

DISCOVER CHIROPRACTIC HEALTH PROFILE

Name _____ Date ____/____/____ Age ____ Male / Female

Address _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Cell _____

Email Address _____ Date of Birth ____/____/____

Occupation _____ Employer's Name _____

Single / Married / Divorced / Widowed Spouse's Name _____

Number of Children _____ Names, Ages & Gender _____

Who may we thank for referring you? _____

PLEASE LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of severity 1= mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____

PLEASE DESCRIBE HOW YOUR HEALTH CONCERNS ARE AFFECTING YOUR LIFE _____

IF YOU ARE EXPERIENCING PAIN, IS IT ____SHARP ____DULL

DOES THE PAIN TRAVEL OR RADIATE ANYWHERE? ____YES ____NO IF IT DOES TRAVEL OR RADIATE, PLEASE DESCRIBE

SINCE YOUR PROBLEM STARTED, IS IT ____ABOUT THE SAME ____GETTING BETTER ____GETTING WORSE

WHAT MAKES IT WORSE? _____

WHAT HAVE YOU DONE THAT HELPS IT FEEL BETTER? _____

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? ____CHIROPRACTOR ____MEDICAL DOCTOR ____OTHER

WHO AND WHEN _____

LIST SURGICAL OPERATIONS AND YEARS _____

LIST ALL MEDICATIONS YOU ARE ON _____

WHEN WAS YOUR LAST AUTO ACCIDENT _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE ___YES ___NO IF YOU HAVE, DR. & DATE _____

HAVE YOU EVER BEEN: KNOCKED UNCONSCIOUS ___YES ___NO FRACTURED A BONE? ___YES ___NO

IF YES, PLEASE DESCRIBE _____

ANY OTHER BODILY TRAUMA? _____

PLEASE CIRCLE ANY AND ALL CURRENT PROBLEMS YOU HAVE HAD IN THE LAST 2 YEARS

- | | | | |
|-----------------|-------------------|------------------|--------------------|
| ASTHMA | ARTHRITIS | TMJ | CHRONIC FATIGUE |
| EPILEPSY | GASTRIC REFLUX | HEART DISORDERS | LUPUS |
| ULCERS | SCIATICA | IRRITABLE BOWEL | NAUSEA |
| DIZZINESS | NUMBNESS IN ARMS | DISC PROBLEMS | MENSTRUAL DISORDER |
| KIDNEY PROBLEMS | NUMBNESS IN LEGS | LIVER DISEASE | NECK PAIN |
| HEADACHES | NUMBNESS IN HANDS | LOW BACK PAIN | MIGRAINES |
| VERTIGO | NUMBNESS IN FEET | MID BACK PAIN | STIFFNESS IN NECK |
| CHEST PAINS | EAR INFECTIONS | STOMACH DISORDER | HIP PAIN |
| ARM PAINS | GRATING IN NECK | LEG PAINS | ANXIETY |
| NERVOUSNESS | SHOULDER PAIN | FAINTING | CHRONIC SINUS |

OTHER _____

PLEASE CIRCLE ANY CONDITIONS YOU HAVE NOW / HAVE HAD:

- STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

IF THIS HEALTH PROFILE IS FOR A MINOR / CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD / MINOR

NAME OF PATIENT WHO IS A MINOR / CHILD _____

I AUTHORIZE DR. JEREMY HESS AND/OR DR. AMANDA HESS AND ANY AND ALL DISCOVER CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR / CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR / CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY DISCOVER CHIROPRACTIC.

DATE

GUARDIAN SIGNATURE

WITNESS SIGNATURE (OFFICE STAFF)

GUARDIAN'S RELATIONSHIP TO MINOR / CHILD

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS.
 WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.
 AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAYS IN OUR FILES.
THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS \$15.00, THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE *VERTEBRAL SUBLUXATIONS*.
 THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF
 DISCOVER CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE
 FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.
BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS

 PRINT YOUR NAME HERE

 DATE

 SIGNATURE

 YOUR AGE

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT
 AT THE TIME X-RAYS ARE TAKEN AT DISCOVER CHIROPRACTIC

 SIGNATURE

 DATE

DO NOT WRITE BELOW THIS LINE · DO NOT WRITE BELOW THIS LINE · DO NOT WRITE BELOW THIS LINE

Sex: M F

<input type="checkbox"/> Lat Cervical CM Kvp Time MAS <input type="checkbox"/> 10-11 <input type="checkbox"/> 78 <input type="checkbox"/> 1/24 12.5 <input type="checkbox"/> 12-13 <input type="checkbox"/> <input type="checkbox"/> 1/20 15 <input type="checkbox"/> 14-15 <input type="checkbox"/> 1/15 20 <input type="checkbox"/> 16-17 <input type="checkbox"/> 1/10 30 <input type="checkbox"/> 2/15 40 MA 300 Size 8x10	<input type="checkbox"/> Flex/Ext CM Kvp Time MAS <input type="checkbox"/> 10-11 <input type="checkbox"/> 78 <input type="checkbox"/> 1/24 12.5 <input type="checkbox"/> 12-13 <input type="checkbox"/> <input type="checkbox"/> 1/20 15 <input type="checkbox"/> 14-15 <input type="checkbox"/> 1/15 20 <input type="checkbox"/> 16-17 <input type="checkbox"/> 1/10 30 <input type="checkbox"/> 2/15 40 MA 300 Size 8x10	<input type="checkbox"/> Lower Cervical CM Kvp Time MAS <input type="checkbox"/> 14-15 <input type="checkbox"/> 70 <input type="checkbox"/> 1/10 20 <input type="checkbox"/> 16-17 <input type="checkbox"/> <input type="checkbox"/> 2/15 30 <input type="checkbox"/> 18-19 <input type="checkbox"/> <input type="checkbox"/> 3/20 40 <input type="checkbox"/> 20-21 <input type="checkbox"/> <input type="checkbox"/> 2/10 50 <input type="checkbox"/> 22-23 MA 300 Size 8x10	<input type="checkbox"/> Lateral Thoracic CM Kvp Time MAS <input type="checkbox"/> 22-23 <input type="checkbox"/> 80 <input type="checkbox"/> 1/15 20 <input type="checkbox"/> 24-25 <input type="checkbox"/> <input type="checkbox"/> 1/10 30 <input type="checkbox"/> 26-27 <input type="checkbox"/> <input type="checkbox"/> 2/15 40 <input type="checkbox"/> 28-29 <input type="checkbox"/> <input type="checkbox"/> 2/10 50 <input type="checkbox"/> 30-31 <input type="checkbox"/> 1/4 75 <input type="checkbox"/> 32-33 <input type="checkbox"/> 3/10 90 <input type="checkbox"/> 34-35 <input type="checkbox"/> 2/5 120 <input type="checkbox"/> 36-37 <input type="checkbox"/> 1/2 150 MA 300 Size 14x17	<input type="checkbox"/> A-P Thoracic CM Kvp Time MAS <input type="checkbox"/> 16-17 <input type="checkbox"/> 75 <input type="checkbox"/> 1/20 17 <input type="checkbox"/> 18-19 <input type="checkbox"/> <input type="checkbox"/> 1/15 22 <input type="checkbox"/> 20-21 <input type="checkbox"/> <input type="checkbox"/> 1/10 30 <input type="checkbox"/> 22-23 <input type="checkbox"/> <input type="checkbox"/> 2/15 40 <input type="checkbox"/> 24-25 <input type="checkbox"/> <input type="checkbox"/> 2/10 50 <input type="checkbox"/> 26-27 <input type="checkbox"/> 1/4 75 <input type="checkbox"/> 28-29 <input type="checkbox"/> 3/10 90 <input type="checkbox"/> 30-31 <input type="checkbox"/> 2/5 120 MA 300 Size 14x17
<input type="checkbox"/> APOM CM Kvp Time MAS <input type="checkbox"/> 14-15 <input type="checkbox"/> 70 <input type="checkbox"/> 1/10 20 <input type="checkbox"/> 16-17 <input type="checkbox"/> <input type="checkbox"/> 2/15 30 <input type="checkbox"/> 18-19 <input type="checkbox"/> <input type="checkbox"/> 3/20 40 <input type="checkbox"/> 20-21 <input type="checkbox"/> <input type="checkbox"/> 2/10 50 <input type="checkbox"/> 22-23 MA 300 Size 8x10	Other View _____ CM _____ Kvp _____ MAS _____ MA _____ Size _____	<input type="checkbox"/> Lateral Lumbar CM Kvp Time MAS <input type="checkbox"/> 26-27 <input type="checkbox"/> 88 <input type="checkbox"/> 3/10 30 <input type="checkbox"/> 28-29 <input type="checkbox"/> 90 <input type="checkbox"/> 2/10 40 <input type="checkbox"/> 30-31 <input type="checkbox"/> 92 <input type="checkbox"/> 1/4 50 <input type="checkbox"/> 32-33 <input type="checkbox"/> 94 <input type="checkbox"/> 2/5 70 <input type="checkbox"/> 34-35 <input type="checkbox"/> 96 <input type="checkbox"/> 1/2 90 <input type="checkbox"/> 36-37 <input type="checkbox"/> <input type="checkbox"/> 3/5 120 <input type="checkbox"/> 38-39 <input type="checkbox"/> <input type="checkbox"/> 4/5 160 <input type="checkbox"/> 40-41 <input type="checkbox"/> 1 200 <input type="checkbox"/> 42-43 <input type="checkbox"/> 1 1/2 <input type="checkbox"/> 2 MA 200 Size 14x17	<input type="checkbox"/> A-P Lumbar CM Kvp Time MAS <input type="checkbox"/> 20-21 <input type="checkbox"/> 76 <input type="checkbox"/> 1/15 40 <input type="checkbox"/> 22-23 <input type="checkbox"/> 78 <input type="checkbox"/> 1/10 50 <input type="checkbox"/> 24-25 <input type="checkbox"/> 80 <input type="checkbox"/> 2/15 75 <input type="checkbox"/> 26-27 <input type="checkbox"/> <input type="checkbox"/> 2/10 90 <input type="checkbox"/> 28-29 <input type="checkbox"/> <input type="checkbox"/> 1/4 120 <input type="checkbox"/> 30-31 <input type="checkbox"/> <input type="checkbox"/> 3/10 150 <input type="checkbox"/> 32-33 <input type="checkbox"/> <input type="checkbox"/> 2/5 170 <input type="checkbox"/> 34-35 <input type="checkbox"/> <input type="checkbox"/> 1/2 210 <input type="checkbox"/> 36-37 <input type="checkbox"/> <input type="checkbox"/> 3/5 <input type="checkbox"/> 38-39 <input type="checkbox"/> <input type="checkbox"/> 4/5 <input type="checkbox"/> 40-41 <input type="checkbox"/> 1 <input type="checkbox"/> 42-43 <input type="checkbox"/> 1 1/2 <input type="checkbox"/> 2 MA 300 Size 14x17	

