WELLNESS ONE
Patient History

Name: _____ Who can we thank for referring you? _____

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

Phone: _____ E-mail (please **print** clearly): _____

Social Security Number: _____ Medical doctor name: _____

Birthdate: _____ Sex: _____ Age: _____ Marital Status: _____ Number of Children: _____

Occupation: _____ Employer: _____

Emergency contact name and phone number: _____ Relationship: _____

REMEMBER: ALL INFORMATION YOU GIVE IS CONFIDENTIAL

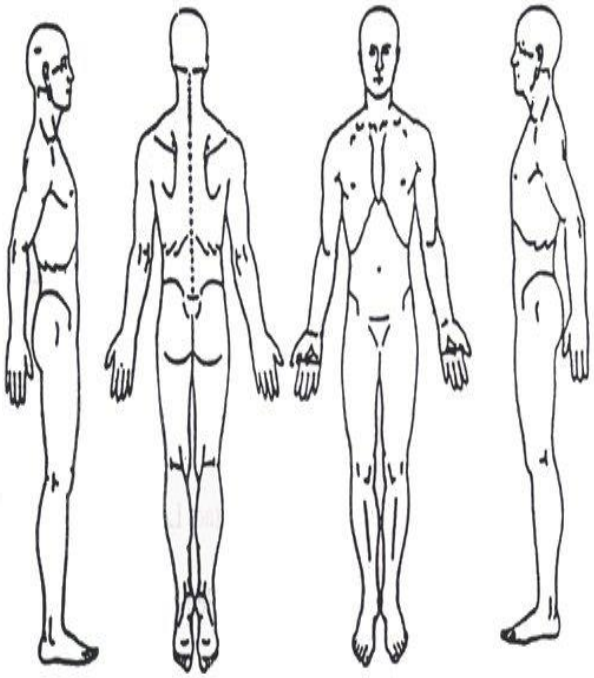
Major Complaints #1: _____
Major Complaints #2: _____
Major Complaints #3: _____
Family history of (circle): Heart disease High blood pressure Cancer Diabetes Stroke other _____
How long have has your current complaint(s) bothering you? _____
What makes it better?_____ What makes it worse?_____
Have you missed any work due to this? Yes / No If so, how much? _____
Have you had these symptoms in the past? Yes / No When? _____
Have you ever been to a chiropractor? Yes / No How often does this bother you?_____

PLEASE CHECK THE BOXES AND MARK THE PAINFUL AREAS

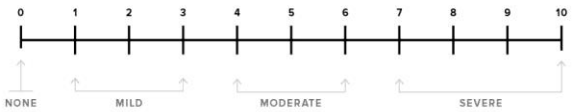
(Use *Quality* Key Below)

Past	Present	Condition
O	O	Headaches
O	O	Migraines
O	O	Arthritis
O	O	Allergies / Asthma
O	O	Anemia
O	O	Joint pain
O	O	Depression
O	O	Irritability
O	O	Sinus problems
O	O	Bruise easily
O	O	Frequent colds
O	O	Fatigue / low energy
O	O	Trouble sleeping
O	O	Shortness of breath
O	O	Chest pain / tightness
O	O	Anxiety
O	O	Dizziness
O	O	High blood pressure
O	O	Recent vision changes
O	O	Vertigo
O	O	Infectious diseases
O	O	Prostate problems
O	O	Uterus problems
O	O	Pregnancy
O	O	Pacemaker
O	O	Increase urination
O	O	Tobacco / nicotine use

Quality
S= Sharp
A = Achy
T=Tight
St = Stiff
B = Burning
D = Dull
R = Radiating



0-10 NUMERIC PAIN RATING SCALE



How would you like to have your problem handled? (check which one)

O Temporary Relief: Help the symptom, but do not fix the underlying cause of the problem.

O Maximum Allowable Correction: Correct the underlying cause while optimizing my future health.

Why did you choose this office and what are "your" expectations?

_____

_____

On a scale from 1-10: (10 being the most and 1 being the least)
How committed are you from the following?

_____ Being at your maximum health potential.
_____ Your family to be at their maximum health potential.
_____ Preventing spinal arthritis.
_____ Preventing degenerative disc disease.
_____ What is your pain level today?

Check if you have had the following surgeries: (what kind and when?)

