues?  Significant burns Significant rashes Skin grafts Psoriatic disorders Other None of the above
Have you had any of the following musculoskeletal (bone/muscle-related) issues?  Rheumatoid arthritis Gout Osteoarthritis Broken bones Spinal fracture Spinal surgery Joint surgery Arthritis (unknown type) Scoliosis Metal implants Other None of the above
Have you had any of the following psychological issues?  Psychiatric diagnosis Depression Suicidal ideations Bipolar disorder Homicidal ideations Schizophrenia Psychiatric hospitalizations Other None of the above  Is there anything else in your past medical history that you feel is important to your care here?

#### **HIPAA NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

#### Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient of Representative	Date	

Patient	Name: Date:
Practiti	oner: Sid L. Dyer, D.C.
Sympto	m 1:
•	On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10  What percentage of the time you are awake do you experience the above symptom at the above intensity:  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100  When did the symptom begin?  O Did the symptom begin suddenly or gradually? (circle one) O How did the symptom begin?  What makes the symptom worse? (circle one) O Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at
	waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):
•	What makes the symptom better: (circle all that apply)  Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe):
•	Describe the quality of the symptom (circle all that apply):  o Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe):
•	Does the symptom radiate to another part of your body (circle one): yes no
	o If yes, where does the symptom radiate?
•	Is the symptom worse at certain times of the day or night? (circle one)  O Morning Afternoon Evening Night Unaffected by time of day
	o Morning Accinoon Evening Night Ondirected by time or day
Sympto	m 2:
•	On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
•	What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
•	When did the symptom begin?  Did the symptom begin suddenly or gradually? (circle one)  How did the symptom begin?
•	What makes the symptom worse? (circle one)
	<ul> <li>Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):</li> </ul>
•	What makes the symptom better: (circle all that apply)
	<ul> <li>Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe):</li> </ul>
•	Describe the quality of the symptom (circle all that apply):
	<ul> <li>Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe):</li> </ul>
•	Does the symptom radiate to another part of your body (circle one): yes no  o If yes, where does the symptom radiate?
•	Is the symptom worse at certain times of the day or night? (circle one)
	O Morning Afternoon Evening Night Unaffected by time of day

Sympton	m 3:
•	On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the
	time: 0 1 2 3 4 5 6 7 8 9 10
	What percentage of the time you are awake do you experience the above symptom at the above intensity:
•	5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
•	When did the symptom begin?
-	Did the symptom begin suddenly or gradually? (circle one)
	How did the symptom begin?
•	What makes the symptom worse? (circle one)
	<ul> <li>Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):</li> </ul>
•	What makes the symptom better: (circle all that apply)
	Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe):
•	Describe the quality of the symptom (circle all that apply):
	<ul> <li>Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe):</li> </ul>
•	Does the symptom radiate to another part of your body (circle one): yes no
	o If yes, where does the symptom radiate?
•	Is the symptom worse at certain times of the day or night? (circle one)
	<ul> <li>Morning Afternoon Evening Night Unaffected by time of day</li> </ul>
Sympton	M 4: On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the
	time: 0 1 2 3 4 5 6 7 8 9 10
•	What percentage of the time you are awake do you experience the above symptom at the above intensity:
	5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
•	When did the symptom begin?
	<ul> <li>Did the symptom begin suddenly or gradually? (circle one)</li> <li>How did the symptom begin?</li> </ul>
•	What makes the symptom worse? (circle one)
	<ul> <li>Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking,</li> </ul>
	running, nothing, other (please describe):
•	What makes the symptom better: (circle all that apply)
	<ul> <li>Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please</li> </ul>
	describe):
•	Describe the quality of the symptom (circle all that apply):
	<ul> <li>Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe):</li> </ul>
•	Does the symptom radiate to another part of your body (circle one): yes no
_	o If yes, where does the symptom radiate?
•	Is the symptom worse at certain times of the day or night? (circle one)  O Morning Afternoon Evening Night Unaffected by time of day
	o morning Acceptable Evening tright offineeted by time of day

