CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____

City State Zip

Sex: ☐ M ☐ F Age___ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Spouse's Name_____

Spouse's Birthdate_____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you? _____

_____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient_____

Insurance Co. _____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_ _____

Relationship to Patient_____

Insurance Co. _____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to ~~Peters Ch.~~ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

3 PHONE NUMBERS

Home_____ Cell phone_____

Work_____ Ext____

Best time and place to reach you _____

E-mail Address_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home Phone_____ Work Phone_____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐Yes ☐No

If yes, when did the accident occur? _____

Type of accident? ☐Auto ☐Work ☐Home ☐Other

To whom have you made a report of your accident?

☐Auto Insurance ☐Employer ☐Work Comp. ☐Other

Attorney Name (if applicable)_____

_____

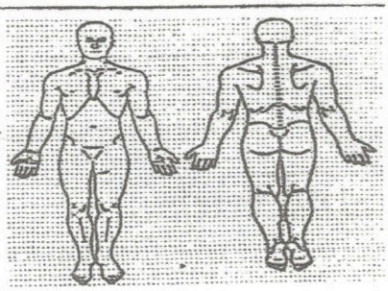
5 PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1(least pain) to 10 (severe pain) ____

Type of Pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting

☐Burning ☐ Tingling ☐Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do have this pain? _____

Is it constant or does it come and go?_____

Does it interfere with your ☐ Work ☐Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Suicide attempt	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tumors/Growth	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Vaginal Infection	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other _____		
Cataracts	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	_____		
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	_____		
Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No			

Exercise
☐ None
☐ Moderate
☐ Daily
☐ Heavy

Work Activity
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Habits
☐ Smoking — Packs/Day _____
☐ Alcohol — Drinks/Week _____
☐ Coffee/Caffeine Drinks — Cups/Day _____
☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had — Description — Date

Falls _____
Head Injuries _____
Broken Bones _____
Dislocations _____
Surgeries _____

7 MEDICATIONS

_____
_____
Pharmacy Name _____
Pharmacy Phone _____

ALLERGIES

VITAMINS/HERBS/MINERALS

Personal Injury Questionnaire

Name_____ Date of Birth_____ Phone_____
Address_____ City_____ State____ Zip_____
Employer Name_____ Employer Address_____
Your Ins.Co._____ Policy#_____ Agent Name_____
Other Driver_____ Ins.Co._____ Policy#_____
Your attorney name: _____ Phone_____
Address_____City_____State____Zip_____
Were there any witnesses?_____Name(s)_____

Nature of Accident:

1. Date of Accident_____Time of day_____Weather_____
2. Were you: Driver □ Passenger □ Front Seat □ Back Seat □
3 Seat belt: None □ Wearing □ Not wearing □
4. Shoulder harness: None □ Wearing □ Not wearing □
5. Head Rest: None □ Integral □ Adjusted in _____ position.
6. Head Position: Ahead □ Right □ Left □ Brakes on: Yes □ No □
7. Number of people in your vehicle?_____Other vehicle?_____
8. Were others hurt: Yes □ No □
9. What direction were you headed? North □ South □ East □ West □ on (name of street)_____
10. What direction was other vehicle headed? North □ South □ East □ West □ on (name of street)_____
11. Were you struck from: Behind □ Front □ Left Side □ Right Side □
12. How fast were you traveling?_____Other vehicles speed?_____
13. Were you knocked unconscious?_____ If yes, for how long?_____
14. Did you have a hat or glasses on: Yes □ No □ Did they come off: Yes □ No □
15. Were the police notified: Yes □ No □ Was a police report made: Yes □ No □
16. Model/Make/Year of your vehicle_____
    Model/Make/Year of other vehicle_____
17. In your own words, please describe the accident:

_____
_____
_____

18. Where were you taken after the accident?_____
19. Have you been treated by another doctor since the accident?_____If yes, please list the doctors name and address:_____
_____
20. What type of treatment did you receive?_____
_____

Nature of your complaints

21. Since this injury occurred are your symptoms:
    Improving □ Getting worse □ Same □

22. Check the symptoms you have noticed since the accident:
Headache___ Irritability___ Numbness in toes___ Face Flushed___ Cold Feet ___
Neck Pain___ Chest Pain___ Shortness of breath___ Buzzing in ears___ Cold Hands___
Stiff Neck___ Dizziness___ Fatigue___ Loss of Balance___ Upset Stomach___
Sleeping Problems___ Head seems too Heavy___ Depression___ Fainting___
Constipation___ Back Pain___ Pins & Needles in Arms___ Lights Bother Eyes___
Loss of Smell___ Cold Sweats___ Nervousness___ Loss of Memory___
Pins & Needles in legs___ Loss of Taste___ Fever___ Tension___ Numbness in fingers___
Ears Ring___ Diarrhea___ Other_____

23. Did you have any physical complaints BEFORE THE ACCIDENTS? If so describe in detail:_____

_____

24. Please describe how you felt:
    a) During the accident: _____
    b) Immediately after the accident:_____
    c) Later that day:_____
    d) The next day:_____

25. What are you present complaints and symptoms?_____

_____

_____

26. Have you lost time from work as a result of this accident?___ If yes, please complete these questions:
    a. Last day worked:_____
    b. Type of employment:_____
    c. Present salary:_____
    d. Are you being compensated for time lost from work?_____ If yes, please state type of compensation you are receiving:_____

27. Do you notice any activity restrictions as a result of this injury?___ If yes, please describe, in detail:_____

_____

Previous History

28. Do you have any congenital (from birth) factors which relate to this problem?_____
    If yes, please describe:_____

_____

29. Do you have any previous illness which relate to this case?____ If yes, please describe:_____

_____

30. Have you ever been involved in an accident before?_____If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received:_____