O Spine _____
O Hip _____
O Knee _____
O Foot / Ankle _____

List medications and supplements you currently take (prescription and over the counter): _____

_____

_____

Who else have you seen for this condition? (check and circle)

O Family doctor / PA / Nurse
O Orthopedic / Neurologist
O Physical therapist
O Chiropractor
O Massage therapist
O Other _____

AUTHORIZATIONS: (I agree)

Dr. Charlie Gray, D.C. (Wellness One) can release, or request records as needed for my care.
I authorize assignment of any insurance benefits (if applicable) paid directly to the provider.
I authorize the staff and/or doctor to render care as deemed appropriate for me, my child, or my children.
After (if) any initial promotional offers, fees are rendered at usual and customary. Fees due are available upon request.
I am responsible for all the charges incurred at this office, this includes any late fees, collections fees, attorney fees, small claims fees, interest added, and/or any fees necessary for non-payment. Any insurance benefits are never a guarantee of payments.
I authorize this office to send my x-rays to any radiologist for an additional review and report. Any x-rays reviewed by any third party is at the expense of the patient. Not all x-rays are sent for review.

Please feel free to discuss all of our fees with us as it relates to your care. Fees are payable when services are rendered unless other arrangements are made in advance. Auto accidents, work injuries, and VA (Veteran's Administration) typically are not the patient's per visit responsibility at the time of service.

Signature: _____ Date: _____

Wellness One
ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Please choose 5 of your worst things you struggle with (functional deficits)

1. _____
2. _____
3. _____
4. _____
5. _____

Patient Print Name:_____ **Patient DOB:**_____

Patient signature: _____ **Date:** _____

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

WELLNESS ONE

Personal Injury Data Form

Date of Collision_____

In your words, describe the Collision:_____

_____

Describe in your words what happened to you upon impact and how you felt: _____

_____

Did you see the Collision Coming? ☐YES ☐NO Did you Brace for Impact? ☐YES ☐NO Were Seatbelts Worn? ☐YES ☐NO

Was your car Braking? ☐YES ☐NO Did the Airbag Deploy: ☐YES ☐NO

After the Collision did you (CIRCLE) Get transported to a local hospital? Continue on with activity? Drove Home?
Denied Transportation? Arranged for a Ride Home? Was Driven to the Hospital?

Did you lose Consciousness? ☐YES ☐NO If Yes, How Long? _____

Where were you seated in the car? (CIRCLE) Driver Seat Front Passenger Rear-Seat/Left Rear-Seat/Middle
Rear-Seat/Right Booster Seat Car Seat/Rear Facing Car Seat/Forward Facing Other_____

What was your Body Position at the time of Impact? (CIRCLE)

Head Turned Left Head Turned Right Looking Back Head Straight Body Rotated Right
Body Rotated Left Body Straight in sitting position Other: _____

At the time of the Collision, can you recall which parts of your head or body hit certain areas inside the car?

_____

As a result of the Collision were you: ☐ Dazed, Circumstances Vague ☐ Rendered Unconscious ☐ Other: _____

Could you move all parts of your body? ☐ YES ☐ NO, Explain_____

Could you walk out of car unaided? ☐ YES ☐ NO, Explain_____

What Bruises and/or cuts did you receive from the Collision? _____

PLEASE MARK ALL SYMPTOMS APPARENT SINCE THE COLLISION: (CIRCLE)

Headache	Loss of Smell	Numbness in Fingers	Cold Feet	Cold Hands	Loss of Taste
Mid Back Pain	Loss of Memory	Light Sensitivity	Fatigue	Diarrhea	Constipation
Low Back Pain	Tension	Shortness of Breath	Chest Pain	Dizziness	Irritability
Fainting	Depression	Numbness in Toes	Cold Sweats	Anxiety	Loss of Balance
Nervousness	Pain Behind Eyes	Sleeping Problems	Ringing/Buzzing Ears	Neck Pain/Stiffness	

Other_____

IF YOU HAVE HAD MEDICAL HELP, PLEASE FILL IN THIS SECTION

Name of Doctor:_____ Name of Medical Facility:_____

Date of Medical Help:_____ Were you Examined? ☐YES ☐NO Imaging? ☐YES ☐NO If Yes, What areas? _____

What treatment/recommendations were given? _____

Were you prescribed ANY drugs or medications? ☐ YES ☐ NO If Yes, What type? _____

Did you take the drugs? ☐ YES ☐ NO Were they effective? ☐ YES ☐ NO If No, why not? _____

Please Briefly Include Past Falls, Injuries, Accidents, Operations, Etc.

