Physicians Plus Spine & Rehab Center
1701 Pulaski Hwy Bear, DE 19701
P.) 302-300-1111
F.) 302-257-5628

General Information (Please complete to the best of your ability. Do not hesitate to ask questions).

Name: _____ **Date:** _____

Home Address: _____

City_____ **State:** _____ **Zip Code:**_____

Home Telephone:_____ **Work Telephone:** _____

Email: _____

Date of Birth: _____ **Age:** _____ **Gender:** ☐ Male ☐ Female

Social Security Number: _____

Primary Care Physician: _____

Primary Care Physician Telephone Number:_____

How did you hear about us?: _____

Date of Motor Vehicle Accident: _____

What hand do you write with? ☐ Right ☐ Left

Were you wearing a seatbelt at the time of the accident? ☐ Yes ☐ No

Did an airbag deploy? ☐ Yes ☐ No ☐ Not Applicable

Position in the vehicle at the time of the accident:
☐ Driver ☐ Passenger Front ☐ Rear Drivers Side ☐ Rear Passenger Side

PREGNANCY WAIVER

I hereby acknowledge that Physicians Plus Spine and Rehab Center has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

_____ _____
Printed Name of Patient Date

_____
Signature of Patient

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Accident Information

Type of Vehicle you were in: _____

Year: _____ **Make:** _____ **Model:** _____

Type of other Vehicle(s) involved (if applicable): _____

_____

My car was: (Please check all that apply)

- ☐ Hit from behind
- ☐ Hit on the passengers side
- ☐ Hit on the drivers side
- ☐ Hit in the front
- ☐ I hit into another vehicle or obstruction. If checked, Please explain_____
- ☐ None of the above. If checked, Please explain_____

Estimated Damage to Vehicle:
$_____

Police Report
☐ Yes ☐ No

If you would like briefly sketch the accident (OPTIONAL):

Body Positioning / Injury Information (Please answer to the best of your recollection)

Were you able to brace for the impending impact?

- ☐ Yes
- ☐ No
- ☐ Uncertain

When the motor vehicle accident occurred did your head hit anything?
(i.e. steering wheel, mirror, windshield)

- ☐ Yes
- ☐ No
- ☐ Uncertain

If yes, what did you impact?

- ☐ Side window
- ☐ Rear view mirror
- ☐ Airbag
- ☐ Dashboard
- ☐ Other _____

Were your hands on the steering wheel at the moment of impact?

- ☐ Yes
- ☐ No
- ☐ Uncertain

If yes, please explain
_____

Did your hands impact the dashboard?

- ☐ Yes
- ☐ No
- ☐ Uncertain

If yes, please explain
_____

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Did your chest or any other body part hit the steering wheel?

☐ Yes
☐ No
☐ Uncertain

If yes, please explain

_____

_____

Was your shoulder forcefully restrained by the seatbelt?

☐ Yes
☐ No
☐ Uncertain

If yes, please explain

_____

_____

Did your knees hit the dashboard?

☐ Yes
☐ No
☐ Uncertain

If yes, please explain

_____

_____

Were your feet jammed or twisted on a pedal of the floorboard?

☐ Yes
☐ No
☐ Uncertain

If yes, please explain

_____

_____

Did any other body part hit anything inside the car?

☐ Yes
☐ No
☐ Uncertain

If yes, please explain

_____

_____

History of Treatment to Date

How would you best describe your condition immediately after your accident

☐ Shaken up but functional ☐ Dazed and confused
☐ Circumstances Vague ☐ Loss of consciousness

Briefly describe your symptoms immediately after your injury (if any).

_____

_____

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Initial Treatment

☐ Yes ☐ No Were you taken to the emergency Room
If yes, How were you transported? _____

If yes, What treatment did you receive? _____

If yes, What instructions were given you when you left the emergency room? _____

_____

☐ Yes ☐ No If you were initially taken to the emergency, were you admitted to the a hospital?
If yes, please describe: _____

_____

☐ Yes ☐ No Did you have any of your present symptoms prior to this motor vehicle accident?
If yes, please describe_____

_____

Treatment of Injuries to Date

☐ **Yes** ☐ **No** **Have your symptoms worsened compared to how they were immediately after your accident?**

☐ **Yes** ☐ **No** **Have you seen your family physician since your injury?**

☐ **Yes** ☐ **No** **Has your family physician prescribed any medication to you for your injuries? If yes, please list:** _____

_____

☐ **Yes** ☐ **No** **Have you been referred for any diagnostic tests due to your Injuries?**
If yes, check below and indicate where you had the test done on the line next to the test.