Dr. Jeremy Hess Dr. Amanda Hess

Notes: _____

CA Initials _____

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.
- C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home, and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

I _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

(Signature)

(Date)

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

(Signature)

(Date)

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE, WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN / STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE, OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE MY CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY, AND TO THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

PRINT PATIENT'S NAME HERE

PATIENT'S SIGNATURE

DATE

IF PATIENT IS A MINOR / CHILD, PARENT OR GUARDIAN MUST SIGN BELOW

SIGNATURE OF PARENT OR GUARDIAN

DATE

RELATIONSHIP TO MINOR / CHILD

WITNESS SIGNATURE (OFFICE STAFF)

DATE

Auto Injury Questionnaire

Name _____ Cell # _____
Your Auto Ins. Co. _____ Home # _____
Name on policy (if other than yourself) _____

Attorney Information

Name _____ Phone () _____
Address _____ City _____ State _____ Zip _____

Nature of Accident

1. Date of accident _____ Time of Day _____
2. Were you: Driver / Passenger / Back Seat Driver Side / Back Seat Passenger Side
3. Does your car have a headrest? Yes / No If Yes, what setting was it at time of accident:
Bottom of neck / Bottom of head / Middle of head
4. Number of people in vehicle: _____ Were you wearing seat belts? Yes / No
5. Were You struck from: Behind / Front / Driver Side / Passenger Side
6. Speed of your car? _____ mph Other car _____ mph?
7. Were you knocked unconscious? Yes / No If Yes, How Long? _____
8. Were Police Notified? Yes / No
9. Kind of car you were driving: Model _____ Make _____ Year _____
10. How much damage to your car \$ _____
11. In your own words, please describe the accident: _____

12. Did you have any physical complaints BEFORE THE ACCIDENT? Yes / No
If yes, please describe: _____

13. Please describe how you felt: During the accident _____
Immediately after the accident: _____
Later that day: _____ The next day: _____

