Nicola Chiropractic

Personal Injury

Patient Information

Date _____

Patient Name _____
First Name

_____
Last Name Middle Initial

Date of Birth _____

Sex: □ Male □ Female Age _____

SSN _____

Address _____

City _____

State _____ Zip _____

Occupation _____

Employer _____

Status: □ Married □ Single □ Divorced □ Minor

Spouse's Name _____

Spouse's Employer _____

Spouse's DOB_____ SSN_____

Contact Information

E-mail _____

Cell Phone (_____)_____

Home Phone (_____)_____

IN CASE OF EMERGENCY, CONTACT

Name _____

Phone (_____)_____

Relationship_____

Would you like your Primary Care Physician to recieve notes from our office?

Yes □
No □

Doctor Name:_____

Phone:_____

Address:_____

_____

Accident Information

Is your condition due to an accident? □ Yes □ No Type of accident: □ Auto □ Work □ Other _____

Date of accident _____ Reason for your visit _____

Attorney Name _____ Phone (_____)_____

Your Auto Insurance _____ Phone (_____)_____

Claim # _____ Policy # _____

Adjuster's Name _____

Do you have medical payments coverage with your auto insurance? □ Yes □ No

Other Party Auto Insurance _____ Phone (_____)_____

Claim# _____ Policy# _____

Adjuster's Name:_____

Nicola Chiropractic

Personal Injury

Health History

Write any ambulance, Hospitals, M.D., Chiropractor, Dentist, PT, Acupuncturists, etc you have seen since accident.

Name	Type	Phone	Address
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date of Last: Physical Exam _____ Spinal X-Rays_____ MRI_____

Mark box "Yes" or "No" to indicate if you have had any of the following:

AIDS/ HIV	□Yes □No	Glaucoma	□Yes □No	Parkinson's disease	□Yes □No
Alcoholism	□Yes □No	Goiter	□Yes □No	Pneumonia	□Yes □No
Allergy Shots	□Yes □No	Heart Disease	□Yes □No	Polio	□Yes □No
Anemia	□Yes □No	Hepatitis	□Yes □No	Prostate problems	□Yes □No
Anorexia	□Yes □No	Hernia	□Yes □No	Prosthesis	□Yes □No
Appendicitis	□Yes □No	Herniated Disk	□Yes □No	Psychiatric Care	□Yes □No
Arthritis	□Yes □No	Herpes	□Yes □No	Rheumatoid arthritis	□Yes □No
Asthma	□Yes □No	High blood pressure	□Yes □No	Rheumatic Fever	□Yes □No
Bleeding disorders	□Yes □No	High Cholesterol	□Yes □No	Scarlet Fever	□Yes □No
Breast Lumps	□Yes □No	Kidney Disease	□Yes □No	STD	□Yes □No
Cancer	□Yes □No	Liver Disease	□Yes □No	Stroke	□Yes □No
Cataracts	□Yes □No	Lupus	□Yes □No	Tonsillitis	□Yes □No
Chemical Dependency	□Yes □No	Migraine headaches	□Yes □No	Thyroid Problem	□Yes □No
Chicken Pox	□Yes □No	Miscarriage	□Yes □No	Whooping Cough	□Yes □No
Diabetes	□Yes □No	Mononucleosis	□Yes □No	Ulcers	□Yes □No
Emphysema	□Yes □No	Multiple Sclerosis	□Yes □No	Vaginal Infections	□Yes □No
Epilepsy	□Yes □No	Mumps	□Yes □No	Other _____	
Fibromyalgia	□Yes □No	Osteoporosis	□Yes □No	_____	
		Pacemaker	□Yes □No		

Please mark in each column which boxes best describes your activities:

HABITS

□ Smoking Packs/day _____

□ Alcohol Drinks/week _____

□ Coffee/Caffeine Drinks Cups/day _____

□ High Stress Level Reason _____

Are you pregnant? □ Yes □ No Due Date:_____

Injuries/Surgeries that you have had:

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

Accidents_____

Patient or Guardian Signature _____ **Date** _____

The Rivermead Post-Concussion Symptoms Questionnaire*

0 = Not experienced at all
1 = No more of a problem
2 = A mild problem
3 = A moderate problem
4 = A severe problem

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches.....	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance.....	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful.....	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, Easily upset by bright light.....	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

1. _____	0	1	2	3	4
2. _____	0	1	2	3	4

*King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592

Nicola Chiropractic

Personal Injury

Duties under Duress / Loss of Enjoyment

Work / Employment:

My current work status is:

Working Unemployed Retired Not working due to pain

If working, why have you continued to work?

