GARNER CHIROPRACTIC AND WELLNESS CENTER

CONFIDENTIAL HEALTH RECORD

Name: _____ Street Address: _____

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

Home Phone: _____ Cell Phone: _____ Cell Carrier Name: _____

Patient Birthdate: _____ Age: _____ Sex: M F Social Security: _____

Occupation: _____ Marital Status: S M D W # of Children: _____

Spouse/Parent/Guardian: _____ Insurance Carrier:_____

Primary Insured's Name (if other than patient):_____ Insured's Birthdate: _____

Emergency Contact Name: _____ Emergency Contact Relationship: _____

Emergency Contact Phone #: _____

Present Family Physician: _____ City, State: _____

Date of Last Physical Exam: _____ By Doctor: _____

Referred By: _____

List Present Complaints (most bothersome to least):

1. _____ How Long? _____

2. _____ How Long? _____

3. _____ How Long? _____

4. _____ How Long? _____

List other doctors consulted for this/these conditions:

Name: _____ Diagnosis: _____

Treatment: _____ Result: _____

Name: _____ Diagnosis: _____

Have you had chiropractic care in the past? Yes No Treatment Date: _____

Dr.'s Name: _____

I GIVE GARNER CHIROPRACTIC AND WELLNESS CENTER PERMISSION TO TREAT ME

Date: _____ _____

Signature (Parent/Guardian if under 18 years)

NAME:_____

GARNER CHIROPRACTIC & WELLNESS CENTER CONFIDENTIAL HEALTH RECORD page 2

What surgeries have you had

What: _____When:_____ Doctor:_____

What: _____When:_____ Doctor:_____

What: _____When:_____ Doctor:_____

Any previous significant injuries (slips, falls, sports related etc.):

What: _____When:_____ Treatment:_____

What: _____When:_____ Treatment:_____

What: _____When:_____ Treatment:_____

List Fractures/Broken bones:

What: _____When:_____

What: _____When:_____

List any medications, vitamins, or diet supplements you currently take

What_____ for_____ Dosage_____ Dr._____

What_____ for_____ Dosage_____ Dr._____

What_____ for_____ Dosage_____ Dr._____

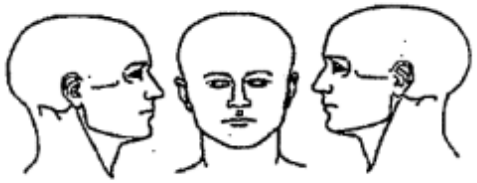
Family History: Do family members have any of the following:

Heart Disease	High Blood Pressure	Diabetes	Stroke	Cancer
Kidney Disease	Tuberculosis	Anemia	Other:_____	

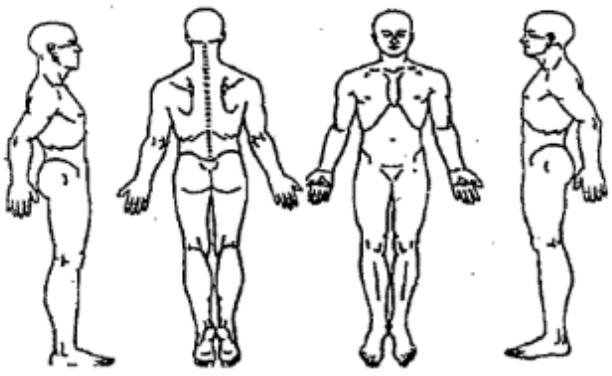
Personal History: Have you had any of the following:

Appendicitis	Scarlet Fever	Rheumatic fever	Typhoid Fever	Lupus	Stroke
Chicken Pox	Small Pox	Whooping Cough	Malaria	Diptheria	Polio
Pneumonia	Heart Disease	High Blood Pressure	Headache	Anemia	Mumps
Arthritis	Tuberculosis	Mental Disorder	Eplilepsy	Eczema	Cancer
Influenza	Pleurisy	Diabetes	Goiter	Measels	AIDS/HIV

Mark on the diagram your complaint area
How do you rate your pain: 1 2 3 4 5 6 7 8 9 10
1=ok 10= tremendous pain



Type of sensation:
Numbness: + + + +
Burning: x x x x x
Stabbing (sharp):= = = = =
Pins and needles: o o o o o
Aching (dull): / / / / / /



REVIEW OF SYSTEMS:

Cardiovascular	**Present**	**Past**	**Respiratory**	**Present**	**Past**	**Allergic/Immunologic**	**Present**	**Past**
Poor Circulation			Asthma			Hives		
Hypertension			Tuberculosis			Immune Disorder		
Aortic Aneurism			Short Breath			HIV/AIDS		
Heart Disease			Emphysema			Allergy Shots		
Heart Attack			Cold/Flu			Cortisone Use		
Chest Pain			Cough					
High Cholesterol			Wheezing			**Ear, Nose, and Throat**	**Present**	**Past**
Pace Maker						Difficulty Swallowing		
Jaw Pain			**Eyes**			Dizziness		
Irregular Heartbeat			Glaucoma			Hearing Loss		
Swelling of legs			Double Vision			Sore Throat		
			Blurred Vision			Nosebleeds		
Genitourinary	**Present**	**Past**				Bleeding Gums		
Kidney Disease			**Psychiatric**	**Present**	**Past**	Sinus Infections		
Burning Urination			Depression					
Frequent Urination			Anxiety			Gastrointestinal		
Blood in Urine			Stress					
Kidney Stones						**Gall Bladder Problems**	**Present**	**Past**
Lower Side Pain			**Endocrine**	**Present**	**Past**	Bowel Problems		
			Thyroid			Constipation		
Neurologic	**Present**	**Past**	Diabetes			Liver Problems		
Stroke			Hair Loss			Ulcers		
Seizures			Menopausal			Diarrhea		
Head Injury			PMS			Nausea/Vomiting		
Brain Aneurysm						Bloody Stools		
Numbness			**Hematologic**	**Present**	**Past**	Poor Appetite		
Severe Headaches			Hepatitis					
Parkinson's			Blood Clots			**Musculoskeletal**	**Present**	**Past**
Carpal Tunnel			Cancer			Gout		
Vertigo			Bruising			Arthritis		
			Bleeding			Joint Stiffness		
Constitutional	**Present**	**Past**	Fever, Chills			Muscle Weakness		
Weight Loss/Gain			Sweating			Osteoporosis		
Low Energy level			Varicose Veins			Broken Bones		
Difficulty Sleeping						Joints Replaced		
			Female Only	**Present**	**Past**	Neck Pain		
			Painful Menstruation			Low Back Pain		
			PMS			Upper Back Pain		
			Last Menstrual Cycle					

COMMENTS: _____

_____

FAMILY HISTORY:

Do any of your family members have any of the following? If yes, state who (father, mother, sister, etc…).

Diabetes □ Parent □ Sibling
Hypertension □ Parent □ Sibling
Heart Disease □ Parent □ Sibling
Cancer □ Parent □ Sibling
Stroke □ Parent □ Sibling

Please Initial: _____

ACCIDENT HISTORY

Date of Accident ___/___/___ Patient_____

Injury: Auto Work Comp Other_____

Location of Accident (City or Location) _____

To Whom was the accident reported? _____

Was an accident report filed? (Y or N) Time of accident? _____

Was a Police Report Made? (Y or N)

To Whom was a citation given?_____

Patient's Attorney Name _____
Address: _____
_____
Telephone Number: _____

Referred By: _____

History:

Driver _____ Passenger _____ Pedestrian _____ Other _____

Were you wearing a seat belt? (Y or N) Make of Vehicle _____
Traveling or stopped facing ____north ____south ____east ____west
Number of vehicles involved in the accident?_____
History of accident:
___ stopped at red light and rear ended
___ hit head on
___ car ran a stop sign or red light and hit _____area of car
___ side swiped
___ lost control of the car
___ other _____
_____
_____

Did you see the accident coming? (Y or N) Brace Yourself? (Y or N)
Did you strike any objects inside the car? (Y or N) What objects?

___ Steering Column	___ Rear view mirror
___ Dash Board	___ Windshield
___ Headrest	___ Driver side window
___ Other _____	___ Can't remember

Did your seat or seat belt break or release upon impact? (Y or N)
Upon impact was your body thrown? How? _____
___ Forward ___Backward ___To the right ___ To the left
What part of your body did you strike? ___Arm/hand ___Back ___Neck
___Head ___Chest ___Face ___Knees ___Ankles ___Shoulder
Were you cut? (Y or N) Did you remain conscious? (Y or N)
Were you able to get out of the car and stand or walk? (Y or N)
Was your car towed away? (Y or N)
Was an ambulance called? (Y or N)

Did you feel any immediate pain? (Y or N) If yes, Where?