14. Where were you taken after the accident? _____
What type of treatment did you receive? _____

15. What other Dr's have treated you since the accident? _____

16. Since the accident, your symptoms are: Improving / Getting Worse / Same

17. Have you lost time from work as a result of this accident? Yes / No

If yes, explain: _____

18. Have you noticed any activity restrictions as a result of this accident? Yes / No

If yes, explain: _____

P.I. PATIENT PROVIDER CONTRACT AND PROMISSORY NOTE

Entered This Day between Dr. Jeremy Hess or Dr. Amanda Hess (Hereinafter 'Provider') and

_____ (Hereinafter 'Patient'). Provider hereby agrees to establish an active account for the Patient and to provide essential services for the purposes of benefiting and improving Patients current health condition. Patient hereby agrees to pay Provider in full for services performed by Provider. Patient and Provider acknowledge that Patient retains any and all rights of suit to procure payment for and benefit Patient may be entitled.

In Consideration Of and for Provider rendering essential chiropractic and or medical services to Patient, and for the temporary suspension of any collection activity by Provider by the maintenance of an active account while not receiving payment at the point of service. Patient hereby authorizes and directs the following actions be taken on Patients behalf.

I. PATIENT AUTHORIZATIONS TO LIABILITY INSURANCE CARRIER: In consideration of the services to be rendered to Patient by Provider that Patient and Provider are privy of contact, and in lieu of Provider sending direct billing to liability insurance carrier Patient authorizes and directs liability insurance company to disclose the settlement status of Patients claim to Provider upon request, including settlement amounts thereof. After Such Time that Patient has settles the claim with the liability carrier, in consideration that Provider has not demanded payment at the point of service. Patient directs the liability carrier to include the name of Provider on any check to Patient Upon such Settlement. In the event payment is made to Patient attorney after settlement of the claim. Patient further authorizes and directs the liability company to issue check to provider for the full amount owed for chiropractic and or medical services rendered to fully satisfy Patients obligation to Provider.

II. PATIENT AUTHORIZATIONS TO ATTORNEY IF REPRESENTED: If Patient hires an attorney; Patient acknowledges that Patient is represented

by _____ Attorney of Law. Patient and Provider Stipulates, that representation by the above-named attorney prior to settlement, judgment or verdict in the Patients claim. Provider shall have the option to terminate this agreement and immediately collect from Patient the full amount then owed to Provider. Patient directs attorney to disclose to Provider upon request the settlement status and amount of Patient claim to include amount of all outstanding medical bills, dollar amount of any offers and counter offers as well as date and reason of termination or dismissal, patients last address, telephone number and place of employment known to attorney. Patient further directs attorney to honor this agreement and to deduct medical expenses from total settlement prior to contingency fee being deducted and to pay Provider for services rendered after any settlement after any settlement, judgment or verdict rendered in patients claim. Patient acknowledges and agrees to remain personally liable to Provider for any unpaid account balance to Provider. This agreement survives this attorney client relationship and all others that may follow in reference to this claim.

III. BINDING ARBITRATION: In the event liability, insurance carrier or Patients attorney do not honor this agreement, both parties agree to submit to binding arbitration prior to the insurance with any funds after settlement is reached. Both parties shall be entitled to legal representation at such hearing, with Patients attorney the likely representative for Patient.

IV. PROMISORY NOTE: For the consideration stated above; Patient promises to pay Provider the full balance in Patients account for services rendered to Patient. Payment shall be due and payable within 30 days of the last date of service or within 3 (three) days of settlement with liability carrier for injuries sustained by Patient and treated by Provider whichever event occurs first, provided agreement has not been terminated by parties prior to these events, in which case the account balance will be due in full 3 (three) days after termination. Further Patient agrees to the following:

IN THE EVENT PATIENTS ACCOUNT IS NOT PAID IN FULL WITHIN 30 DAYS OF THE LAST DATE OF SERVICE OR WITHIN 3 (THREE) DAYS OF SETTLEMENT WITH LIABILITY CARRIER OR ATTORNEY FOR INJURIES SUSTAINED BY PATIENT AND TREATED BY PROVIDER, OR WITHIN 3 (THREE) DAYS OF TERMINATION, WHICHEVER EVENT OCCURS FIRST, PATIENTS ACCOUNT SHALL BECOME DELINQUENT. IF PATIENTS ACCOUNT BECOMES DELINQUENT, PATIENT AGREES TO PAY COLLECTION AGENCY FEES AT 16% OF THE PATIENT ACCOUNT BALANCE AS OF THE LAST DATE OF SERVICE. PATIENT FURTHER AGREES TO PAY ALL COSTS AND ATTORNEY FEES SHOULD THOSE EFFORTS BE UNDERTAKEN BY THE PROVIDER.

