Dear Patient,

You have a right, as a patient, to be informed about your condition and the recommended chiropractic adjustments and other procedures to be used, so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to alarm you, it is simply an effort to better inform you so you may give or withhold your consent to the procedure with the appropriate knowledge.

In the practice of chiropractic there are some risks to examination and treatment procedures including, but not limited to; fractures, disc injuries, dislocations, sprains/strains and increased symptoms and pain, or no improvement of the symptoms or pain. A very rare but serious risk associated with neck manipulation is stroke. X-rays may be a part of the examination and the use of x-ray equipment may pose an added risk if you are pregnant.

The Doctor of Chiropractic is not able to anticipate and explain all of the risks and complications, but relies on clinical judgement based on all the facts known at the time of the procedure, and makes decisions that according to the facts available, are to the best interest of the patient. There are no guaranties or assurances concerning the intended results of the treatments.

The results of the examination I receive at Westwood Chiropractic will be explained to me. Including the proposed plan of care and the possible risks associated with the treatment. I understand that my care will be rendered by a licensed Doctor of Chiropractic. I also understand the cost of the treatment proposed.

I have read and understand the statements written on this form. I understand that I will have the opportunity to ask the Doctor questions, and my questions will be answered. Based on this information:

❑ I consent to this treatment ❑ I do not consent to this treatment

In signing this statement you are consenting to treatment in this office.

_____ Date of Birth _____ / _____ / _____

Patient's Name (Please Print)

_____ Today's Date _____ / _____ / 20____

Patient's Signature

_____ Today's Date _____ / _____ / 20____

Signature of Parent of Guardian consenting to treatment for a minor

CONFIDENTIAL PATIENT DATA

Today's Date: _____ / _____ / 20____

Patient's Legal Name: _____ Date of Birth: _____ / _____ / _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: (____) ____-_____ Cell :(____) ____-_____ Work Phone: (____) ____-_____

Email Address: _____ Nick Name: _____

Social Security #:_____ - ____- _____ Age: _____ ❑ Male ❑ Female

Marital Status: ❑ Partnered ☐Married ❑Single ❑Divorced ❑Widowed ❑Other _____

Name of Emergency Contact: _____ Relation: _____ Phone:(____) ____-_____

Your Occupation_____ Your Employer:_____

Referred to this Office by: ❑Friend/Family Member-Name_____

❑Search Engine ❑ Email/ Mail ❑Clinic Location ❑Facebook/Instagram ❑Other_____

Payment for Services will be by: ❑ Automobile Insurance Policy (PIP/Med Pay) ❑3rd Party Auto Insurance Policy

❑Automobile Insurance Policy Other ❑Worker's Compensation Policy ❑Health Insurance Policy & Cash/Check/Credit

❑Provided Insurance Card & Identification (Please provide these to the office staff to make a copy for your records. Thank you!)

HEALTH HISTORY

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Name & Location of Doctors previously seen for any/all present health conditions Health condition Approximate date last seen

_____

_____

_____

_____

_____

Are you allergic to any medications? ☐NO ☐YES & WHAT KIND?_____

Are you taking any medications? ☐NO ☐YES & WHAT KIND?_____

Are you Pregnant? ☐YES ☐NO ☐MAYBE First day of your Last Menstrual Period _____ / _____ / _____

Do you have any metal implants? ❑No ❑Yes Describe : _____

Have you ever been shot by a gun? ❑No ❑Yes _____ / _____ / _____

Patient's Name (Please Print)_____

MEDICAL HISTORY

FAMILY MEDICAL HISTORY (Please indicate which conditions have been experienced by you or your parents by marking appropriate boxes)

Father	Mother	Self	Father	Mother	Self	Father	Mother	Self
❑	❑	❑Aids	❑	❑	❑epilepsy	❑	❑	❑multiple sclerosis
❑	❑	❑allergies	❑	❑	❑German measles	❑	❑	❑polio
❑	❑	❑arthritis	❑	❑	❑high blood pressure	❑	❑	❑poor circulation
❑	❑	❑asthma	❑	❑	❑HIV/ARC	❑	❑	❑reproductive disorder
❑	❑	❑bone fracture	❑	❑	❑heart trouble	❑	❑	❑rheumatic fever
❑	❑	❑cancer	❑	❑	❑headaches	❑	❑	❑rheumatism
❑	❑	❑concussion	❑	❑	❑hepatitis	❑	❑	❑scarlet fever
❑	❑	❑convulsions	❑	❑	❑indigestion	❑	❑	❑sinus trouble
❑	❑	❑diabetes	❑	❑	❑kidney disorder	❑	❑	❑ tuberculosis
❑	❑	❑dislocated joints	❑	❑	❑muscular dystrophy			