- ☐ I would lose my job if I took time off.
- ☐ I couldn't support my family otherwise.
- ☐ My business would fail if I took time off.

What days (if any) have you missed work:_____

I have experienced the following changes / difficulties in my ability to perform at work:

Postural:	☐ Bending	☐ Sitting	☐ Standing
Mobility:	☐ Walking	☐ Kneeling	☐ Lifting
Emotional:	☐ Anxiety	☐ Depression	☐ Fatigue
Neurological:	☐ Dizziness	☐ Ringing in Ears	☐ Poor Concentration

Home / Domestic:

I experience pain while performing the following home activities:

☐ Cleaning ☐ Preparing Meals ☐ Laundry ☐ Vacuuming ☐ Other

Due to my injuries, I have brought in the following assistance:

☐ Paid Assistance/ Help ☐ Unpaid Assistance/ Help ☐ No Assistance

My family status would best be described as:

☐ Single	☐ Single with Kids	Number of Children at Home: _____
☐ Spouse Only	☐ Spouse and Kids	Number of Children at Home: _____

Loss of Enjoyment:

I have experienced the following changes / difficulties in my lifestyle as a result of my injuries:

☐ Dining Out	☐ Movies	☐ Hobbies: _____
☐ Gardening	☐ Vacation / Travel	☐ Sports / Exercise: _____
☐ Sexual	☐ Studies	☐ Sleep: (Hours Lost Per Night) _____
☐ Misc._____		

Patient or Guardian Signature _____ **Date** _____

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

BACK

PERSONAL INJURY QUESTIONNAIRE

1. Date and type of accident: Date _____ □ Auto □ Other_____

2. What type of vehicle were you riding in? _____ Year? _____

3. What type of vehicle was the other vehicle? _____ Year? _____

4. Were you the: □ Driver □Front Passenger □ Back Passenger □Right or □ Left

5. Was your car: □ Stopped at Red Light □ Moving thru intersection □ On Freeway □ Making a turn
□ At Stop Sign □ Slowing down for traffic/construction □ Other_____

_____

6. Type of collision? □ Head-On □ Rear-ended □ Side Swiped □ T-Boned

7. Other vehicle: Pulled out: □ from Driveway □ from Cross Street □ Turned Left/Right in front
□ Failed to Yield □ Other_____

8. Where was your vehicle damaged? □ Front End □ Front Driver's Side □ Front Passenger's Side
□ Rear Bumper □ Driver's Rear Quarter □ Passenger's Rear Quarter

9. Did your car hit anything else? □ Yes □ No If yes, what_____
What area of your car hit the object? _____

10. Which way were you looking at time of impact? □ Left □ Right □ Rear-view Mirror □ Straight Ahead

11. Were both hands on the steering wheel? □ Yes □ No

12. Were the brakes applied as accident occurred? □ Yes □ No

13. Wearing seatbelt at time of crash? □ Yes □ No

14. Were you aware that an accident was about to occur? □ Yes □ No

15. Did your head strike headrest? □ Yes □ No If yes, where? □ Top □ Middle □ Bottom or
□ Missed Completely

16. Did airbags deploy? □ Yes □ No □ Car not equipped with air bags
If airbag deployed, what body parts did it strike □ Face □ Chest □ Other_____

17. Do you recall any other body parts striking anything inside the vehicle? □ Yes □ No
If yes, what area? _____

18. Did you notice any cuts, scratches, or bruises as a result of the accident? □ Yes □ No
If yes, where? _____ Any blood loss? □ Yes □ No

Continued on next page...