- ☐ **X-rays** _____
- ☐ **CAT Scan** _____
- ☐ **EMG** _____
- ☐ **MRI** _____
- ☐ **Other** _____

☐ **Yes** ☐ **No** **Have you been to physical therapy? If yes:**

- **A. When did you start?** _____
- **B. Where did you go?** _____
- **C. How long did you go for?** _____

☐ **Yes** ☐ **No** **Have you been seen by any specialists (i.e. Physical Medicine, Rehabilitative specialists, Surgeons or Chiropractors)? If yes, Please list.**

1. _____
2. _____
3. _____

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About Your Injuries

Important – We strive to learn as much as possible about each and every injury that occurred to you as a result of this motor vehicle accident so that we may establish a comprehensive and efficient treatment plan.

Please complete the left side of the page (below) to let us know where you are injured, but you are not required to go into detail. The right side of the page will be utilized by your physician and your injuries will be covered in detail.

Patient Overview of Symptoms	Physician Detailed Review / Symptoms
As a result of your injury please check any of the following activities that you find to be difficult and / or painful.	**(This side office use only- please do not write in box)**
1.____ Headaches	**___ 1. Headaches:** **Frequency: 100% 75% 50% 25%** **Description: throb ache** **Regions:** suboccip || temporal || entire head **VAS:** ____/10 ☐ Concussion ☐ Photophobia ☐ Nausea ☐ Dizziness ☐ Vertigo ☐ Cognitive Impairment
2.____ Jaw Pain	**___2. TMJ:** _____ ____/10 ☐ Auscultory click ☐ Deviation ☐ Pain with Chewing ☐ Tooth Fractures
3.____ Neck Pain	**___3. Cervical Spine:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** ☐ LUE Radicular Features ☐ RUE Radicular Features **VAS:** ____/10

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About Your Injuries

Patient Overview of Symptoms	Physician Detailed Review / Symptoms
As a result of your injury please check any of the following activities that you find to be difficult and / or painful. **4.____Left Shoulder Pain** --- **5.____ Right Shoulder Pain** --- **6.____ Mid Back Pain** --- **7.____ Low Back Pain**	**(This side office use only- please do not write in box)** **___4. Left Shoulder:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** **VAS:** ____/10 --- **___5. Right Shoulder:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** **VAS:** ____/10 --- **___6. Mid Back:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** **VAS:** ____/10 --- **___7. Low Back:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** ☐ LLE Radicular Features ☐ RLE Radicular Features **VAS:** ____/10

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About Your Injuries

Patient Overview of Symptoms	Physician Detailed Review / Symptoms
As a result of your injury please check any of the following activities that you find to be difficult and / or painful.	**(This side office use only- please do not write in box)**
8._____ Left Knee Pain	**___ 8. Left Knee:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** VAS_____/10 ☐ Clicking ☐ Locking
9._____ Right Knee Pain	**___ 9. Right Knee:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** VAS_____/10 ☐ Clicking ☐ Locking
10._____ Left or Right Foot/Ankle Pain	**___ 10. Left or Right Foot/Ankle:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** VAS_____/10
11._____ Left or Right Elbow Pain	**___11. Left or Right Elbow:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** VAS_____/10 ☐ Contusion ☐ Jammed
12._____ Right or Left Wrist Pain	**___12. Right or Left Wrist/Hand** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** VAS_____/10
13._____ Rib Cage Pain	**___ 13. Ribcage / Sternal Pain:** **Frequency: 100% 75% 50% 25%** **Description: throb ache dull sharp burn deep** VAS_____/10

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About Your Injuries

Patient Overview of Symptoms
Physical Limitations

As a result of your injury please check any of the following activities that you find to be difficult and / or painful.

___ Lifting
___ Bending
___ Twisting
___ Turning
___ Reaching
___ Sitting
___ Standing
___ Walking
___ Pushing
___ Pulling
___ Gripping
___ Sexual Activity
___ Performing every day activities of daily such as dressing, housework, driving, shaving, etc

Patients Overview of Symptoms
Secondary Symptoms

As a result of your injury please check any of the following activities that you find to be difficult and / or painful.
Additionally, I have experienced:

A._____ Difficulty Sleeping

B._____ Nervousness

C._____ Depression

D._____ Difficulty Concentrating

E._____ Difficulty Breathing

F._____ Visual Changes

G._____ Irritation

H._____ Difficulty tasting / smelling

I. _____ Please list any social or recreational activities that you once enjoyed prior to your injuries but now find it either difficult or impossible (i.e. playing with children, exercising, golf, traveling or general social activities).