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	lid the syr	•	-												
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0	to right,	bending	g forwa	d at wai	st, ben	ding b	ackwa	rd at wa	ist, til	ting le	eft at v	waist,	tiltin	g right at wais	to left, turning head t, twisting left at
	running						g, getti	ng up tr	om sit	ting p	ositio	n, IIIti	ng, a	iny movement,	, driving, walking,
What r	nakes the						nnly)								
0		, heat, st						nedicat	ion, m	uscle	relaxe	ers, no	thin	g, other (pleas	e
Describ	e the qua		ne sym	ptom (	circle a	ıll tha	it appl	v):							
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Does tl	e sympto	m radia	te to a	nother	part o	f you	r body	(circle	one)	:	yes		1	no	
0	If yes, w	here doe	es the s	ymptom	radiate	e?									
Is the s	ymptom v	vorse at	certai	n times	of the	day	or nig	ht? (cir	cle o	ne)					
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n 6:							_								
	ale from (	)-1(). Wii											ı		
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Date of Collision:	Hour of Accident:	AM / PM
Please describe how the collision happe	ened:	
What was your position in the car? (Circ	cle) Driver / Front Passenger / Left	Rear / Right Rear
If "Driver", were your hands on the stee	ring wheel? Both / Left / Right	
Did the airbags deploy? Yes / No		
Did you strike another vehicle? Yes /	<b>No</b> Did another vehicle strike your ve	ehicle? Yes / No
Angle of Impact: Front / Back / Left	·	
If Second Collision – Angle of 2 <sup>nd</sup> impac		
In relation to the back of your head, was	s your headrest set: Low / Middle /	High
Were you surprised by the impact? Y	•	
If "NO", how did you brace? With	Hands / With Feet	
Where was your head facing at the time		Riaht / Behind
Were you leaning forward at the time of	,	3
What type and year of vehicle were you	·	
What was the approximate speed of you		
What type and year of vehicle struck yo		-
What was the approximate speed of the		
		-
Were you wearing a seatbelt? Yes / I	,, ,	er Beit / Both
Did you feel pain immediately after the a		
Were you rendered unconscious as a re		
Did you strike anything in the vehicle at your body struck what: (i.e. head, chest		YES", specify what part o
□ Steering Wheel	□ Windshield	
□ Dashboard	Roof	
□ Left Side Door	□ Right Side Door	
Left Window	□ Right Window	
□ Other		
Did your seat break or bend? Yes / N		
Immediately following the accident, how Upset / Disoriented / Nervous / Nause		Dizzy / Dazed / Weak /

#### **Police and Ambulance:**

Was the accident reported to the police? Yes / No	
Were traffic citations issued? Yes / No If "YES", to whom?	
Did you go to the hospital? Yes / No If "YES", when?	
If "YES", how did you get there?	ransportation
Were you admitted? Yes / No If "YES", how long?	
Name of Hospital? Attended	by Dr
What treatment given? (Circle all that apply) None / X-rays / Pain Me	edication / Stitches /
Muscle Relaxants / Bandaged / Cervical Collar / Physical Thera	py / Instructed Regarding
Concussion / Instructed Regarding Sprains & Strains / Instruct	ed to Call an Orthopedist /
Instructed to Call a Private Physician / Referred to This Office /	Other:
What other doctor have you seen as a result of this injury?	
Do you have difficulty in excessive: Standing / Walking / Riding / Be	ending / Twisting
Do you have difficulty in excessive lifting: Light / Moderate / Heavy /	Repetitive
Symptoms other than above:	
Detient Cimenture	Data
Patient Signature	Date

#### **Duties Under Duress Summary**

Complete the following summary as it relates to your living and work duties and how the injury(s) are affecting your performance. List the day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. Include those duties/responsibilities which require that you reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your performance.

		·
Reason for the difficulty	Duration	
Increased Pain		_
Reason for the difficulty	Duration	
Increased Pain		_
Reason for the difficulty	Duration	
Increased Pain		_
Increased Anxiety		_
Increased Pain		_
Increased Pain		_
Increased Pain		_
Reason for the difficulty	Duration	
Increased Pain		_
Increased Anxiety		_
Increased Pain		_
Increased Pain		_
Increased Pain		_
	Reason for the difficulty  Increased Pain	Reason for the difficulty  Increased Pain

#### **Loss of Enjoyment Summary**

Complete the following summary as it relates to your lifestyle, work environment and activities which you normally would be enjoying, but are currently not enjoying, as a result of the motor vehicle collision. Include all areas which you have had to reduce the time you are capable of experiencing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your participation in any of the following areas:

Work	Reason for the difficulty	Duration
Lifting	Increased Pain	
Bending	Increased Pain	
Sitting	Increased Pain	<u></u>
Walking	Increased Pain	
Computer duties	Increased Pain	<u></u>
Other:	Increased Pain	
Studies/School	Reason for the difficulty	Duration
Lifting	Increased Pain	
Bending	Increased Pain	
Sitting	Increased Pain	
Walking	Increased Pain	
Computer duties	Increased Pain	
Studying	Increased Pain	
Other:	Increased Pain	
Domestic Duties	Reason for the difficulty	Duration
Vacuuming	Increased Pain	<u> </u>
Taking care of kids	Increased Anxiety	
Cleaning	Increased Pain	
Preparing meals	Increased Pain	
Other:	Increased Pain	
Household Duties	Reason for the difficulty	Duration
Yard work	Increased Pain	<u></u>
Transportation	Increased Anxiety	
Shopping	Increased Pain	
Taking out trash	Increased Pain	
Other:	Increased Pain	
Sports	Reason for the difficulty	Duration
Social		
Competitive		
Regional		
Other:		<u></u>

