5445 W Sahara Ave.
Las Vegas, Nevada 89146
P: 702-368-0508
F: 702-368-2049

THE PAIN CLINIC
-Chiropractic-Acupuncture-Massage Therapy-

Roper Dollarhide, DC
Fawod Majidi, DC
Lisa Berger, DC
Mathias Backus, DC
Khai Nguyen, OMD

CONFIDENTIAL PATIENT CASE HISTORY

WELCOME TO OUR OFFICE!

Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent records and will help us get a better understanding of your overall health. THANK YOU!

PERSONAL INFORMATION

Last Name/ Apellido: _____ Middle Name/ Segundo Nombre: _____

First Name/ Primer Nombre: _____ Date of Birth/ Fecha de Nacimiento:_____/_____/_____

Age/ Edad: _____ Sex: Male Female Marital Status/ Estado Civil: S / M / D / W

Address/ Direccion: _____

City/ Ciudad: _____ State/ Estado: _____ Zip/ Codigo Postal: _____

Social Security/ Seguro Social: _____-_____-_____ Home Phone/ Teléfono (Casa): _____

Cell Phone/ Teléfono (Celular): _____ E-mail/ Correo Electronico: _____

May we send you appointment reminders via cell phone or email? Yes _____ No _____ Please Initial: _____

***¿Podemos nosotros enviarle recordatorios de citas via cellular o correo electrónico*? Si _____ No _____ Please Initial: _____**

Occupation/ Ocupaciòn: _____ Employer/ Empleador: _____

Employer Address/ Direccion del Empleador:_____ Work / Trabajo: _____

Emergency Contact Name/ Contacto de Emergencia Nombre: _____

Contact Phone/ Teléfono de Emergencia: _____ Relationship/ Relaciòn: _____

How did you hear about us? ¿Comò se entero de nosotros? _____

What are you being seen for today in this office? ¿Razon de su visita?

Chiropractic/ Quiropractico _____ Acupuncture/ Acupultura _____ Massage Therapy/ Terapia de Masaje _____

INSURANCE INFORMATION

How do you plan to pay for your visits?

____Cash ____Health Insurance ____Auto Insurance ____Attorney Lien

PLEASE INDICATE BY CHECKING YES OR NO IF YOU HAVE HEALTH BENEFITS AVAILABLE THROUGH H.E.R.E.I.U./ CULINARY HEALTH FUND WHICH INCLUDES LOCAL 226-CULINARY, LOCAL 369-MUSICIANS, LOCAL 165-BARTENDERS, LOCAL 720-STAGE HANDS: _____ YES _____ NO

Subscriber's Name/ Nombre del Asegurado: _____ Relationship/ Relaciòn: _____

Insurance Company/ Compañia de Seguro: _____

Patient ID/ N◦ ID: _____ Group #/ N◦ Groupo : _____

Is the patient covered by additional or secondary insurance? ____Yes ____No

If yes, what is the name of your secondary insurance company? _____

Auto Accident Form

Patient Name: _____ Date of Accident: _____

Please describe how the accident happened: _____

_____

_____

Please **Circle One**: auto/auto auto/truck auto/motorcycle auto/pedestrian auto/object slip & fall

Were you the: Driver / Passenger Seated in: Front / Backseat Behind the driver? Yes / No

Were you wearing a: Seatbelt? Yes/No With a Shoulder Harness? Yes/No

Did you strike anything in the vehicle at the time of impact? If yes, please list the area/object below:

_____

Were you hit from: Behind / Front Right Side / Left Side

Did your car hit anything else after the impact? Yes / No If yes, what? _____

Were you surprised by the impact? Yes / No Was your foot on the break? Yes / No

Did you brace yourself prior to impact? Yes /No

At time of impact, my head was facing: Forward / Left / Right / Up / Down

Did you black out? Lose track of time? Become Dizzy? Vomit? _____

Did you feel pain immediately after the accident? Yes / No Where? _____

Were you transported to the hospital by ambulance? Yes / No

Which hospital? _____

Were X-rays taken? Yes / No Any Scans? CT MRI

Were you given prescription medication? Yes / No Muscle Relaxant / Inflammation / Other