SURGICAL HISTORY:

1._____Date:_____ /_____/_____

2._____Date:_____ /_____/_____

3._____Date:_____ /_____/_____

4._____Date:_____ /_____/_____

ACCIDENT HISTORY:

1. ❑Job ❑Auto ❑Other Date: _____ / _____ / _____

2. ❑Job ❑Auto ❑Other Date: _____ / _____ / _____

3. ❑Job ❑Auto ❑Other Date: _____ / _____ / _____

CURRENT COMPLAINTS:

SYMPTOMS DEVELOPED FROM: ☐JOB RELATED INJURY ☐AUTO ACCIDENT ☐OTHER ☐ACCIDENT ☐ILLNESS ☐UNKNOWN CAUSE ☐GRADUAL ONSET

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: Rate your symptoms 1-10 (with 1 being least serious)

❑Headache- Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Neck- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Shoulder- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Pain /tingling down arm- R / L Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Mid Back- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Low Back- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Hip- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Pain down Leg- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Other _____ Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Other _____ Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10

Symptoms Began: _____ / _____ / _____ SYMPTOMS ARE WORSE IN ☐MORNING ☐AFTERNOON ☐NIGHT

SYMPTOMS HAVE PERSISTED FOR # ___HOUR(S) ___DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)

SYMPTOMS/COMPLAINTS: ☐COME & GO ☐ARE CONSTANT ☐ ARE NEARLY CONSTANT

HAVE YOU EVER HAD THIS BEFORE: ☐NO ☐YES & WHEN?_____

Please check the following activities that **AGGRAVATE** your condition: ❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD ❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING ❑WORK DUTIES

Please check the following activities that **RELIEVE** your condition:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING ❑CHIROPRACTIC TREATMENT

ADDITIONAL SYMPTOMS you may be experiencing: ❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss /confusion ❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia (trouble sleeping) ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

The above information is accurate and complete to the best of my knowledge.

Patient's Signature: _____ Date: _____ / _____ / 20____

AUTO ACCIDENT INFORMATION

Patient's Legal Name (Please Print): _____

Date of Accident_____ / _____ / _____ Time: _____: _____am / pm Was a Police Report Filed? ☐ No ☐Yes

Location of accident: _____City: _____ State: _____

How many vehicles were involved? _____ Has fault been assigned? ☐ No ☐Yes: to whom? _____

Vehicle 1: Type of vehicle you were in: _____ ☐Car ☐Truck ☐SUV ☐Van ☐Bus

Color _____ Speed of vehicle at the time of impact: _____ mph

Total number of people in your vehicle including yourself _____

Were you: ☐ Struck by another vehicle ☐My vehicle struck another vehicle ☐My vehicle struck an object

Were you the: ☐ Driver ☐ Front Passenger ☐ Back Driver-Side Passenger ☐ Back Passenger-Side Passenger

☐Pedestrian ☐Riding a Bicycle ☐Motorcycle

Vehicle 2: Type of vehicle you were hit by: _____ ☐Car ☐Truck ☐SUV ☐Van ☐Bus

Color _____ Speed of vehicle at the time of impact: _____ mph Total number of people in that vehicle _____

Please describe the details of the accident in your own words: _____

_____

_____

_____

_____

Did the air bags deploy? ☐ Yes ☐ No Were you wearing a seatbelt? ☐ Yes ☐ No

Did you strike: ☐Window ☐Door ☐Dash ☐Steering Wheel

Did you hit your: ☐Head ☐ Knee ☐Shoulder/Arm Other: _____

Did you lose Consciousness? ☐No ☐Yes, for how long? _____

Were you taken to the hospital? ☐ No ☐Yes, by ☐ambulance ☐relative ☐drove myself When? ☐same day ☐next day ☐other

What Hospital: _____ Location _____

Have you seen any other physicians since your accident? ☐ No ☐Yes, Name & location _____

_____

Were you kept at the hospital overnight? ☐No ☐Yes

Did you have x-rays taken? ☐No ☐Yes, what area? _____

Treated for fractures? ☐No ☐Yes, where? _____

Examined & released? ☐No ☐Yes

Prescribed medication(s)? ☐No ☐Yes. What: _____

Describe your Pain after the accident: _____

_____

_____

Loss of Enjoyment/Duties Under Duress Summary

Complete the following questionnaire as it related to day-to-day living or work duties that are painful or difficult for you to perform as a result of the injuries you sustained.
Then mark the appropriate box describing how this limitation affects you.