Post Accident

1. Did you lose consciousness? □ Yes □ No

2. Where was your pain immediately after the accident? □Head □Neck □Face □Chest □Upper/Mid-Back
□Low Back □L Arm/Hand □R Arm/Hand □L Thigh/Leg/Foot □R Thigh/Leg/Foot □Other_____

3. Other symptoms immediately after the collision: □Headache □Ringing in Ear R/L □Anxiety □Nausea
□Vomiting □Other_____
Did your symptoms worsen? □ Same day □ Next day □ Later _____

4. Did you go to the hospital? □ Yes □ No
If yes, what was the date? _____ By Ambulance? □ Yes □ No
Which hospital did you go to? _____

5. Medications provided_____
_____

6. Have x-rays been done? □ Yes □ No If yes, of what area? _____

7. Have you seen any other doctors? □ Yes □ No If yes, what was the date? _____
Please list below name & number below:
Doctor_____
Doctor _____

7. What advice / recommendations were you given by the doctor(s) you saw?_____
_____

8. Circle all symptoms you have NOW or SINCE accident date:

Headache	L / R Shoulder Pain	L / R Arm Numbness
Neck Pain	L / R Elbow Pain	L / R Leg Numbness
Mid Back Pain	L / R Wrist Pain	Muscle Spasm
Low Back Pain	L / R Arm Pain	Anxiety
Jaw Pain	L / R Ankle Pain	Dizziness
Blurred Vision	L / R Knee Pain	Chest / Ribs Pain
Ringing in Ears	L / R Leg Pain	Sleep Loss

Other: _____

9. What lowers your pain/discomfort level: □ Prescribed Meds □ Advil/Motrin/Tylenol □ Rest □ Ice □ Heat
□ Other:_____

10. What increases your pain/discomfort level: □ Bending □ Lifting □ Prolonged Standing/Sitting □ Work
□ Other:_____

11. Have you missed work /school due to this injury? □ Yes □ No How many days? _____

Nicola Chiropractic

Personal Injury

Office Policies

Nicola Chiropractic has made a copy of the Notice of Privacy Practices available to me at my request. I understand I have right to review the Privacy Practices prior to signing this document. This Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations of Chiropractic and wellness. Nicola Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy of these forms by calling the office and requesting a revised copy be sent to me in the mail or ask for one at the time of my next appointment. I have the right to revoke this consent, in writing, except to the extent that Nicola Chiropractic has taken action in reliance on this consent.

Initial_____

I understand that Nicola Chiropractic may leave a message on my answering machine and or with a third party regarding limited protected health information, pending appointments, and the time and place of my scheduled appointments, or other healthcare related communications.

I give the following persons access to the use or disclosure of my health information:

_____

_____

I give Nicola Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor/ technician privately at any time I may ask for a private room.

Initial_____

Nicola Chiropractic will maintain your medical records for five years after your last date of service. Once five years have passed your medical records will be destroyed in a manner currently meeting federal regulations.

Initial_____

In an effort to avoid missed appointments, you will receive an automated reminder of your appointment the day prior to your appointment. Any appointment cancelled or missed with less than 24 hours notice will be billed for a missed appointment. The missed appointment fee of $25.00 must be paid prior to / or at the time of your next appointment. This amount is not eligible for insurance billing and is the responsibility of the patient.

Initial_____

MINOR CONSENT (Minor is anyone under 18 years old at the time of care)

I am the parent, guardian, or personal representative of _____ (child's name) and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize Nicola Chiropractic and staff to perform necessary services for the child named above, including but not limited to x-rays and treatments which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. I agree to hold Nicola Chiropractic free and harmless from any claims and /or suits from damages or complications which may result from such treatment.