Did you have ANY physical complaints before the accident? ☐YES ☐ NO

If Yes, Please Describe in Detail: _____

Prior to this Accident, have you EVER had symptoms similar to what you are experiencing Now? ☐ YES ☐NO

If Yes, Please Explain: _____

CURRENT WORK INFORMATION

Occupation: _____ Employer: _____

Have you missed time from work: ☐ YES ☐NO If yes, how long? _____

ATTORNEY INFORMATION

Do You have an Attorney on this Case? ☐ YES ☐ NO If Yes, Who?_____

Patient Print Name:_____ Patient DOB:_____

Patient Signature: _____ Date: _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop," such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare," about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in a million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare."

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.

Dr. Gray history: If you have any fears or concerns, please speak with me directly. With my 13+ years of chiropractic experience there has never been ANY incident of serious harm or injury. Chiropractic when done precisely is the safest form of healthcare.

I have read the explanation above. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have decided to undergo the treatment and hereby give my full consent.

Patient Print Name:_____ Patient DOB:_____

Patient Signature: _____ Date: _____

Please check which one applies to you

Typically, no insurance coverage is 100%, but if you have any benefits for chiropractic coverage for our office, we certainly will do everything we can to help your out of pocket expenses be as low as possible.

O **No Insurance:** Easy! Our care plans and simple payment plans have helped over thousands of people and will work great for you too!

O **Health Insurance / HSA:** Many insurances today pay very little or limited amounts for natural drugless care to get you healthy. We make it easy! We verify any benefits you have and file these claims directly to your insurance company. You are responsible for any deductibles, co-pays, co-insurance, and unpaid visits. For your convenience, all payment arrangements are made in advance.

O **Auto Injury:** Auto accidents are typically covered at 100%, even if you were at fault, not at fault, or were a passenger. You can get the care you need and it costs nothing. Great for you! All we need is a claim #, insurance information, and / or your attorney's information.

O **Work Injury:** Work injuries are covered 100% for between 12-24 visits. All we need is your claim # and worker's comp information.

O **Medicare:** Regardless of your condition, Medicare pays for a maximum of 12 weeks of care. They have strict rules and limitations and do NOT cover all office services. When benefits are exhausted, you are eligible for a significant discount.

O **VA (Veteran's Administration)**: We love helping our veterans. You will need a direct referral and authorization. Typically, 12 total visits are allowed per year. Certainly, this helps cover the cost of some of your initial care! VA does not cover all of our services.

Initial ___

Office policies for Personal Injury patients

This office will accept you as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of your injuries. Your responsibility to this office will be to follow the doctor's recommendations and to provide the appropriate financial information so that the payment for services can be received.

Patients need to bring the following:

1- Copy of police report and/or a copy of the information exchange slip

2- Name of individual and insurance company of party that's Liable. Please include policy number.

3- Name and telephone number of attorney if an attorney has Been retained.

You are asked to give 24-hour notice if you need to reschedule an appointment. All appointments that have been missed without notice may be billed to your account.

Following the completion of your treatment in this office, your bill will be forwarded to the responsible party. Please note that this account is still your responsibility, we bill as a courtesy. Your account can include all fees necessary to settle your bill which can include collection services, attorney fees, small claims fees, late fees, and/or recurring monthly interest charges of 1.5% effective 30 days following your initial visit.

You are responsible for informing our office of any and all open settlements with the at-fault insurance company immediately. By signing below you acknowledge that you are responsible for any balance, fees and interest that exceeds your settlement.

Patient Print Name:_____ Patient DOB:_____

Patient Signature: _____ Date: _____

MEDPAY INFORMATION

A lot of people have benefits (MEDPAY) included in their automobile policies and don't even realize it. Our office highly recommends that you use your Medpay coverage, if you have it, in the event that you've been injured in an automobile accident, regardless of who is at fault.

Here are 3 reasons why we recommend that we file your Medpay.

1) **Medpay is similar to health insurance**- Using it does not cause your rates to increase. If your rates increase, it's not because you filed your Medpay, it's most likely because: a) it was determined that you were at fault, b) you received the police citation or ticket, or c) you've been involved in numerous reported auto accidents within a brief period of time and therefore are now considered to be "high-risk."