# Please list any and all doctors seen in the last year - two years. Doctor: Address: \_\_\_\_\_ (if known) Reason for visit / treatment: Doctor: \_\_\_\_ Address: (if known) Reason for visit / treatment: Doctor: Address: \_\_\_\_\_ (if known) Phone: Reason for visit / treatment: Address: \_\_\_\_\_ (if known) Phone: \_\_\_\_\_ Reason for visit / treatment:

### DYER CHIROPRACTIC CLINIC

33 EAST COUNTY LINE ROAD STE. A, GREENWOOD, IN 46143

**Phone** (317) 882-4922 **Fax** (317)882-4898

### PATIENT REQUEST FOR RECORDS

DATE:	
то:	
ADDRESS:	
CITY:	STATE:ZIP:
I hereby authorize the release o	of:  All Medical records  X-rays  Blood work results  MRI results  Other
Please MAIL records to:	Dyer Chiropractic Clinic 33 East County Line Rd Greenwood, In 46143
Please <b>FAX</b> records to:	FAX: 317-882-4898
*Please fill out only this section	and leave above blank:
Patient's Printed Name:	
Birthdate:	Social Security Number:
Patient's Signature:	

# ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the \_\_\_\_\_\_

Insurance Company to pay by check made out and mailed directly to:					
DYER CHIROPRACTIC CLINIC P.C. 33 East County Line Road Ste. A Greenwood, In 46143					
If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it to:					
33 East County Line Road Ste. A Greenwood, Indiana 46143					
The professional or chiropractic expense benefits allowed and otherwise payable to me under my current insurance policy will be used as payment toward the total charges for professional services I have received.					
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.					
Dated thisday of, 20					
Signature of policyholder Signature of Claimant, if other than Policyholder					

Date:		
Patient:		
Claim#		
To Whom It May Concern:		
This letter is to authorize release of information policy including my Med Pay Benefits.	n to Dyer Chiropractic Clini	c regarding my Auto Insurance
Thank you,		
Printed Name		
Timed Name_		-
Signature		

### PROVIDER/PATIENT ATTORNEY CLAIM AGREEMENT AND LIEN

This	agreement is entered into amo					
			utual obligations set forth herein and			
		g the pendency of Patient	's claim arising from Patient's acciden	it of,		
20_	, (hereinafter "Claim").					
1.	Patient hereby gives a lien to Provider against all proceeds derived from this Claim (whether by settlement, judgment, or otherwise to secure payment of all fees owed to Provider by Patient for treatment arising out of injuries sustained as of the time such proceeds are received. Patient hereby directs Attorney to honor said lien and to pay such sums as are secured thereby directly to Provider, as soon as possible after any proceeds are received.					
2.		gnizes that even though this lien has been given, Patient still remains personally responsible yment of them must be made by Patient regardless of whether any money is received				
3.	Patient hereby authorizes Provider to provide Attorney, at reasonable intervals upon Attorney's request, with complete reports of Patient's medical condition, care and cost of treatment. Provider agrees to furnish these reports within reasonable time, and at a reasonable cost.					
4.	Attorney hereby agrees that Attorney is a party to this contract and further recognizes that Attorney is receiving a benefit from this agreement and therefore there is a valid consideration and Attorney is thereby bound by the terms agreed to it this contract.					
5.	Patient agrees to direct and require all legal counsel to execute another copy of this Claim Agreement and Lien, when one is furnished by Provider.					
6.	Attorney and patient; hereby a	eby agree to notify Provider immediately should Patient retain new legal counsel.				
7.	Patient hereby instructs that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.					
8.	. Attorney and Patient hereby agrees to not rescind this document and that any attempt to do so will not be honored by Attorney.					
9.	Attorney agrees to notify Provider of any settlement or other disposition of the claim within 10 days thereafter. Before Attorney distributes any monies received through this Claim, Attorney agrees to make a request and Provider agrees to provide a response in regard to the Patient's outstanding account balance.					
10.	. Should any party to this agreement seek judicial enforcement of it, the party prevailing in such lawsuit shall be entitled to reasonable attorney's fees.					
 Pat	ient's Signature	– ————— Date	Attorney Signature	 Date		
	to d Nove -		Drivet of Nove			
Printed Name		Date	Printed Name Firm Name&	Date		
Witness Signature		Date	Address			