Print Child's Name _____

Parent or Guardian's Signature _____ Date _____

Nicola Chiropractic

Personal Injury

Office Policies

Our office is pleased to accept your health insurance as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you whenever we can. However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance. If you carrier has a "network" of providers, it is your responsibility to make sure we are in network. Your insurance should pay within 30 days. If your insurance has not paid within 60 days you must pay the balance due and be reimbursed by your insurance company when and if it pays. There will be an interest charge of 7% per annum (year) charged on all unpaid balances over 60 days. We will bill your insurance weekly as long as you are receiving chiropractic care with our office. Once we have received a check from your insurance company you will be billed for any differences in payment. Cash patients will pay at the time of service. Our office does not guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied you are responsible for the full amount of your bill. Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. Auto injury policies will be billed as the primary medical coverage if you have been in an auto accident. Once your policy is exhausted you may either go thru an attorney or pay for your following treatment as you go. If you are represented by an attorney, you must sign a doctor's lien that will be forwarded to your attorney. Please be advised that you are responsible for your bill regardless of the circumstances. There will be a $25.00 charge on all returned check fees. Patient is responsible for all charges and commissions that may be assessed from a collection agency due to unpaid balances. Patient further agrees to pay interest rate of 2% per month, 24% per year from the first date the account becomes delinquent of 60 days.

Initial_____

I hereby request and consent to the performance of Chiropractic care by Nicola Chiropractic and their staff. I have had the opportunity to discuss with the doctor and his staff the purpose and benefits of chiropractic treatment. Though chiropractic adjustments and treatments are usually beneficial an seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include but are not limited to: fractures, disc injuries, strokes, bruising, dislocations, and sprains. I understand that I may be receiving the following treatment: HOT/COLD THERAPY, MINERAL ICE (OR LIKE SUBSTANCE), ULTRASOUND, EMS, MANUAL/ FLEXION TRACTION, TRIGER POINT THERAPY, VIBRATORY/ DEEP TISSUE MASSAGE, TENS, THERAPEUTIC EXERCISES, LIFSTYLE AN DERGONOMIC INSTRUCTIONS, SPINAL ADJUSTMENT, JOINT MOBILIZATION TECHNIQUES, POSTURAL CORRECTION, NUTRITIONAL SUPPLEMENTATION, DIETARY RECOMMENDATIONS, X-RAYS, MECHANICAL TRACTION, AND LASER THERAPY. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Initial_____

I certify I have read and understand all the information provided by Nicola Chiropractic. I certify the information provided by me is true and correct to the best of my knowledge.

Print Patient Name _____ **Date** _____

Patient or Guardian Signature _____

Nicola Chiropractic

Personal Injury

7380 W. Sahara Ave. #100 Las Vegas, NV 89117
Phone (702) 252-7256 Fax (702) 251-9650

Physician's Lien and Medical Reports Authorization

Patient Name (Print): _____I do hereby authorize Nicola Chiropractic and other listed medical providers to furnish my attorney with a full report of all medical records, including physician's and examination notes, technical results and other relevant documents regarding the incident in which I was involved on **(Date of Accident) _____** and which required treatment by Nicola Chiropractic and their staff.

I hereby authorize and direct my attorney or insurance company to pay directly to **Nicola Chiropractic** as may be due and owing them for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office, and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctors. And I hereby further give a lien on my case to said doctors against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree that I will not rescind this document and that a rescission will not be honored by my attorney. My agreement not to rescind this document is a consideration for my doctor rendering treatment to me while my case is being actively pursued through the process of negotiation, settlement and/or litigation. In the event that my first attorney discontinues representation, I grant Nicola Chiropractic an irrevocable assignment of proceeds up to the amount of medical bills. In the event that another attorney is substituted in this matter the assignment of proceeds may be assigned back to me at the discretion of Nicola Chiropractic.

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

I therefore acknowledge and fully accept the terms of this document by signing below. I have been advised that if my attorney does not wish to co-operate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis, and that my doctor may also proceed against my attorney to recover such funds if my attorney received such funds and refuses or fails to disperse such funds to my doctor.

I expressly waive the Statute of Limitations regarding my doctor's right to recover.

It is further understood that the doctor shall be entitled to all reasonable costs of collection including, but not limited to, his attorney's fees and costs of suit to recover his full costs of treatment as a result of myself or my attorney receiving any recovery, settlement or compromise and failing and/or refusing to pay promptly the doctor for all medical services he and his office have rendered on my behalf.