Do you: ❑Work full-time ❑Work part-time ❑Full-time student ❑Unemployed ❑Disability ❑On Sick Leave ❑Retired

Your position / job description: _____

If you are on temporary or permanent disability, your last day of work was: _____ / _____ / _____

❍**Lifting,** because of; ❑ increased pain ❑restricted movement ❑weakness ❑fatigue ❑cannot perform this activity

❍**Bending**, because of; ❑ increased pain ❑restricted movement ❑weakness ❑fatigue ❑cannot perform this activity

❍**Sitting**, because of; ❑ increased pain ❑restricted movement ❑weakness ❑fatigue ❑cannot perform this activity

❍**Walking**, because of; ❑ increased pain ❑restricted movement ❑weakness ❑fatigue ❑cannot perform this activity

❍**Computer Duties**, because of; ❑ increased pain ❑restricted movement ❑weakness ❑fatigue ❑cannot perform this activity

❍**Other** activity you are required to perform for work/school_____,

because of; ❑ increased pain ❑restricted movement ❑weakness ❑fatigue ❑cannot perform this activity

❍**Studying**, because of; ❑ increased pain ❑restricted movement ❑weakness ❑fatigue ❑cannot perform this activity

❍**Vacuuming**, because of; ❑ increased pain ❑restricted movement ❑weakness ❑fatigue ❑cannot perform this activity

❍**Taking care of kids,** because of; ❑ increased pain ❑restricted movement ❑weakness ❑fatigue ❑cannot perform this activity

❍**Cleaning duties**, because of; ❑ increased pain ❑restricted movement ❑weakness ❑fatigue ❑cannot perform this activity

❍**Preparing meals**, because of; ❑ increased pain ❑restricted movement ❑weakness ❑fatigue ❑cannot perform this activity

❍**Yardwork** & outdoor duties, because of; ❑ increased pain ❑restricted movement ❑weakness ❑fatigue ❑cannot perform this activity

❍**Driving**/ridding in a vehicle, because of; ❑ increased pain ❑restricted movement ❑weakness ❑fatigue ❑cannot perform this activity

❍**Shopping**, because of; ❑ increased pain ❑restricted movement ❑weakness ❑fatigue ❑cannot perform this activity

❍**Taking out the trash**, because of; ❑ increased pain ❑restricted movement ❑weakness ❑fatigue ❑cannot perform this activity

Do you participate in a **regular activity(s):** ❍tennis ❍bowling ❍softball ❍cycling ❍running ❍working-out ❍camping ❍dancing ❍other _____

How has this activity been affected:_____

Name (Please Print)_____

Signature _____ date ____ / ____ / _____

Insurance & Claim Information: (Please Print)

Patient's Name: _____

Vehicle I was in belongs to:

Self or Owner's name _____ Insurance Company_____

Policy # _____ Claim # _____

Office Phone: (_____) _____-_____ Fax: (_____) _____-_____

My Auto Insurance Company (if different from above**):** _____

Policy # _____ Claim # _____

Office Phone: (_____) _____-_____ Fax: (_____) _____-_____

Driver's Auto Insurance Company (If you were a passenger in a vehicle that did not belong to the driver)

Policy # _____ Claim # _____

Office Phone: (_____) _____-_____ Fax: (_____) _____-_____

My Health Insurance Company: _____

Member ID # _____ Group # _____

Subscriber of the Policy _____ Their DOB _____ / _____ / _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

3rd Party or Other Vehicle:

Driver's Name: _____ Vehicle Owner's Name _____

Insurance Company Name: _____

Address _____ Phone # (_____) _____-_____

Policy # _____ Claim # _____

Office Phone: (_____) _____-_____ Fax: (_____) _____-_____

Attorney: _____

Law Office Name: _____

Address _____ City _____State: _____Zip _____

Office Phone: (_____) _____-_____ Fax: (_____) _____-_____

☐Please provide the office staff any/all insurance cards, your identification card (driver's license) and police report you have to make a copy for records.

FINANCIAL AGREEMENT

I agree that insurance reimbursement is NOT A SUBSTITUTE FOR PAYMENT. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is the patient's responsibility to pay any deductible amount, co-insurance, or any other balance not paid by the insurance company.