___ Headache	Right	Left	Both	sides
___ Neck pain	Right	Left	Both	sides
___ Midback pain	Right	Left	Both	sides
___ Low Back pain	Right	Left	Both	sides
___ Shoulder pain	Right	Left	Both	sides
___ Face pain	Right	Left	Both	sides
___ Elbow pain	Right	Left	Both	
___ Wrist pain	Right	Left	Both	
___ Hand pain	Right	Left	Both	
___ Knee pain	Right	Left	Both	
___ Ankle pain	Right	Left		
___ Foot pain	Right	Left		

After the accident, did you: ___ go home ___ go to hospital
___other_____
If you went to hospital, how did you get there?_____
Name of hospital? _____ Name of physician? _____
Were you seen in the emergency room or admitted? _____
If admitted how long was your stay? _____
What was done at the hospital?

___ Examined	___ Xrays taken	___ Cervical collar
___ Medicated	___ Therapy	___ Stitches
___ Lab work	___ Casts	___ other _____

After your release what did you do? _____
What other doctors did you consult? When? _____
Doctor's name _____
Specialty?_____
What treatment did this other doctor perform?

___ xrays	___ examination	___ diathermy
___ ultrasound	___ traction	___ physiotherapy
___ prescription	___ manipulation	___ other _____

If physiotherapy was rendered, for how long? _____
Did you receive these treatments in his office? _____
How many times per week were you treated? _____
How long were you under his care? _____
Are you still under his care? _____
Did this doctor refer you to another physician? (Y or N)
Whom and where?_____
Have you ever been in any previous accidents of any kind? (Y or N)
If yes, give details. _____
_____
_____
Have you ever been treated for neck or back problems prior to this accident? (Y or N) If yes, please explain. _____
_____
_____
Have you enjoyed good health prior to this accident? (Y or N) If no please explain. _____
_____
Have you lost any time from work since the accident? (Y or N) Are you still off work? (Y or N) Date returned to work? _____

GARNER
CHIROPRACTIC & WELLNESS
C E N T E R

OFFICE POLICY

1. We will try to assist the patient whenever possible, but it must be understood that: waiting for insurance payments is a courtesy that may be withdrawn at any time. We will bill your **primary** insurance carrier only. You will be responsible for billing your secondary insurance carrier.
2. We file claims in a timely manner and expect insurance payments to be timely as well. Payment should be made in 30-90 days. If the insurance carrier fails to pay in that time, the patient must pay all fees in full.
3. Patients are required to pay their deductible, co-insurance, and/or co-pay required by their insurance plan. We will file insurance toward your deductible.
4. If the patient discontinues care, or is discharged by the doctor, the bill is due in full immediately.
5. If the patient fails to keep scheduled appointments, they can be discharged from care. The bill is then due in full immediately.
6. When we receive an insurance payment, and if a balance is due, you will be notified.
7. As a service, we will get an estimated verification of benefits for you. This is not a guarantee that your insurance company will pay.
8. We will not enter a dispute with your insurance company over payment or coverage. This is your responsibility.
9. Any costs incurred Garner Chiropractic & Wellness Center to collect any unpaid balance will be your responsibility.
10. There may be an additional charge for any extra paperwork required for settling accounts by you or your insurance company(ies).
11. A two percent (2%) interest charge per month will be assessed on any balance 30 days past due.
12. You are required to keep us current with information regarding insurance coverage.

If you have any questions on any of the statements provided above, please ask before signing below. We are happy to answer any questions. The above statements are provided to inform all parties of their responsibility so that there are not any surprises or questions regarding payments.

I hereby state that I have read and understand the terms of the Garner Chiropractic & Wellness Center, PLLC. office policy and that I agree with and will abide by the terms set forth.

_____ _____

Signature of Patient (Parent/Guardian if under 18 years) **Date**

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully**.

YOUR RIGHTS

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request but we will tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example: home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request and we may say "no" if it would affect your care.

ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request (i.e. your request is to not file your claims to your insurance company) not to share that information for the purpose of payment or our operations with your health insurer. Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we have shared information

You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights have been violated

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations below, talk to us. Tell us what you want us to do and we will follow your instructions.

In these situations, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- Contact you for fundraising efforts*.