_____

_____

31. Have you been awarded prior workers compensation or personal injury settlement?

_____

32. Other pertinent information:_____

_____

_____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Peters Chiropractic

Sports Therapy, Acupuncture & Massage

3rd Party Information

Patient: _____

Claim Number: _____

Company: _____

Adjuster: _____

Phone: _____

Fax: _____

Address: _____

E-mail: _____

Date: Dialog:

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Peters Chiropractic

Sports Therapy, Acupuncture and Massage Therapy

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Peters Chiropractic.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure, which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Peters Chiropractic to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____

_____

Patient's Name (Please Print) Date

_____

Patient or Guardian's Signature

Peters Chiropractic

Sports Therapy, Acupuncture and Massage Therapy

Policy Regarding Massage and/or Personal Training

We are pleased to offer you massage therapy and personal training options here at Peters Chiropractic as well! We will verify your insurance coverage for you here at our office and then alert you if your coverage includes massage or personal training. For those that do not have insurance coverage, we offer terrific cash prices or packages.

We schedule our therapist and trainers on an individual basis to meet your needs. Therefore, appointments are necessary and very important. They can be made through our office. We have a strict 24-hour cancelation policy if you cannot make your appointment. We understand things come up and we will do our best to re-schedule. However, if you must cancel on the same day as your appointment, we will charge a $20 fee to cover the cost of the trainer or therapist.

Please sign below in agreement with the above policy.

_____ _____

Name Date

Peters Chiropractic
Sports Therapy, Acupuncture and Massage

Personal Injury Financial Agreement

We would like to take a moment to **welcome** you to our office and to assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policies of our office, we would like to explain your options of paying your bills.

1. If you are covered by automobile Med-Pay insurance then you likely will have 100% coverage for all medical expenses within the limits of your policy. Please check with your provider if you have this type of coverage. We will accept payment for all of your charges directly from the insurance company pending verification that they will pay us directly.

2. If the person or entity responsible has auto coverage other than Med-pay, you should be able to collect reimbursement from that insurance company. You will be asked to provide the contact information of your insurance company, so that we can work with them on your case. Generally, the insurance companies will not pay our office directly. Therefore, you agree to sign over the total payment of charges for services rendered. Upon signing below, you are guaranteeing payment from any settlement monies realized and agree to personally being responsible for any balance of charges not paid through said settlement within 90 days of settlement.

3. If you hire an attorney, we will ask you to sign a lien form authorizing the attorney to pay us directly out of your settlement. You will be asked to provide your attorney's contact information, so that we can work with them on your case.

4. If you have health insurance coverage and are not covered by auto insurance and do not retain an attorney, we will make every effort to bill your health insurance for payment. Please review our financial policy for insurance patients for your payment options.

5. You may pay for your services and be reimbursed by your insurance company or attorney.

It is important that you understand that your health supersedes methods of payment. We are here to help you with the above options in order to take care of your health needs. You are also personally responsible for your entire balance. By signing below, you are hereby making a mutual agreement between Dr. Steven M. Peters, D.C. and yourself, to reimburse total payment of charges for services rendered at the end of treatment.

I HAVE READ AND AGREE TO THE ABOVE.

_____ _____

Patient's Name Date

18351 Beach Blvd., Unit H Huntington Beach, CA 92648 Tel 714.913.3310
www.DrPetersChiropractic.com

Peters Chiropractic
Sports Therapy, Acupuncture and Massage

Assignment and Instruction for Direct Payment to Doctor

Patient Name: _____
Address: _____
Insurance Company/Attorney: _____
Claim Number: _____

I hereby instruct the above named insurance company to pay, by check, made out to and mailed directly to:

Peters Chiropractic
18351 Beach Blvd., Unit H
Huntington Beach, CA 92648

If my current policy prohibits payment directly to the doctor, then I hereby instruct and direct you to make the check payable to and mail to the following:

_____ and Peters Chiropractic
18351 Beach Blvd., Unit H
Huntington Beach, CA 92648

This check is to be paid for professional medical expense benefits allowable and otherwise payable to me under my current insurance policy (or that of a 3rd party, responsible for payment on this claim). THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the abovementioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and or fees, over and above the 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, adjustor or attorney for the purpose of securing payment under this policy.

Date: _____

Policyholder Signature: _____

Signature of Claimant, if other than Policyholder: _____

Attorney:

_____
_____
_____

Doctor:

Peters Chiropractic
Steven M. Peters, D.C.
18351 Beach Blvd, Unit H
Huntington Beach, CA 92648

NOTICE OF DOCTOR'S LIEN

I do hereby authorize Drs. Steven Peters D.C. to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved on _____.

I hereby authorize you, my attorney, to pay directly to said doctors such sums as may be due and owing them for medical service rendered me both by reason of this accident and by reason of any other bills that are due their office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctors. And I hereby further give a lien on my case to said doctors against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection wherewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I understand that this agreement is made solely for providers' additional protection and in consideration for the providers awaiting payment and that payment of providers' fees is not contingent on settlement, judgment, or verdict by which the patient may recover said fee. I agree that if no suit on this claim is filed by the attorney during the statutory period provided therefore, that all providers' fees shall become due and payable at the expiration of the statute period.

Please acknowledge this letter by signing below and returning to the doctors' office. I have been advised that if my attorney does not wish to cooperate in protecting the doctors' interest, the doctor will not await payment but may declare the entire balance due and payable.

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctors above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Date: _____ Patient's Signature: _____

Date: _____ Attorney's Signature: _____