Were you working on the job at the time of the accident? Yes / No

Did you treat with any other Doctors prior to coming to this office? Yes / No

Have you been in prior automobile accidents? Yes / No If so, when? _____

Patient Signature: _____ Date: _____

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CURRENT PRIMARY HEALTH CONCERN

HEALTH COMPLAINTS/ COMPLAINTS DE SALUD

Please check the specific complaints you are experiencing at this time and CIRCLE the location on the diagram. Then rate its severity on a scale of 1-10 with 1 being the least discomfort you have experienced and 10 being the most discomfort you have ever experienced.

__ Headache Pain/ Dolor de Cabeza

__ Neck Pain/ Dolor de Cuello

__ Upper-Mid Back Pain/ Dolor de espalda superior/ Media

__ Low Back Pain/ Dolor de espalda baja

__ Leg Pain/ Dolor de pierna

__ Arm Pain/ Dolor de braso

__ Other/ Otro: _____

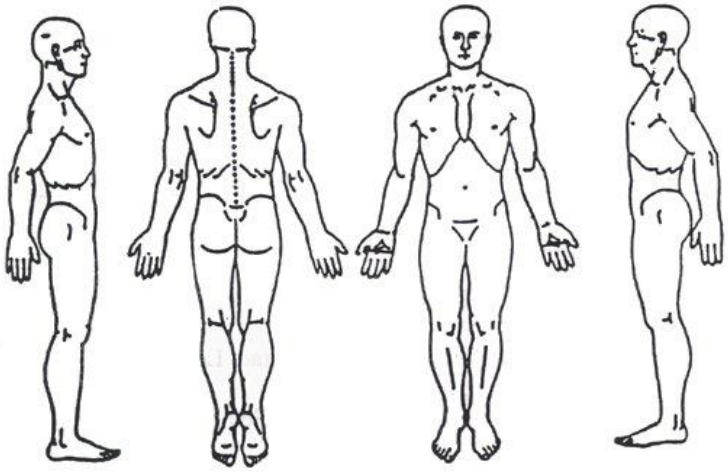
Rate Your Pain Intensity:

Current Pain: 0 1 2 3 4 5 6 7 8 9 10

At Its Worst: 0 1 2 3 4 5 6 7 8 9 10

At Its Best: 0 1 2 3 4 5 6 7 8 9 10

Use the Key below to describe your type of pain & location:



A= ACHING/ DOLOR
B= BURNING/ ARDIENTE
D= DULL/ DOLOR LEVE
N= NUMBNESS/ ENTUMIDO
P= PINS AND NEEDLES/ ALFILERES Y AGUJAS
S= SHARP OR STABBING/ DOLOR AGUDO
T= THROBBING/ PUNSANDO
X= SHOOTING/ DOLOR RADIANTE
Z= SPASMS/ ESPASMOS
O= OTHER/ OTRO : _____

What is your main symptom? ¿Cual es su principal sintoma? _____

How long have you had this condition? ¿Cuanto tiempo ha tenido esta condiciòn? _____

What do you think caused this condition? ¿Que piencas que causo el pròblema? _____

Over time, is this condition: (Circle One)/ Con el tiempo, esta condiciòn (Circule Uno):

Improving/ Mejorando Unchanged/ Sin Cambios Getting Worse/ Cada vez peor

Is this condition interfering with your/ Esta condiciòn interfiere con su: (Check all that apply)

____Work/ Trabajo ____Sleep/ Durmiendo ____Exercise/ Ejercicio ____Daily Routine/ Rutina Diaria

MEDICAL HISTORY

Have you had in the past or currently have any of the following: (Check all that apply)

___ Arthritic Conditions ___ Cancer ___ Diabetes

___ Heart Problems ___ High Blood Pressure ___ Vascular Condition

___ Lung Problems ___ Usual Childhood Diseases ___ Unusual Childhood Diseases

___ Low Back Pain ___ Upper/ Mid Back Pain ___ Neck/ Shoulder Pain

___ Allergies: Explain? _____

___ Surgeries: Explain? _____

To comply with the federal standards for healthcare, please answer the following questions:

Smoking Status?