If you are not able to tell us your preference (i.e. if you are unconscious) we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

***We may contact you for fundraising efforts but you can tell us not to contact you again.*

In these situations, we <u>never</u> share your information unless you give us written permission:

- Marketing purposes.
- Sale of your information.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways:

- **Treat You**
  We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
- **Bill for your services**
  We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance so it will pay for your services.*

How else can we share or use your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- **Help with public health and safety issues**
  We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.
- **Do research**
  We can use or share your information for health research.
- **Comply with the law**
  We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **Respond to organ and tissue donation requests**
  We can share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director**
  We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests**
  We can use or share health information about you: for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.
- **Respond to lawsuits and legal actions**
  We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective January 16, 2019

_____ _____ _____

Printed Name of Patient **Signature** of Patient (Parent/Guardian if under 18 years) **Date**

GARNER
CHIROPRACTIC & WELLNESS
C E N T E R

Informed Consent Document

PATIENT NAME:_____

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 I use as a Doctor 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 with a goal of gaining better range of motion, better symmetry and balance, reducing pain, and enhancing how you feel. That may cause an audible "pop" or "click", much as you experience when you "pop" your knuckles. You may feel a sense of movement.

Examination / Analysis / Treatment:
As part of the examination, analysis, and treatment, Garner Chiropractic is fortunate to have some of the most up-to-date and advanced technologies listed below. Any may benefit your treatment/condition. You are consenting to the following procedures:

____ I consent to **any/all treatments/protocols** the doctor believes will help me/my condition.

____ I consent **ONLY** to the following, which I have initialed:

_____ spinal manipulative therapy
_____ range of motion testing
_____ muscle strength testing
_____ ultrasound
_____ radiographic studies
_____ palpation
_____ orthopedic testing
_____ postural analysis

_____ hot/cold therapy
_____ acupuncture
_____ power-vibe rehab
_____ vital signs
_____ basic neurological testing
_____ electrical muscle stimulation (EMS)
_____ rehab/exercises
_____ nutritional recommendations

_____ other (please explain) _____

The material 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, dislocation, muscle strain, cervical myelopathy, costovertebral strains and separations, and skin irritations. 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. I will make every reasonable effort during the examination to screen for contra-indications to care. However, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform the doctor(s).

The probability of those risks occurring:
Fractures are rare occurrences and generally result from some underlying weakness of the bone which is checked for during the compilation of your history and during examination and X-Ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are described generally as rare.

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-inflammatories, muscle relaxants, and pain-killers,
- Hospitalization, and/or
- Surgery and injections.

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks (death, infections, etc.) and benefits associated with these options, and you may wish to discuss these with your primary care medical physician.

The risks and dangers with 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.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.

I have read [ ]: or

I have had read to me [ ]:

the above explanation of the chiropractic adjustment and related treatment(s). I have discussed it with Dr. Perry Kirch 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 it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

_____	_____
Printed Name of Patient	Printed Name of Doctor
_____	_____
Signature of Patient (Parent/Guardian if under 18 years)	Signature of Doctor
_____	_____
Date	**Date**

PERSONAL INJURY PAYMENT POLICY

We appreciate the opportunity to assist with your healthcare. Periodically, an insurance company and/or your attorney (if applicable) may request a reduction in payment for you reclaim due to circumstances of the case, or in the case of pro-rata payments, send less than the total due.

Any reduction for your claim must be presented and approved **PRIOR** to any disbursement to Garner Chiropractic & Wellness Center (GC&WC). In certain circumstances, we understand that you may request assistance with a reduction in the total amount due. For example, if your attorney reduces 10%, then most likely we will reduce 10%. If the attorney requests that the doctor's bill be reduced greater than what they are willing to reduce, please do not expect the doctor to reduce a bill greater than what the attorney is willing to reduce theirs (for example by 30% if your attorney does not reduce any, or reduces by just 10%).

Sometimes we can assist you, and we will always try and help our customers. **But,** we will only consider reduction if GC&WC is notified by you and/or your attorney **before** the claim is paid. **If we are not notified prior to receiving payment, we will not be able to modify any outstanding bill.**

In the case where pro-rata payments are made in pursuant to N.C.G.S Sections 44-49 and 44-50, they will be applied to the total bill. However, you will be liable for the balance due. **Please ask our office and/or your attorney if you need additional clarification on this.**

By signing below, I fully understand that I am responsible for full payment and I fully understand the need for me (name below) and/or my attorney to contact Garner Chiropractic & Wellness Center **PRIOR** to any disbursement that is LESS than 100% of the total amount due.

_____	_____
Printed Name of Patient	**Printed** Clinic Representative
_____	_____
Signature of Patient (Parent/Guardian if under 18 years)	**Signature** of Clinic Representative
_____	_____
Date	Date

ELECTION NOT TO FILE HEALTH INSURANCE CLAIMS
PERSONAL INJURY

The chiropractor(s) at this clinic are participating ("in-network") providers for your health benefit plan. As participating providers, we are obligated to file claims for reimbursement with your plan for all covered services provided to you UNLESS you instruct us in writing not to file.