2) **Filing your Medpay doesn't relieve the other party from having to pay in full for your loss.** On the contrary, by filling your Medpay, when you collect from the other driver's liability insurance, a greater amount of the settlement will go directly to you because your bill at our office may be paid in full. If the other driver's liability insurance refuses to make payment to you for whatever reason, filing your Medpay will help to ensure that you are not stuck with all the medical bills.

3) **If you have Medpay coverage and choose not to file it, then you are paying for an option, but not receiving any benefit.**

For the same reasons, our office also recommends that you file your commercial health insurance. The important thing to remember is that you are not guaranteed of receiving full payment from the other driver's liability insurance company. Filing both your Medpay and your health insurance will help ensure that you are not left to pay the medical bills. If we receive overpayment on your account, we will be happy to refund you the difference.

Patient Print Name:_____ Patient DOB:_____

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the US Department of Health and Human Services at www.hhs.gov.
We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handle appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, US mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payors in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to require restrictions in the use of your PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, on this date _____, to hereby consent and acknowledge my agreement to the terms set forth in this HIPPA INFORMATION AND CONSENT FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature: _____

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between ("Patient") and **Wellness One** hereinafter referred to in the singular as ("Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers, sets over and assigns to Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patient's behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patient's favor as may be necessary to fully pay any and all financial obligations owed to the Provider by the Patient. This Assignment is to be complete and current transfer of Patient's right, title, and interest, separate from any statutory or contractual lien or claim to which the Provider may also be entitled. Patient acknowledges that Provider has a substantial pecuniary interest in the enforcement of this Assignments.

The Patient agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Provider's total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Provider any and all causes of action that Patient might have or that might exist in Patient's favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patient's attorney-in-fact any officer of Provider, to prosecute said causes(s) of action either in Patient's name or in the Provider's name and Patient further authorizes the Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Provider, Patient hereby grants a lien to said Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Provider. The Patient further agrees that the statute of limitations applicable to Provider's right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing

Notwithstanding the foregoing, the Patient agrees that until the Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Provider to await payments from any source, and in the event the Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Provider to release this Assignment and any information pertinent to Patient's case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to patient by said Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Notice: Automobile Accident Patients. If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form you are giving to your health care provider the right to receive some or all of that payment directly from your automobile insurance company. If you have health insurance and your healthcare provider is in-network: as long as you provide information necessary to verify your health insurance coverage the healthcare provider may only bill the amount you owe for any copayment, coinsurance, or deductibles to your automobile insurance and you may be entitled to any remainder of your automobile insurance benefit. If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your healthcare provider is not in your health insurer's provider network: your health care provider may bill their full charges to your automobile insurance. You may want to consult your insurance agent or attorney before signing or initialing this form. You are not required to sign/initial this form to receive care. By initialing here, I acknowledge that I have read or had the opportunity to read this notice. _____ (Patient's Initials)

Patient acknowledges that as a courtesy Provider may choose to bill Patient's insurance, including but not limited to Patient's secondary insurance and Patient's automobile insurance, but that Provider is not required to do so.

YOU ARE NOT REQUIRED TO EXECUTE THIS ASSIGNMENT IN ORDER TO RECEIVE CARE.
However, if you do not sign this form, you will be required to (i) pay any applicable co-pays and deductibles at the time the services are provided and allow us to bill your health insurance company or (ii) pay for all care at the time of service.

Witness the following signatures and seal as of the indicated date:

Patient's Signature _____ Printed Name _____

SS# _____ Date _____

Witness _____

Advantage Radiology Service

(419) 269-2424 (844) 283-4163

This form is for a third-party business, Advantage Radiology Service (ARS), that will review your x-rays if necessary, at the discretion of Wellness One, and prepare a report of their findings. This office, Wellness One, needs your permission to send your x-rays to this company for a thorough review and report. Their service is a complete and separate entity. Most insurances cover this charge. In the event that this fee is not covered, a small fee may be incurred. * A maximum of $ 37 would be incurred.

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to ensure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, VA, and/or to my attorney in the case of a personal injury. In the event that I receive a bill for these services, I agree to promptly remit payment to ARS.

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company attorney, and/or third part payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning their claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as describe above.

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

Name:_____ Social Security # _____

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

Phone: _____ Birthdate: _____ Sex: _____ Age: _____