___ Current Every day Smoker
___ Current Some Day Smoker
___ Former Smoker
___ Never Smoked

Current Height: _____ft. _____in.

Current Weight: _____ lbs.

Have you recently lost or gained more than 10 lbs.?

☐ Yes ☐ No

Are you currently taking any medications?

___ Not currently prescribed any medications
___ Yes. Please list all medications below

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Do you have any allergies to medication? ☐ Yes ☐ No

If so, please list: _____

_____

Consent to X-ray and/or Pregnancy Release

I hereby authorize **The Pain Clinic** Staff and whomever the physician may designate as his/her assistants to take X-rays, and release **The Pain Clinic** from any and all liability.

***For Female Patients**: Are you currently pregnant?* Yes _____ No _____

Print Name: _____

Patient Signature: _____ Date: _____/_____/_____

Authorization/ Signature On File

I certify that I have read and understand all the information provided to me in this packet to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information is unlawful and may be dangerous to my health. I authorize **The Pain Clinic** to release any information including the diagnosis and records of any treatment or examination rendered to me or my dependant during the period of such chiropractic care to third party payers and/or health practitioners only. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I authorize the use of my **Signature on File** for all insurance submissions relating to any medical treatment that myself or my dependant(s) receive at The Pain Clinic for payment. I understand that, should I not meet my payment responsibilities, I am fully responsible for all collection fees, travel expenses, interest charges, filing fees, court cost and attorney fees associated with the collection(s) regarding any of my outstanding debt.

Print Name: _____

Patient Signature: _____ Date: _____/_____/_____

Consent For Treatment Of Minor Child

I acknowledge that I am the parent, guardian or custodian of _____, age_____, and do hereby authorize, request and direct the doctor's office as shown above, its doctors and staff to perform examinations, diagnostic x-rays, and any treatment that is in their best judgment, which is deemed advisable or required. It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests and treatments as will be needed while the listed minor shown above is under care in the office until legal age is attained.

As legal parent/guardian, I understand that I will be fully responsibility for all charges and payments due at time of service, and/ or all charges that the insurance company will not pay under my covered plan.

Parent/ Guardian Name: _____

Parent/ Guardian Signature: _____ Relationship to Patient: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I,_____ (your name) acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of **The Pain Clinic**, which describes the practice's policies and the procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice. I also authorize **The Pain Clinic** to send correspondence by either US Postal Service or email, if available.

Print Name: _____

Patient Signature: _____ Date: _____/_____/_____

FOR OFFICE USE ONLY

The practice has made a good-faith effort to obtain an acknowledgement of _____
Receipt of our privacy practices. In spite of these efforts, the practice has been unable to obtain a signed acknowledgement of receipt for the following reasons:

____ Patient Unavailable ____ Patient Physically Unable ____ Patient Unwilling

In an effort to obtain the patients acknowledgement, the practice has attempted to provide patient with a notice of privacy practices in the following manner:

____ Personally ____ Mail ____ Phone ____ Other: _____

In an effort to obtain the patients acknowledgement of _____, the patient has refused to sign the stated documentation for the following reason(s) :

_____

_____

Office Staff Signature: _____ Date: _____/_____/_____

Printed Name: _____

Witness Signature: _____ Date: _____/_____/_____

Printed Name: _____

THE PAIN CLINIC

-Chiropractic-Acupuncture-Massage Therapy-

Cancellation Policy

No Call/ No Show Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment or care. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a $25.00 fee; this will not be covered by your insurance company.

Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on their scheduled time as a courtesy to everyone.

If a patient is 7 minutes past their scheduled appointment time and DOES NOT contact our office to let us know, we will have to reschedule the appointment based on availability. In such situations, the patient may be charged the no-show fee.

By signing this document, I fully understand the policy stated above.

Patient Name: _____

Patient Signature: _____ **Today's Date:** _____

THE PAIN CLINIC
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BUSINESS POLICIES/INFORMED CONSENT- PLEASE READ CAREFULLY!

We have recently updated our disclosures and informed consent forms to further clarify our business policies and practices. Please read all updates below. If you have not done so, we kindly ask that you please update your health history/informed consent with our front office.

POLICY DETAILS

Therapist Training & Experience / Limitations of Massage Therapy

All of the massage therapists working at The Pain Clinic have completed a minimum of 550 hours of massage training from a state-approved school and passed the state licensing requirements. Massage therapists at The Pain Clinic are knowledgeable in sports massage, deep-tissue, trigger point, stretching and myofascial techniques. Massage therapists do not diagnose medical diseases or musculoskeletal conditions. **Massage therapy is not a substitute for medical examination and/or treatment.** Massage therapists do not prescribe herbs or drugs, including aspirin or ibuprofen, or medical treatments. They do not perform spinal adjustments and they cannot counsel patients about emotional or spiritual issues as would be provided by a mental health professional or spiritual leader. **If you are experiencing symptoms that lead you to believe you may have a medical condition, it is recommended that you visit a physician for diagnosis and treatment.**

Expectations and Rights

The patient is expected to demonstrate good hygiene and not use illegal drugs or alcohol before the session (the use of drugs and alcohol make it unsafe for a client to receive massage). **Patients and therapists are expected to refrain from any behavior of a sexual nature, including sexual jokes, nicknames, or immodest conduct. Sexual behavior from the therapist toward a patient is grounds for therapist termination and may lead to a formal complaint filed with the state board of massage. This may lead to the loss of the therapist's license. Sexual behavior from the patient toward the therapist is inappropriate and will lead to the termination of the session and refusal of further service.** The patient has a right to prompt, professional service in an environment that is clean, private, and safe. Patient information is not shared with any patrons of the public or other health-care providers unless the patient releases the information in writing. A court of law may order the patient's healthcare records released to the court as part of a legal proceeding. Therapists are obligated to report information about the abuse of a child, elderly person, or mentally or physically challenged person in the event that such information is related during the session. Therapists are obligated to report threats of self-harm, or threats that the patient plans to harm another person, to authorities. The patient has the right to end the session at any time should they feel dissatisfied or uncomfortable with the session in any way. Patients who are dissatisfied with a therapist are encouraged to contact the clinic office manager or company president, Dr. Roper Dollarhide.

Formal complaints can be filed with the state on their website: http://massagetherapy.nv.gov/

Your Massage Session and Adverse Massage Reactions

After you complete the health intake form, the therapist will take you to a private treatment room and discuss your goals for the session. The therapist will customize the massage to meet your specific needs within the limits of his or her training and scope of practice. The therapist will then leave the room while you undress and position yourself under the drape on the massage table. Only the area being massaged at the time is undraped as the session proceeds. The breasts, genitals, and anus are never undraped during a session, and every effort is made to respect and protect both the patient's and therapist's modesty. You may leave on your underclothing if you prefer. While the therapist will ask you a few questions—for instance, about the comfort of the stroke pressure, room temperature, or choice of session music—and you should let the therapist know immediately if you are not comfortable, other conversation during the session is generally discouraged. Silence allows you to focus and take full advantage of the session. Massage may lead to adverse reactions in certain situations or when used with certain conditions or medications. The massage therapist will evaluate your health-

history intake and may ask you questions in order to make sure it is safe for you to receive a massage. In the event the massage therapist is uncertain that massage will be of benefit to you, he or she may ask you to provide a note from your physician stating that it is safe for you to receive massage. Please provide complete details of medical conditions and medications to your massage therapist in the beginning of your session. **Failure to inform the massage therapist of all medical conditions and medications may place you at increased risk for adverse reactions**.