1. _____

2. _____

3. _____

4. _____

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Past Injury History (Work or Auto)

VERY IMPORTANT!! Have you ever been involved in a Work Injury or Auto Injury? YES or NO

If yes, approximately when? _____

This part is for office use only- please do not write in

Any permanent injuries? _____
100% Asymptomatic? ☐ Yes ☐ No

Personal Medical History

Have you ever been diagnosed with any of the following:

☐ Yes	☐ No	Hypertension
☐ Yes	☐ No	Diabetes
☐ Yes	☐ No	Allergies
☐ Yes	☐ No	Anemia
☐ Yes	☐ No	Asthma
☐ Yes	☐ No	Back Pain
☐ Yes	☐ No	Depression / Anxiety
☐ Yes	☐ No	Stomach / Intestinal Problems
☐ Yes	☐ No	Blood Disorder
☐ Yes	☐ No	Headaches
☐ Yes	☐ No	Hepatitis
☐ Yes	☐ No	Liver Disease
☐ Yes	☐ No	Cancer
☐ Yes	☐ No	Heart Disease
☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Hypoglycemia
☐ Yes	☐ No	HIV
☐ Yes	☐ No	Thyroid Disease
☐ Yes	☐ No	Gastro intestinal
☐ Yes	☐ No	Reflux Disease
☐ Yes	☐ No	Hiatal Hernia
☐ Yes	☐ No	Gall Bladder Disease

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Surgical History

Please list all of the surgeries you have had (if any) with the approximate date.

1._____ 4._____

2._____ 5._____

3._____ 6._____

Medical History

List all Medications prescribed for the injury

(Please list dosage, frequency and prescribing doctor)

1._____ 4._____

2._____ 5._____

3._____ 6._____

List all Medications that you were taking prior to the injury

1._____ 4._____

2._____ 5._____

3._____ 6._____

Allergies

Please list all known allergies (including medications)

1._____ 4._____

2._____ 5._____

3._____ 6._____

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Job Description and Work History

Employer: _____
Job Title: _____
❒ **Yes** ❒ **No** Does your job require lifting?
If yes, what is the maximum amount you are required to lift? _____

Place an ✓ next to all that apply to your job requirements:

- ❒ Lifting (max weight)
- ❒ Bending
- ❒ Twisting
- ❒ Gripping
- ❒ Repetitive Use of arms
- ❒ Pushing
- ❒ Pulling
- ❒ Reaching
- ❒ Overhead Activity
- ❒ Repetitive use of legs

Others: _____
What is the average number of hours you are required to sit per day? _____
What is the average number of hours you are required to stand per day? _____
What is the average number of hours you are required to work per week? _____

Social History

1. Martial Status: _____ **Number of Children:** _____

2. Education Status (check all that apply):

- ❒ Grade School
- ❒ High School
- ❒ GED
- ❒ Some College
- ❒ Associates Degree
- ❒ Specialty Degree (PTA, Dental Hygienist, Chiropractic Tech, MRI Tech)
- ❒ 4 Year Degree
- ❒ Graduate Degree
- ❒ Doctorate (PhD, MD, etc)

3. Alcohol and Tobacco History

❒ **Yes** ❒ **No** Do you smoke tobacco? (if yes how much do you smoke) _____ packs per week.
❒ **Yes** ❒ **No** Do you chew tobacco?
(If yes, On Rare Occasions _____ Moderate _____ Heavy _____).

❒ **Yes** ❒ **No** Do you consume alcohol?

a. Never _____
b. Very Rarely _____
c. Lightly_____ (average 1 drink or less per day)
d. Moderately _____ (average 2-3 drinks per day)
e. Heavily _____ (average 4 or more drinks per day)

Scale: 1 Drink = 12 oz. of Beer
5 oz. of Wine
1 oz. of Hard Liquor

❒ **Yes** ❒ **No** Have you ever been addicted to alcohol, prescription drugs, or street drugs?

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Insurance Information

Name: _____ Date: _____

Name of the Insurance carrier responsible for payment: _____

Insurance Claim Number: _____

Name of Insurance Company's Claim Adjustor that has been assigned to handle the bodily injury portion of your claim: _____

Adjustors Telephone Number: _____ Ext: _____

Important - for your protection

[ ] Yes [ ] No	I have completed and returned all of the required insurance forms to initiate payment of my medical bills.
[ ] Yes [ ] No	I am fully aware that it is my responsibility to complete all forms as mandated by my insurance company in order to have my medical expenses paid.
[ ] Yes [ ] No	I am aware that if I have not completed all paperwork (in a timely manner) my medical expenses will not be covered and it is possible for my insurance carrier to deny payment of my entire claim.
Note:	We're fully aware that dealing with insurance companies after an injury can be potentially confusing. We are here at your service to provide support to the very best of our ability. Please never hesitate to ask for assistance.