IN ORDER TO CONTROL THE PATIENT'S OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE, AND DEDUCTIBLE AT THE TIME OF SERVICE.

If the patient's account is assigned to an attorney or outside agency for collection and/or suit, WESTWOOD Chiropractic shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any charges related to my treatment at WESTWOOD Chiropractic.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I the undersigned, have insurance or employee health care benefits coverage, and hereby assign and convey directly to WESTWOOD Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered by WESTWOOD and its providers.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize WESTWOOD to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to WESTWOOD any and all plan documents, insurance policy and/or settlement information upon written request from WESTWOOD in order to claim such medical benefits, reimbursement, or applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby authorize WESTWOOD to claim such medical benefits, insurance reimbursement, and any applicable remedies to the full extent permissible by law and under any applicable insurance policies and/or employee health care plan, or other right I may have to insurance and/or employee health benefits coverage, with respect to medical services provided by WESTWOOD. I further agree in response to any reasonable request for cooperation, to cooperate with WESTWOOD in any attempts to pursue a claim, chose in action or right, against my insurers and/or employee health care plan, including if necessary, bringing suit with WESTWOOD against insurers and/or employee health plan in my name but at the expanse of WESTWOOD.

_____ _____ / _____ / 20___

Patient Name (please print) Date

_____ _____

Patient Signature INSURED'S SIGNATURE if patient is a Minor

HIPPA DECLARATION

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI

(b) Under the Privacy Rule, may be required by State law to great greater access or maintain greater restriction on the use or release of your PHI than that which is provided for under federal law

(c) Is required to abide by the terms of the Privacy Notice

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains

(e) Will distribute any revised Privacy Notice to you prior to implementation

(f) Will not retaliate you for filing a complaint

EFFECTIVE DATE

This Notice is in effect as of 7/26/04

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

_____

Patient name (please print)

_____

Patient signature

_____ / _____ / 20____

Date

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith EFFORT to Obtain Acknowledgement

Patient's acknowledgement of this notice could not be obtained because:

__Patient refused to sign

__Communication barrier prohibited obtaining acknowledgment

__Emergency circumstances

__Other

Details:

Westwood Chiropractic

Signature of Practice

PROVIDER/PATIENT, LIEN, PIP ASSIGNMENT, RECORDS RELEASE AND PAYMENT AGREEMENT

This agreement, entered into this date between _____, hereinafter called "Patient", and Westwood Chiropractic, hereinafter called "Provider".

Whereas Patient desires to receive healthcare services form Provider and desires to assign certain rights and benefits to Provider as an inducement to cause Provider to wait for the payment of such benefits, it is hereby agreed:

Section 1. Patient assigns to Provider any and all benefits payable by Patient's insurance or healthcare plan(s) as a result of charges incurred by Patient for services rendered by Provider. Patient also assigns to Provider any and all contractual rights Patient has against any insurance company, healthcare benefit plan, or any other party contractually liable to Patient for payment of healthcare costs incurred by Patient as a result of services rendered by Provider. This assignment of benefits and contractual rights relating to those benefits include, but are not limited to health insurance, auto insurance, etc. This assignment of benefits and contractual rights to those benefits will not exceed the total amount of charges incurred by Patient for service rendered by Provider. Patient agrees that payment for services rendered by Provider is due upon receipt of said services and that Provider may revoke this assignment at any time.

Section 2. Patient hereby grants Provider a lien against any proceeds resulting from any claim Patient has or may have against any party whose negligence may have caused Patient's injuries or illnesses. Patient also herby grants a lien against the proceeds of any insurance policy or healthcare plan to which Patient is entitled as a result of services rendered to Patient by Provider. Said liens will not exceed the total amount of expenses incurred by patient for services rendered by Provider.

Section 3. Patient herby directs all insurers and other person's responsible for Patient's healthcare costs to make payments for healthcare services rendered by Provider directly to Provider.

Section 4. Patient agrees that in the event Patient receives any check, draft or other payment subject to this agreement, Patient agrees to act as fiduciary agent and will immediately deliver said check, draft or payment to Provider. Provider agrees to apply the proceeds from said check, draft or payments to Patient's debt for services rendered.

Section 5. Provider agrees to submit a copy of this agreement with the initial claim form(s) which Provider submits to third party payer(s) as notice to the third party payer(s) of the assignment and other agreements contained herein. A copy of this document will be as binding as the document bearing original signatures. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patients file and may be picked up by the Patient/insured at any time or will, upon request by Patient/insured, be mailed to a designated address.