Business Policies and Practices- 24 HOUR CANCELLATION POLICY!

You may book a 30, 60 or 90 (approval needed for 90 minutes) minute massage session. The Pain Clinic accepts cash, as well as all major credit cards and requires that all guests have a valid/current picture id that matches the name on the credit card provided. We do not bill insurance companies for services unless it is a covered benefit per our provider contract. The first session may require a slightly longer intake process, so new patients please share as much info as possible on your health form as well as any special requests, likes/dislikes, etc. to expedite your first visit. **Patients arriving late will still be charged for the full session time booked and the session will end promptly at the scheduled time. Patients must cancel sessions with 24 hours notice or pay the $25 late cancellation fee which is NOT covered by any insurance.** Business hours are Monday, Wednesday and Fridays 9:00am-5:00pm, Tuesday and Thursdays 9:00am-7:00pm and Saturday 9:00am-12:00pm. Walk-in appointments are accepted if therapists are available. We are located at 5445 W. Sahara Avenue, Las Vegas, Nevada 89146. Children and teens are welcome, but an adult guardian must be present with those under the age of 15 in the treatment room throughout the entire session.

INFORMED CONSENT

I, _____ have read and clearly understand the attached **BUSINESS POLICIES/ INFORMED CONSENT** detailed by The Pain Clinic, and I would like to receive a massage session or request a session for my child or dependent. I understand that a copy of these policies is available to me at any time by request and also located on The Pain Clinic website www.painclinic-lv.com. I understand the benefits and limits of massage therapy and understand massage may cause adverse reactions in certain situations. If I experience any discomfort during the session, I will immediately inform my therapist so he or she can modify the massage strokes. I understand massage therapists do not diagnose diseases or conditions, prescribe medications or treatments, or perform spinal adjustments. I recognize that massage therapy is not a substitute for medical treatment and should I need medical treatment, I will seek out the appropriate healthcare professional (physician, psychotherapist, chiropractor, etc.). I understand that it is my responsibility to keep the massage therapist informed of changes in my (or my child's or dependent's) health status, diagnosed medical conditions, and medication. I understand that failure to inform the therapist of these changes may place me (or my child or dependent) at greater risk of adverse reactions to massage. I release the massage therapist of any liability if I fail to disclose the appropriate health-related information. I understand that The Pain Clinic will charge a $25.00 fee for cancelling less than 24 hours prior to my scheduled appointment time or if I no call/no show. I understand that **any sexual advances, innuendo or inappropriate touch is EXPRESSLY FORBIDDEN!**

Please sign and date below for acknowledgement of receipt of our new policy and consent form. If you have any questions, please feel free to speak with one of our office staff or practice physicians.

Patient Name: _____ **Today's Date:** _____

Patient Signature (Legal Guardian): _____

Re:
Updated Disclosures and Informed Consent
December 01, 2020

THE PAIN CLINIC
-Chiropractic-Acupuncture-Massage Therapy-

Roper Dollarhide, D.C.
Lisa Berger, D.C.
Khai Nguyen, OMD.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME:_____ **DATE:** _____

DATE OF BIRTH:_____ **SSN:** _____

ADDRESS:_____

I authorize _____

To furnish all medical records and other documentation regarding my healthcare to:

NAME: **THE PAIN CLINIC** **PHONE: 702-368-0508**

ADDRESS: 5445 W SAHARA AVE, LAS VEGAS, NV 89146 **FAX: 702-368-2049**

I understand these records may contain information from other health care providers, as well as information which are administrative in nature. I specifically consent to the release of any information contained in the medical records that may relate to my medical conditions and/or other related conditions.

I understand that I may revoke this authorization at any time by giving written notice to this provider. Unless revoked earlier, this authorization with terminate two years from the date authorization is obtained.