Patient or Guardian Signature _____ **Date** _____

Witness Signature _____

The undersigned being attorney of record or insurance company representative for the above patient does hereby acknowledge receipt of Lien and agree to honor above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor/healthcare facility above named.

Attorney Signature _____

Nicola Chiropractic

Personal Injury

Irrevocable Assignment of Proceeds

Name _____ **Email** _____

Address _____

Phone _____ **DOB** _____ **Date of Injury** _____

Insurance Company _____ **Claim Number** _____

I(Patient) do hereby authorize and direct the above-named medical facility (Nicola Chiropractic) to furnish INSURANCE COMPANY (Insurance Company) with all reports, findings, Interpretations, Impressions, treatments, diagnoses, or diagnostic studies that you may perform on me, including any studies performed In connection with any injury which I was involved arising out of the above-stated date of injury.

I forever and Irrevocably assign any and all proceeds that I may receive from the Insurance Company to be paid directly to Nicola Chiropractic's attorney, CRAIG K. PERRY & ASSOCIATES, up to the amount that may be due and owing for medical services rendered to me in connection with this date of Injury, as well as any other amounts owed by me to Nicola Chiropractic for services unrelated to the date of Injury. As such, these sums of money no longer belong to me but now belong to Nicola Chiropractic. Accordingly, I authorize and direct Insurance Company to withhold from any settlement, judgment, verdict, or other economic recovery that I may have been entitled to receive and to pay them to Nicola Chiropractic, up to the full amount of my medical bills with them. Nicola Chiropractic agrees to participate ininter-pleader actions as necessary and further agrees not to impose any additional material burden upon the Insurance Company.

I fully understand that I am directly and fully responsible to Nicola Chiropractic for all medical bills associated with the services provided to me, whether or not there is a financial recovery of any kind, and that this Assignment is made in the event there is a financial recovery from the Insurance Company that can pay all or pay any portion of the medical bills incurred with Nicola Chiropractic. This is in consideration of Nicola Chiropractic to agree to await payment instead of receiving payments at the time of treatment. I also understand and agree that this Assignment tolls any law that commences the time to take action to collect amounts I owe for the services rendered, and that my obligations to pay these bills are not contingent on my receiving any recovery in my case.

If I ever decide to retain an attorney, I agree to notify and direct each retained attorney of this Irrevocable Assignment of Proceeds to Nicola Chiropractic. I also agree to notify Nicola Chiropractic of each attorney I retain. I further direct each retained attorney to pay Nicola Chiropractic the full amount of the assignment, within two weeks of receipt of the first proceeds of any recovery. In the event that the Insurance Company does not honor this assignment and sends these assigned, designated proceeds to my attorney(s).

I acknowledge that the fees for Nicola Chiropractic's services are fair, reasonable and reflect appropriately the treatment I need and Nicola Chiropractic's risk of waiting for its payment until my claim or case is resolved. I acknowledge that this Assignment provides a collateral source for the amounts I owe for services rendered and does not constitute a payment arrangement or other agreement regarding the payment of any amounts I owe that remain unpaid. I hereby authorize Nicola Chiropractic to re assign this Assignment, in its discretion, for collection or for purchase by another, and to provide copies of all my records relating to this Assignment of Proceeds to its designated assignee. I understand and agree that any assignee of Nicola Chiropractic is entitled to all of the rights and privileges provided to Nicola Chiropractic by this agreement. I understand that such an assignment will not affect my obligations or my attorney's obligations to honor this Assignment or pay any unpaid bills.

Print Patient Name _____ **Date** _____

Patient Signature _____

Nicola Chiropractic acknowledges that the law firm of CRAIG K. PERRY & ASSOCIATES Is Nicola Chiropractic's attorney and grants it limited power of attorney to receive, endorse and deposit Into Its trust account these assigned proceeds from Patient.