Either party may terminate this agreement at any time, provided Patient's account remains in active status. It is agreed that, in the event Patient terminates this agreement. Patient shall pay full balance of Patients account within 3 (three) days of termination or the account shall be in default. Patient and Provider acknowledge that this document contains full, final and entire agreement between the parties. There are no other terms to this agreement. Patient has read and fully understands the terms of this agreement. In the event any portion of this agreement is rendered null or void it is expressly agreed by the parties that all remaining provision shall remain in full force.

Date of Agreement _____

Patient Signature or Guardian If A Minor

Witness

Provider

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty.

1 = "I can do it without any difficulty", 2 = "I can do it without much difficulty, despite some pain", 3 = I manage to do it b y myself, despite marked pain", 4 – "I manage to do it, despite the pain, but only if I have help", 5 = "I cannot do it all because of the pain". Only fill in areas affected.

Difficulties with Self Care and Personal Hygiene Activities

Bathing.....	Drying hair.....	Brushing Teeth.....	Putting on shoes.....
Preparing meals...	Showering.....	Combing hair.....	Making bed.....
Tying shoes.....	Eating.....	Doing Laundry....	Washing hair.....
Washing face.....	Putting on pants	Cleaning dishes...	Going to toilet.....

Difficulties with Physical Activities

Standing.....	Walking.....	Kneeling.....	Reaching.....
Twisting left.....	Twisting right	Stooping.....	Leaning back.....
Leaning forward..	Leaning left...	Leaning Right.....	Bending left.....
Bending right.....	Bending back..	Bending forward..	Reclining.....
Squatting.....		Standing for long periods.....	
Sitting for long periods.....		Walking for long periods.....	
Kneeling for long periods.....			

Difficulties with Functional Activities

Carrying small objects.....	Carrying large objects.....	Carrying brief case.....
Carrying large purse.....	Lifting weights off floor.....	Lifting weights off table...
Climbing stairs.....	Climbing inclines.....	Pushing things while seated
Pushing things while standing	Pulling things while seated...	Pulling things while standing
Exercising upper body.....	Exercising lower body.....	Exercising arms.....
Exercising legs.....		

Difficulties with Social and Recreational Activities

Bowling...	Jogging...	Swimming...	Ice Skating...	Competitive sports...
Dating.....	Golfing...	Dancing.....	Skiing.....	Roller skating.....
Hobbies...	Dining Out			

Difficulties with Traveling

Driving in a motor vehicle.....	Driving for long periods of time.....
Riding as a passenger.....	Riding as a passenger on an airplane.....
Riding as a passenger on a train.....	Riding as a passenger for long periods.....

Use the following 1 to 5 scale to describe the difficulties below:

1 = "This area is not affected by my condition", 2 = "This area is slightly affected by my condition", 3 = "My condition moderately restricts my ability in this area", 4 = "My condition seriously limits my ability in this area", 5 = "My condition prevents me from using this ability".

Difficulties with Different Forms of Communication

Concentrating.....	Hearing.....	Listening.....	Speaking.....	Reading.....
Writing.....	Using a keyboard.....			

Difficulties with the Senses

Seeing...	Hearing...	Sense of touch...	Tasting...	Smelling...
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Difficulties with Hand Functions

Grasping....	Holding....	Pinching....	Percussive movements....
Sensory discrimination.....			

Difficulties with Sleep and Sexual Function

Able to have normal, restful nights sleep.....	Able to participate in desired sexual activity.....
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Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above): _____

DOCUMENTATION NEEDED:

PLEASE BRING THE FOLLOWING WITH YOU ON YOUR FIRST VISIT

- VALID DRIVER'S LICENSE
- POLICE REPORT (if you don't have it yet, please bring with you on your next visit)
 - YOUR HEALTH INSURANCE CARD, IF YOU HAVE INSURANCE
 - YOUR AUTO INSURANCE CARD (even if you were not at fault)
- ATTORNEY INFORMATION (name and phone number or a copy of attorney's business card)
- ANY OTHER INFORMATION PERTINENT TO YOUR ACCIDENT (claim #s, name & phone number of adjuster, etc.)