I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by the HIPAA Privacy regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state and federal laws and regulations.

I understand that you have no responsibility for the use or distribution of this information by the party to whom it is released. I release you from all liability that may arise from your compliance with this request to release records. I authorize you to transmit this information by facsimile transmission. Any failure to receive transmission of my faxed records is the responsibility of the recipient.

_____ _____
PATIENT/LEGAL REPRESENTATIVE **SIGNATURE DATE**

_____
WITNESS

_____
IF NOT SIGNED BY THE PATIENT, LIST RELATIONSHIP OF LEGAL REPRESENTATIVE HERE

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Roper Dollarhide, DC
Lisa Berger, DC
Khai Nguyen, OMD

Medical Lien

Attorney/ Law Firm: _____ Fax: (_____)_____

I, the undersigned patient (or legal guardian of a minor), grant to The Pain Clinic (hereafter "medical facility") a lien upon the recovery of any and all proceeds from any source obtained through settlement, judgment, for any medical services rendered to me or the minor, for treatment of injuries sustained or the exacerbation of any medical condition(s) (hereafter "treatment") that I or the minor have indicated, believe or did in fact arise out of an incident that occurred on or about the date set forth below (hereafter "incident"). I further authorize the medical facility to furnish my attorney with a full report of the examinations, diagnoses, treatments, prognoses, as well as billings for treatment from this incident. I hereby notify and authorize you, my attorney, to pay directly to the medical facility the unpaid amount due for services rendered.

I understand that apart from this lien, I am directly and fully responsible to the medical facility for all medical bills submitted by it for services rendered, even for bills incurred for the minor (as indicated below) who may reach the age of majority, for which I may be required to make a lump sum or periodic payments, at the election of the medical facility. This lien is made solely for said medical facility's additional protection, and in consideration of its awaiting payment. Except as otherwise provided below, I intend for this lien to continue until all charges have been satisfied. I agree that the statute of limitations of my obligation to pay is tolled and does not begin to run while the medical facility is awaiting payment by way of this lien. I further understand that the payment of services is not contingent upon any settlement, judgment, or verdict that the minor or I may eventually recover.

Except as provided below, I agree never to rescind this lien, and I do not grant any attorney that may represent the minor or me the right to rescind it. However, if my first attorney does not promptly sign, acknowledge and return this lien to the medical facility within 10 (ten) days of receipt of this lien, or if the first attorney for any reason (e.g., withdraws, resigns, is released by me, or substituted by another attorney) no longer represents me or the minor child for injuries arising from this incident, then the Irrevocable Assignment of Proceeds that I have signed with this medical facility supersedes this lien and takes immediate effect. Alternatively, if an attorney modifies this lien in any way, then the Assignment of Proceeds supersedes this lien and takes immediate effect when the modification occurs. I agree to promptly notify medical facility of any change of my address or change or addition of attorney(s).

To my attorney: Please acknowledge this medical lien by signing below and returning it to the medical facility's office.

Date of Incident: _____ _____
Print Name

Today's Date: _____ _____
Signature of Patient or Legal Guardian of Minor

I, the undersigned attorney, state that I am the attorney of record for the this patient; I acknowledge that I am in receipt of this lien; and I agree to observe its terms by withholding the sums from any settlement, judgment or verdict that are owed to the medical facility, for their compensation or benefit. I also agree to promptly (1) notify the medical facility if I discontinue representation of this patient/client, and to (2) provide any subsequent attorney of the patient for this incident a copy of this lien, along with all of the medical facility's records and billings in my or my law firm's possession. In the event this lien is litigated, the prevailing party will be awarded attorney's fees and costs.

_____ _____
Attorney Signature Signature Date

Please sign, date and return one copy to medical facility's office within 10 days after receipt. Also keep one for your records.