You have indicated that rather than using your own health insurance, you wish to consider seeking payment from other third-party payers such as the at-fault driver's liability insurance. To help you make an informed decision, please carefully review the following information.

If you elect NOT to file claims on your health insurance:

1.) The clinic will rely on your decision and extend credit to you for the cost of care based on the assumption that your bill will be paid by sources other than your health insurance. You will be required to assign to the clinic the right to receive monies paid by liability insurers, medical payments insurers or other third-party payers to the extent necessary to satisfy your bill.

2.) You will not be required to pay co-payments/co-insurance and/or deductibles that would normally be required by your health benefit plan.

3.) The cost of your treatment will be billed at the clinic's usual rates rather than the discounted rates that routinely apply to services covered by your health benefit plan.

4.) If the combined payments received from other sources do not fully satisfy your bill, you may be personally liable for any unpaid balance.

5.) None of the charges for your treatment will be applied towards satisfying the annual deductibles associated with your health benefit plan.

If you elect TO file claims on your health insurance:

1.) Your health insurance should pay the cost of covered services associated with this accident/injury EXEPT FOR copayments, co-insurance and/or deductibles, which you will be expected to pay directly to the clinic at the time services are rendered.

2.) You will be responsible for paying to the clinic the cost of any non-covered services you elect to receive, and your payment will be due at the time services are rendered.

3.) If your health benefit plan initially pays the clinic for your treatment and later determines that it is not legally responsible for payment, the plan administrator may require the clinic to refund to the plan all or part of the payments received. If that happens, you will become responsible for reimbursing the clinic the amount it was required to refund.

4.) Your health benefit plan requires the clinic to submit claims in a timely fashion and while timely filing requirements vary, most plans require claims to be filed within 3-6 months from date of service. If your action or inaction causes a claim to be submitted late, the claim could be denied, and you would be responsible for paying this clinic for those services which were denied.

Election not to file health insurance claims:

1.) By my signature below, I attest that I have read and understand the above information regarding the options available to me and have been given an opportunity to ask questions and to have those questions answered.

2.) I hereby instruct the clinic not to file claims on my health insurance for services associated with this accident/injury, and I authorize the clinic to seek payment from, and send my treatment records to, other third-party payers who are potential sources of payment.

3.) I understand that the clinic is relying on my decision not to file health insurance claims, and that with regards to claims related to this accident/injury, this decision is irrevocable.

4.) I understand that no subsequent action on my part shall impair the clinic's right to bill and receive payments from third-party payers; subject only to any contractual obligation the clinic may have to my health benefit plan.

_____	_____
Printed Name of Patient	**Printed** Clinic Representative
_____	_____
Signature of Patient (Parent/Guardian if under 18 years)	**Signature** of Clinic Representative
_____	_____
Date	Date

A complete copy of this executed agreement must be maintained in the patient's health record, and a copy must be provided to the patient.

Dr. Perry J. Kirch, DC
1428-D Aversboro Rd
Garner, NC 27529
Phone: (919) 779-2225 (BACK)
Fax: (919) 779-9569

To: Attorney/Insurance Carrier

_____

_____

_____

Doctor

Garner Chiropractic & Wellness Center_____

_____

_____

Patient Name/SS #: _____

Re: Patient Records and Doctor's Lien

I do herby authorize the above doctor at Garner Chiropractic & Wellness Center to furnish you, my attorney/insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred/began on _____.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for service rendered to me, and to withhold sums from such settlement, claim, judgment or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all bills submitted by him for service rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fees.

_____ _____

Patient Signature (Parent/Guardian if under 18 years) **Date**

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

_____ _____

Authorized Signature **Date**

Notice: Please sign, date and return a copy to doctor's office by fax to 919-779-9569. Keep one copy for your records.

ASSIGNMENT OF BENEFITS

In consideration of the willingness of Garner Chiropractic & Wellness Center (GC&WC) to treat me on credit without demand for payment at the time of services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to GC&WC any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to GC&WC, from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, works compensation benefits, judgements, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due to GC&WC for its services rendered.

I appoint GC&WC as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with GC&WC.

I authorize GC&WC to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to GC&WC for services rendered, including any balance remaining after the application of insurance payments and settlement or judgement proceeds. If GC&WC is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse GC&WC for its costs of recovery, including reasonable attorney's fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by me in any way.

_____

Printed Name of Patient

_____

Signature of Patient (Parent/Guardian if under 18 years)

_____

Date

_____

Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, GC&WC herby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

GC&WC herby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. GC&WC agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

_____ _____

Clinic Name Date