Section 6. Patient agrees to be responsible for insurance or health plan deductibles and co-payments. For the cost of services not covered by said insurance or healthcare plan(s). With the above exception, Provider agrees to accept as payment in full, for services rendered, the proceeds of insurance or healthcare plan benefits.

A. This Section is void if applicable insurance or health care plans do not provide coverage for chiropractic services.
B. This Section is void if prohibited by law or the terms of the Patient insurance policy or health care plan.
C. Both Provider and Patient have the right to terminate the provisions of this Section at any time by providing written notice to the other. Such termination will have no effect on assignments, assumptions or payments due, prior to said notice of termination.

Section 7. In the event that any Section or provision of the Agreement is legally void, invalid or unenforceable, all other Sections and provisions of this agreement will remain in full force and effect.

Section 8. The assignments and agreements contained in this document may not be revoked by Patient without the express written consent of the Provider, with the exception of the provision of Section 6.

In WITNESS WHEREOF, this Agreement has been entered into the day and year set forth below.

_____ / _____ / 20_____ _____
Date Patient's Signature

_____ _____
Witness Signature Provider's Signature

LIEN FOR SERVICES

Westwood Chiropractic, 4711 Mission Road, Westwood, KS 66205 (hereinafter "Clinic") and _____ (hereinafter "Patient) agree as follows:

WHEREAS, Patient reports Patient was injured in a (motor vehicle accident) (slip and fall) (other event) on _____ / _____ / 20_____, and,

WHEREAS, Patient has presented to Clinic requesting that Clinic treat said injuries, and;

WHEREAS, Patient may not have adequate insurance or money to pay Clinic for treatment of said injuries, and;

WHEREAS, Patient is making claim against the person(s) or party(ies) responsible for said injuries and Patient desires to grant to Clinic a lien on the proceeds of Patient's personal injury claim against the person(s) or party(ies) responsible for Patient's injuries in the exact amount necessary to pay Patient's care costs:

NOW,THEREFORE, BY THESE PRESENTS, pursuant to 430.225 et seq., RSMo.2003, in consideration of the following, Patient grants unto Clinic a lien upon the proceeds of Patient's personal injury claim against the person(s) or party(ies) responsible for Patient's injuries in the exact amount necessary to pay the reasonable charges for the necessary treatment to Patient's injuries rendered by Clinic. Clinic agrees to treat Patient for said injuries upon such terms and await full payment until Patients claim settles or is otherwise paid. Patient shall remain personally liable for such sums not paid by the person(s), party(ies) or their insurance company(ies) responsible for Patient's injuries treated by Clinic with instructions that Clinic be paid directly is Patient settles Patient's claim.

FURTHER, Patient grants Clinic a limited power of attorney to sign patients name or any instrument issued solely to pay Patients' Clinic care costs on which Patient is also a payee. Patient further authorizes Clinic to send the information concerning Patient necessary to pay Clinic's bill for Patient's care. Patient and Clinic agree that the terms of this lien shall not be modified, changed, revoked or amended without that express mutual consent of Patient and Clinic, done in writing, and that this lien is the full agreement of Patient and Clinic.

_____ _____

Patient Signature Clinic Representative

Subscribed and sworn to before me this _____ day of _____, 20_____.

My Commission Expires:

_____

Notary

Lien Amount $ _____

LIEN & AUTHORIZATION INSURANCE BENEFITS AND ATTORNEY

Insurance Company_____

Patient: _____ Policy / Claim # _____

Date of Loss:_____ address_____

Attorney _____ Insurance Company_____

_____ address_____

_____ _____

Policy / Claim # _____

To Whom It May Concern:
I hereby authorize and direct you, my insurance company, liability insurance adjuster and/or my attorney to pay directly to: Westwood Chiropractic such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, benefits, medical payments benefits, No Fault Benefits/ Personal Injury Protection Benefits, workman's compensation benefits or any other insurance benefits obligated to reimburse me or from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect Westwood Chiropractic. I hereby further give a lien to Westwood Chiropractic against any and all insurance benefits named herein and any all proceeds of any settlement, judgement or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Westwood Chiropractic.

I understand that I remain personally responsible for the total amounts due to Westwood Chiropractic for their services. I further understand and agree that this Lien & Authorization does not constitute any consideration for Westwood Chiropractic to await payments and they may demand payments from me immediately upon rendering services at their option. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. I agree to pay all costs of collection and any balance due to Westwood Chiropractic, including reasonable attorney's fees. This agreement is made solely for said provider's additional protection in consideration of Westwood Chiropractic awaiting payment in this matter.