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Patient Name: _____

D.O.B: _____ SSN (last four): _____ DL State and No.: _____

Insurance Company: _____

Claim No(s).: _____

Date of Incident: _____

ASSIGNMENT OF PROCEEDS

I, the undersigned Patient (or as legal guardian of the minor Patient), (also referred to below as "Patient") of The Pain Clinic ("Medical Provider"), without assigning any cause of action to this Medical Provider, unconditionally and irrevocably assign the proceeds of any settlement, judgment or verdict, up to the full amount of the unpaid medical services rendered by Medical Provider to Patient relating to the Date of Incident. I authorize these proceeds to be paid directly to the Medical Provider's attorney, the law firm of CRAIG K. PERRY & ASSOCIATES. I understand and agree that said law firm is authorized to contact the Insurance Company and me on behalf of the Medical Provider, to obtain information concerning the facts and status of Patient's case (e.g., completion of care, settlement status, insurance company information, etc.). Payment to a Patient, if a minor, shall be made by way of a minor's compromise, as required by law. The total amount owed, when it becomes a sum certain, will be provided to Insurance Company from one or more of the following sources: Patient, Medical Provider or attorney.

Upon execution of this agreement, I authorize and direct the Medical Provider or its attorney to furnish the Insurance Company with all reports, findings, interpretations, impressions, treatments, diagnoses, and/or diagnostic studies that Medical Provider may perform or order for Patient received relating to the Date of Incident.

I fully understand that this assignment of proceeds is contingent upon the outcome of my claim or case, and if there is no recovery from the Insurance Company, or if less than the full amount is assignable to the Medical Provider then this assignment will not satisfy my obligation to pay the Medical Provider in full for services rendered. I fully understand that I remain directly and fully responsible to Medical Provider for all unpaid balances of medical bills associated with the services rendered to Patient, whether or not there is any financial recovery from the Insurance Company or other source. I agree that the statute of limitations for the Medical Provider to take action for the collection of any unpaid balance commences (1) six years after it is determined that this assignment of proceeds will not satisfy the amount owed or (2) six years after day of Patient's or Patient's parent/legal guardian's last payment towards the amount owed, whichever is later. The balance owed will accrue interest at the rate of 18 percent per annum from the date of the statute of limitations begins to run. Collection fees shall be the responsibility of the Patient.

If Patient does not initially retain an attorney, but later decides to retain one, then I agree to promptly (1) furnish Medical Provider with the attorney's contact information, and (2) notify Patient's attorney concerning existence of this Assignment of Proceeds. In the event that the Patient is paid by way of settlement, judgment or verdict, Patient agrees not to accept any money from either the Insurance Company or Patient's attorney from any of the proceeds that have been assigned to the Medical Provider. Medical Provider shall be paid in full out of the first proceeds of any money paid by Insurance Company or Patient's attorney.

Print Name of Patient: _____

_____ _____

Signature of Patient or Legal Guardian of Minor Patient **Date**

Medical Provider acknowledges that the law firm of CRAIG K. PERRY & ASSOCIATES is the Medical Provider's attorney and grants the law firm limited power of attorney to enforce this Assignment of Proceeds, and to receive, endorse and deposit into its trust account any funds received.

Date: _____ **Authorized Representation of Medical Provider: _____**

OFFICE FINANCIAL POLICY

Your understanding of our financial policy is an essential part of your care and treatment. If you have any questions, please don't hesitate to discuss them with our office staff.

- As a courtesy we will contact your insurance carrier to verify your coverage, but this is only an estimate of what the insurance company will pay until we receive an actual payment. It is not a guarantee of payment.
- Your insurance policy is a contract between you and your insurance company. Also as a courtesy, we will file your insurance claims for you if you assign benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly.
- We are glad to assist you in billing your insurance, but you are ultimately responsible for full payment.