Authorized Rep of Nicola Chiropractic _____ Date _____

Nicola Chiropractic

Personal Injury

Health Insurance Waiver

I hereby direct you, as my medical provider, not to bill or utilize my personal health insurance for any of the treatment rendered by you and your office for injuries sustained in the incident for which I am now seeking treatment.

I believe, and have told you as my provider, that the incident was not my fault. I do not wish to be penalized in any manner for someone else's wrongdoing. My health insurance rights may be adversely affected, such as limiting my total number of office visits to a yearly maximum and if I use them for the injuries from this incident, I will lose that insurance entitlement for future office visits. Or, I do not wish to be responsible for any co-pays, deductibles or non-covered services for these same reasons. I desire, and choose, to preserve my health insurance visits and co-pays or deductibles for any similar future medical care where I can then choose to use my healthcare coverage.

Consequently, while you are allowed to bill my auto med-pay policy if med-pay is available, you are instructed not to bill my healthcare insurance. This directive is effective immediately and covers me from the date of my first visit with your office related to this incident, and continues until the conclusion of my treatment for these injuries. I make this directive voluntarily, of my own preference and without any coercion or duress of any kind by you or your staff members.

I understand that by choosing this option, I agree that I shall not rescind this directive once given unless that rescission is given in writing by me within fourteen (14) calendar days of signing this directive. Otherwise, you, as my medical provider, would likely be past the time deadline for the submission of my bills for payment to my health insurer, or I would be creating other problems for the payment of your services under my healthcare plan. I will be solely responsible to notify any attorney I now or later retain of this directive. In the event of any litigation arising under this directive, the prevailing party shall be entitled to recover their reasonable attorney's fees and costs. Venue for any litigation arising out of this incident shall be where the medical services were provided.

Print Patient Name _____ **Date** _____

Patient Signature _____

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Patient Name (printed)_____ DOB_____

I authorize any physician, dentist, chiropractor, hospital, pharmacist, medical professional, health care provider, insurance company, worker compensation provider, or employer to disclose all information about past and present medical care, history, physical condition, and injuries including itemized statements to Nicola Chiropractic.

I agree that this authorization will remain valid up to one year of the signed date, unless revoked by delivery of written notice to Nicola Chiropractic.

I hereby designate the above named company and its claims personnel as my designated representative, pursuant to NCGS Sec 90-411 for the purpose of obtaining copies of my medical records, the production of which is authorized herein. It is specifically my intent that this designation provide to the company named above the benefit of the maximum fees established in NCGS Sec 90.41.

I understand that I (or my representative) am entitled to receive a copy of this authorization. A photocopy of this form may be accepted as the original.

I (or the patient named above) have received health care treatment from the following providers:

_____ _____
Provider Name Phone

_____ _____
Provider Name Phone

_____ _____
Insurance Company Phone

Requesting: □ Entire File □ Related to MVA on _____ □ Diagnostic Tests
□ Progress Notes □ Auto Insurance Declaration Page

Please send records to:

Nicola Chiropractic
7380 W Sahara Ave #100
Las Vegas, NV 89117
Phone # (702) 252-7246
Fax # (702) 251-9650

_____ _____
Signature of Patient or Person Authorized to Act on Patient's Behalf **Date**

CIM Complete Injury Management®

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____ **Social Security Number:** _____

Date of Injury: _____

I authorize any physician, dentist, chiropractor, hospital, pharmacist, medical professional, health care provider, insurance company, worker compensation provider or employer to disclose all information about past and present medical care, history, physical condition, and injuries including itemized statements to Complete Injury Management for the purpose of review and evaluation in connection with a legal claim.

I agree this authorization will remain valid until the conclusion of my claim. I understand I have the right to revoke this authorization at any time and must do so in writing.

I understand I am entitled to a copy of this authorization. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand signing this authorization may not condition treatment, payment, enrollment or eligibility for benefits.

TO: _____

Name of Healthcare Provider/Physician/Facility **Phone**

Please send records to:
Complete Injury Management
7380 West Sahara Avenue, Suite 110
Las Vegas, NV 89117
Phone: 702.227.4878
Fax: 702.272.2013

Signature of Patient or Legal Representative **Relationship to Patient** **Date**