Private Insurance Information

The name of your private insurance company: _____

ID Number: _____

Please Note:	This information is important for your protection in the unlikely event of the denial of your claim.
Important:	Please allow us to make a copy of your insurance card for our own records.

Attorney Information (If applicable)

[ ] Yes [ ] No Do you have an attorney to assist you? If yes, please complete below.

Attorney _____
Law Firm: _____
Paralegal: _____
Address: _____
Telephone: _____

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Informed Consent

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, exanimation, and treatment, you are consenting to the following procedures: ***(Please initial each procedure to give consent.)***

__ spinal manipulative therapy __ palpation __ range of motion testing
__ orthopedic testing __ basic neurological testing __ muscle strength testing
__ postural analysis testing __ ultrasound __ hot/cold therapy
__ radiographic studies __ EMS __ vital signs
__ Other *(please explain)*: _____

The risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable eff0rt during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during exanimation and X-ray. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Physicians Plus Spine and Rehab Center to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HA VE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Physicians Plus Spine and Rehab Center and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: _____ Date: _____

_____ _____

Patient's Name Doctor's Name

_____ _____

Signature Signature

_____

Signature of Parent or Guardian (if a minor)

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AUTHORIZATION FOR COMMUNICATION

❒ I authorize communication between Physicians Plus Spine and Rehab Center staff and the person(s) listed below on my behalf regarding my information including medical records, billing, and/or scheduling. *(This communication may be sent by email if requested.)*

- ❒ Family Member: _____
- ❒ Other: _____
- ❒ Physician's Office: _____

❒ I authorize Physicians Plus Spine and Rehab Center to *leave voicemail and/or text message reminders* about scheduling and/or billing at the number indicated on these forms and/or at _____.

❒ I **DO NOT** authorize the release of information to anyone. *(I understand by doing this no one can talk on my behalf and no information will be release to any one including other doctor's office or attorney's office.)*

❒ I **DO NOT** authorize Physicians Plus Spine and Rehab Center to leave voicemail and/or text message reminders about scheduling and/or billing.

By signing below, I authorize Physicians Plus Spine and Rehab Center to communicate by mail or email with myself and/or those I have given authorization. I know that I am under no obligation to authorize Physicians Plus Spine and Rehab Center to send emails and/or text messages. I understand that releasing medical information or communicating by email and/or text messages is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in email communication may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in email and/or text messages communication may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information. This ***Authorization for Communication*** will remain in effect until terminated by me in writing.
By signing below, I accept and understand the risk explained above.

Acknowledgment of Privacy Practices

Our practice is committed to protecting privacy and confidentiality. With my consent, Physicians Plus Spine and Rehab Center, may use and disclose Protected Health Information (PHI) about me or my dependent to perform treatment, payment and healthcare operations (TPO). Please refer to Notice of Privacy Practices of Physicians Plus Spine and Rehab Center for a complete description of such uses and disclosures. I acknowledge that a copy of said Notice of Privacy Practices was offered to me.

Date: _____ Date: _____

_____ _____
Patient's Name Name of Parent or Guardian (if a minor)

_____ _____
Signature Signature of Parent or Guardian (if a minor)

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HIPPA Authorization

Patient Name:_____ DOB:_____

THE FOLLOWING PHI IS TO BE RELEASED: (PATIENT OR PATIENT REPRESENTATIVE MUST CHECK ONE BOX FOR EACH ITEM):

Yes	No	Items Requested	Yes	No	Items Requested
❒	❒	Physician Notes	❒	❒	All Medical Records on file
❒	❒	X-Ray Reports	❒	❒	Lab Results
❒	❒	MRI Scans	❒	❒	Claims/Billing Information
❒	❒	CT Scans	❒	❒	Other: _____

REVIEW OF PROCEDURES AND SELECTION OF INSPECTION OR COPYING OF MEDICAL RECORDS:

Your request to inspect or copy your PHI will be reviewed by the Medical Records Clerk of Physicians Plus Spine and Rehab Center who will determine if the information requested can be made available to you. We may legally prohibit from making certain information available to patients or the patients' representatives, including: Psychotherapy Notes, information related to legal proceedings, information that federal or state laws prevent us from disclosing, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, and information that was obtained under a promise of confidentiality.