  Patients are encouraged to contact their carrier for clarification of benefits prior to services being rendered. You are considered a cash-based patient until we verify and determine the extent of benefits under your policy.
- Due to frequent erroneous information given to us from insurance carriers and the frequent difficulty in collecting payments from the carrier, we may ask for active assistance from you in rectifying the situation.
- All payments are due at the time of service. No personal balance is to exceed $100. We accept cash, checks, care credit, and most major credit cards.
- All deductibles and co-payments are due at the time of service or by an authorized payment plan. Most insurance does not cover 100% of services rendered. Because of this and the delay in payment common with insurance carriers, you will be asked to pay your deductible and your portion of your charges the day the service is rendered.
- After 90 days, any outstanding balances will be due in full by you. Balances over 90 days past due will be charged at a 1.5% monthly (18% annual) interest rate.
- You must inform this office of all insurance changes and referral requirements. In the event the office is not informed or the proper referral was not obtained by you in advance, you will be responsible for any charges denied by your insurance carrier as a result of not informing us or not obtaining the authorized referral.
- Insurance is designed for sick care and only reimburses for services that are deemed "medically necessary" according to their guidelines. In many cases, most insurance companies do not cover preventative care and health maintenance care and therefore may not be reimbursable.
- Non-compliance with a prescribed treatment plan may jeopardize insurance reimbursement. If you discontinue care or suspend care for any reason other than discharge by the doctor, any fees for professional services will become immediately due and payable in full by you, regardless of any claim submitted.
- There is a service fee of $25 for all returned checks. Your insurance company does not cover this fee.
- Past due accounts (those over 120 days) are subject to collection proceedings, which may affect your credit. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

Keep this copy for your information.

THE PAIN CLINIC
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APPOINTMENT POLICY

We want to thank you for choosing us as your chiropractic healthcare provider. We understand that your time is as valuable as ours. Because of this, it is our goal to provide to you with our highest quality care in the most cost effective and efficient manner. An understanding of our appointment guidelines is essential for a healthy relationship.

Advanced Multiple Appointments: As you know, healing takes time. Your care will likely require repeated visits as your body progresses through the healing process. As a means of reducing your costs and improving efficiency, advanced multiple appointments are recommended in order to limit your time in our office by reducing the need to schedule visit-by-visit with the front desk staff. Any deviation from the prescribed treatment schedule may potentially jeopardize insurance reimbursement.

Rescheduling Appointments: Please remember that we have reserved appointment times especially for you and that your appointments are "written in pencil", meaning that it is okay to reschedule if something unexpected arises. Please let us know at least 24 hours in advance of the need to reschedule an appointment. Giving us advance notice will allow time to fill in that appointment with someone else who needs it.

Cancelling Appointments: Please let us know at least 24 hours in advance of the need to cancel an appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. Canceled appointments will be recorded in your medical record.

Missed Appointments "No-Show": An appointment that is missed without at least a 24-hour advance notice to cancel or reschedule, is considered a missed appointment. It is the policy of this office to assess a $25 missed/ no-show appointment fee. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits after your second missed appointment. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others. This fee is not reimbursable by any insurance plan and therefore you will be responsible. Missed appointments will be recorded in your medical record.

Arriving Early: You are more than welcome to arrive early for any appointment; however, you will be seen by the doctor at your reserved appointment time.

Arriving Late: If you arrive more than 7 minutes after your scheduled appointment time you will be worked into the schedule at the next available time slot in order to honor the appointment times of others.

Walk-In Appointments: As a patient of our clinic, we do accept walk-ins based on availability. You are welcome to come in at any time during our office hours and we will do our best to fit you in the schedule. We are obligated to get our scheduled patients back to see the doctor first based on their appointment time. We encourage you to call and schedule an appointment in advance to avoid any wait time if you choose to walk in without a scheduled appointment time.

Open Door Promise: We understand that life can get busy. So if at any time you get "side- tracked" and decide to put your healthcare on hold, please know that you are always welcome back at any time. Our door is always open to you whenever you decide to start again.

Keep this copy for your information.

THE PAIN CLINIC
-Chiropractic-Acupuncture-Massage Therapy-