I authorize Westwood Chiropractic to release any information pertaining to my case to any insurance company, adjuster or attorney to facilitate collection under this Lien and Authorization. I agree that Westwood Chiropractic be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill. 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. A photocopy of this Agreement shall be considered as effective and valid as the original.

Patient Signature _____ Date: _____ / _____ / 20____

Witness: _____

**The undersigned for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor above named.

Date: _____ / _____ / 20____ Signature: _____

**Note: If you prefer, please send your acknowledgement of this lien on your letterhead.

AUTHORIZATION FOR RELEASE OF RECORDS

A. Authorization for Release of Records

- I understand that if I complete record is checked on this form, all medical information will be released, including psychiatric records, alcohol or drug screening and HIV test results.

This information is be disclosed to: **Westwood Chiropractic**

4711 Mission Rd., Westwood, KS 66205
phone: (913)432-5678 fax (913)236-8726
chirowestwood@gmail.com
www.westwoodchiropractickc.com

- I understand that if the person or entity that receives the requested information is not a health care provider or health plan covered by federal privacy regulations, the information described may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken thereon this authorization will expire 90 days from the date of authorization.
- Access to medical information is a right of every patient; duplication and distribution is a service. Releases are subject to copy and distribution cost. I understand the potentiality of charge for service and release of medical information and accept financial responsibility.

B. Patient Information (please print)

Patient Legal Name: _____

Date of Birth _____/_____/_____ last 4 digits of social security number _____

address: _____

home phone: (_____) _____-_____ cell: (_____) _____-_____

C. Information Requested

I authorize the professional staff of _____ at

address_____

phone: (_____) _____-_____ fax: (_____) _____-_____ ; to disclose the following patient's specified information to the professional staff of Westwood Chiropractic.

Information to be released: _____by mail _____fax _____ hand carried

_____ Complete health record _____ MRI Report of _____

_____ History & physical exam _____ Visit Notes for _____ / _____ / _____ to _____ / _____ / _____

_____ Radiology reports _____ Exam notes for _____ / _____ / _____ to _____ / _____ / _____

_____ Radiology films _____ Discharge Summary

Other: _____

Patient Signature _____ Date_____ / _____ / 20____

Personal Injury Information Auto / Work Comp/ Other: _____

Total Charges $
Ins Paid $
W/O $
Balance
Date

Todays Date: _____/ ____/ _____

Name: _____ Acc#_____ Driver / Passenger /Pedestrian

Accident Date: _____/ ____/ _____ Referred By: _____

Additional Patients Involved _____

Accident was in What State_____Hospital/ Other _____

were x-rays taken? ____Requested records on _____/ ____/ _____ Received on ____/ ____/ _____

Police Report: _____ Case # _____

Liens Notarized _____/ ____/ _____ What x-rays did we take? Cervical, Thoracic, Lumbar, Extremity: _____

X-Rays Send Out _____/ ____/ _____ X-Ray Report Received _____/ ____/ _____

Tens Unit Distributed _____/ ____/ _____ Unit #_____ Faxed to Compliance _____/ ____/ _____

- Attorney: _____Law Office _____

Phone (____) _____-_____ Fax(____)_____-_____ contact _____

Addy_____

Liens mailed to Attorney_____/ ____/ _____ Green Card received and stapled in file _____/ ____/ _____

- Patients Car Ins: _____ Med Pay / PIP

Policy Holder's Name_____ Policy #_____

Claim # _____ Medical Paperwork completed? _____ /_____ /_____ Copy in file ___

Phone (____) _____-_____ Fax(____)_____-_____ Adjuster _____

Claims mailing Addy _____

Liens mailed to Ins Co _____/ ____/ _____ Green Card received and stapled in file _____/ ____/ _____

- 3rd Party Car Ins _____

Name: _____Policy #_____ Claim # _____

Phone (____)_____-_____ Fax(____)_____-_____ Adjuster _____

Claims mailing Addy _____

Liens mailed to 3rd party Ins Co _____/ ____/ _____ Green Card received and stapled in file _____/ ____/ _____

- Health Ins _____

Released _____/ ____/ _____ Move to other binder, prepare records

Records Requested _____ _____/ ____/ _____ Mailed/ drop off/ picked up_____/ ____/ _____

Records Requested _____ _____/ ____/ _____ Mailed/ drop off/ picked up_____/ ____/ _____