- **Inspection of Medical Records:** We will complete our review of your request and will arrange for you to inspect your records at our Bear office within **a minimum of 14 business days** of your request.
- **Copying of Medical Records:** We will complete our review of your request and within the limitations of the law, we will make every effort to accommodate your request. **If we deny your request**, in whole or in part, you may request that we review that decision. It will take a **minimum of 14 business days** before your records will be copied. We will call you when your records are ready to be picked up at the Bear office.

Indicate the reason why you want your medical records copied: _____

Provide full name and address if you want your records mailed to your doctor: _____

I understand that my PHI may be redisclosed by the person or entity receiving my PHI from Physicians Plus Spine and Rehab Center, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI from Physicians Plus Spine and Rehab Center I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying Physicians Plus Spine and Rehab Center in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by Physicians Plus Spine and Rehab Center in reliance on this authorization before Physicians Plus Spine and Rehab Center receives my request for revocation or modification. I must sign and date my written request and send it to the following address: Medical Records Department, Physicians Plus Spine and Rehab Center, 1701 Pulaski Highway, Bear, DE 19701.

The authorization will expire on (date no more than one year in advance): _____

Signature of Patient/Guardian:_____Date:_____

If you are signing as the patient's representative, print your name: _____

Please indicate your relationship to the patient:

❒ Parent, guardian or caregiver of a minor patient.
❒ Guardian or conservator of an incompetent patient.
❒ Beneficiary or personal representative of a deceased patient.
❒ Other: _____(Specify Relationship)

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LIEN ASSIGNMENT – LETTER OF PROTECTION

I herby enter into the following agreement with **(Physicians Plus Spine and Rehab Center LLC)**, hereinafter known as "the provider" in order to guarantee payment for services rendered by the provider to me. I understand that I am directly and fully responsible to the provider for all medical bills for services rendered to me. I understand that I am directly and fully responsible to the provider for any remaining balance on all medical bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier. This document further serves to acknowledge my responsibility to repay all remaining balances subsequent to all the applicable insurance payments. I agree to make myself available to appear or correspond with the provider as often as may be necessary for any collections effort that is undertaken.

I agree to comply with all Insurance Company regulations including, but not limited to examinations under oath and independent medical examinations. I understand that any failure on my part to comply with any condition precedent to insurance coverage, may, at the election the medical provider, serve to revoke any assignment of benefits.

The Provider agrees to seek compensation from the appropriate insurance carrier prior to invoking the terms of the lien based on the accuracy of the information the patient has provided. The patient shall provide all necessary insurance information, police reports, and any additional documentation, or information deemed necessary by the provider for the submission of the aforementioned insurance claim as applicable. Failure to provide the accurate insurance information leading to a viable source of coverage may serve to invalidate any executed assignment of benefits.

I hereby give and grant this lien on my case to **Physicians Plus Spine and Rehab Center LLC** against any and all proceeds of settlement, judgement, verdict, or other disposition of any litigation filed or contemplated on my behalf that may be paid to me **OR MY ATTORNEY** as a result of the injuries for which I have been treated. I grant the provider the aforesaid lien against such sums of the aforesaid settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse the provider for services rendered to me and towards all outstanding balances.

I hereby agree to provide accurate contact information for the attorney pursuing any litigation on my behalf.

I hereby **direct** and **authorize** direct payment to the provider, such sums as may be due and owing for medical services rendered to me. I further direct my **ATTORNEY** to honor the aforesaid lien and to withhold such sums from any settlement, judgement, verdict or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse the provider for services rendered to me towards all outstanding balances.

I understand that this document may **NOT** be rescinded and that my **ATTORNEY** shall not honor any such rescission. I hereby instruct that in the event another **ATTORNEY** is substituted in my case, the new ATTORNEY honor this lien as inherent to the settlement, judgement, verdict, or other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct my attorney, on demand, to provide the status of such litigation to the provider or this attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact the provider prior to disbursement of any funds to ascertain any outstanding balances due and owing to **Physicians Plus Spine and Rehab Center LLC**

By signing below, I am stating that I have read and understand this agreement that I have signed.

Date: _____ Date: _____

_____ _____
Patient's Name Name of Parent or Guardian (if a minor)

_____ _____
Signature Signature of Parent or Guardian (if a minor)

As the Attorney of record for the above patient, I agree to observe the terms of this agreement and to act in accordance with the agreement between the Clinic and my client by paying directly from the proceeds of any settlement, judgment or recovery that patient is entitled to receive after attorney fees and costs and any valid hospital liens are paid.

Date: _____ _____
Signature of Attorney