

Lovett Chiropractic Pain Relief Clinic
REQUIRED FOR YOUR CASE HISTORY FILE
(Form CH2017)

Name: _____ Date of Birth: _____ Age: ____ Gender: Male Female
 Address: _____ City: _____ State: ____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Email: _____ Occupation: _____
 Emergency Contact: _____ Phone: _____ Relationship: _____
 Insurance Carrier: _____
 Marital Status (circle): Married Single Widowed Divorced Separated Number of Children: ____
 Name of Spouse/Guardian: _____
 Smoking Status: Current Daily ____ Current Some Days ____ Former ____ Never ____
 Please list current medications with dosages (mg): _____

Please list medication allergies: _____
 Race: White Black Native American Asian Other Unknown Ethnicity: Hispanic Non-Hispanic
MAIN COMPLAINT TODAY: _____

- Any other current symptoms? (check all answers)**
- Headaches Dizziness Sleeping Problems Buzzing in Ears Fainting
 - Neck Pain Feet Cold Nervousness Loss of Smell Face Flushed
 - Neck Stiff Hands Cold Head Feels Heavy Loss of Taste Cold Sweats
 - Back Pain Depression Loss of Memory Lights Bother Eyes Ears Ring
 - Tension Fatigue Shortness of Breath Head Feels Heavy Diarrhea
 - Irritability Fever Numb in Fingers Pins/Needles in Arms Loss of Balance
 - Chest Pain Constipation Stomach Upset Pins/Needles in Legs/Toes

Please list any health conditions/surgeries you have been treated for in the last year: _____

Please explain any previous serious illness: _____

Anyone in your family history with the following? If yes, please list relationship to you:

Heart Disease _____	Back Problems _____
Cancer _____	Disc Problems _____
Diabetes _____	Arthritis _____
Other _____	

Have you ever suffered from: (circle your answer)

Dizziness	Yes No	Arthritis	Yes No	Neuritis	Yes No
Backaches	Yes No	Headaches	Yes No	Digestive Disorders	Yes No
Heart Trouble	Yes No	Numbness	Yes No	Nervousness	Yes No
Diabetes	Yes No	Lung Problems	Yes No	Sinus Trouble	Yes No
Tuberculosis	Yes No	Anemia	Yes No	Rheumatic Fever	Yes No
Cancer	Yes No	Kidney Trouble	Yes No		

If yes, explain: _____

FEMALES ONLY (For X-ray Purposes): Are you possibly pregnant? Yes ____ No ____

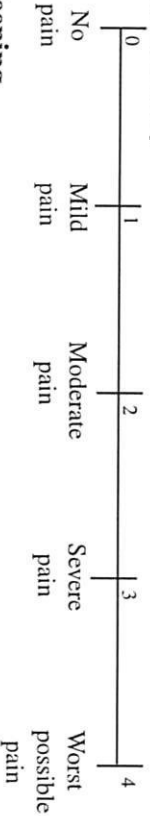
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Functional Rating Index

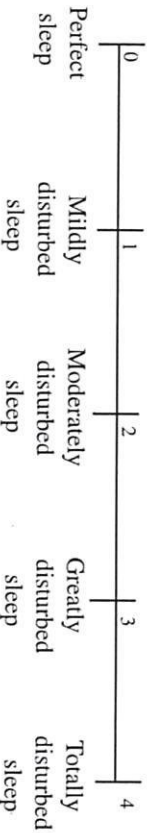
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

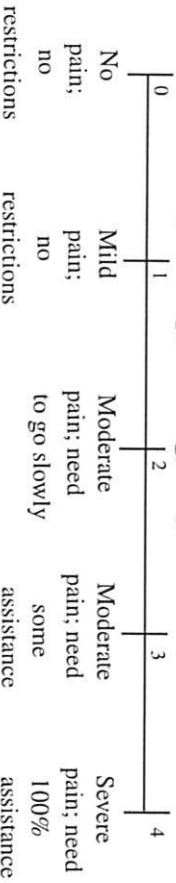
1. Pain Intensity



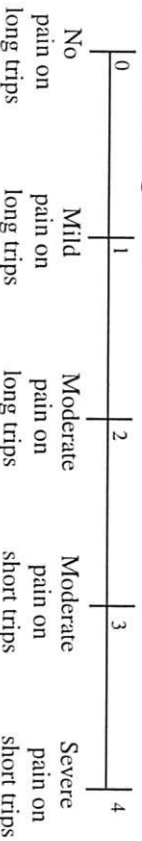
2. Sleeping



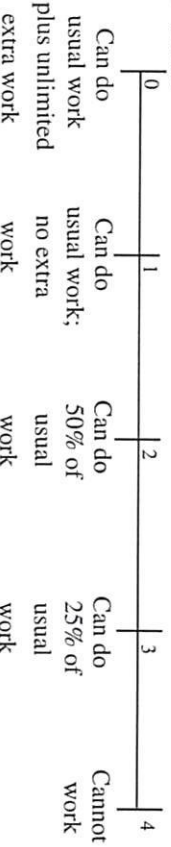
3. Personal Care (washing, dressing, etc.)



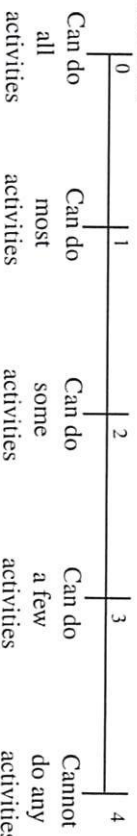
4. Travel (driving, etc.)



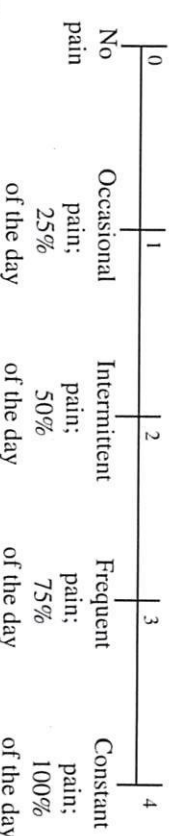
5. Work



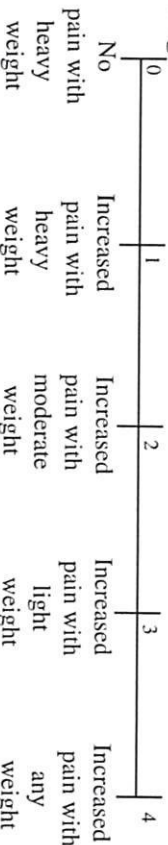
6. Recreation



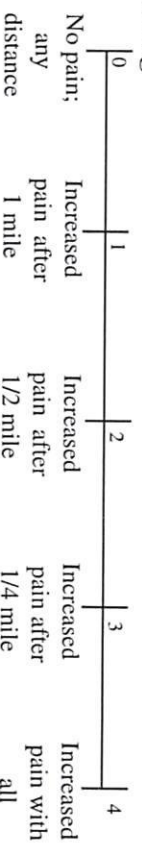
7. Frequency of pain



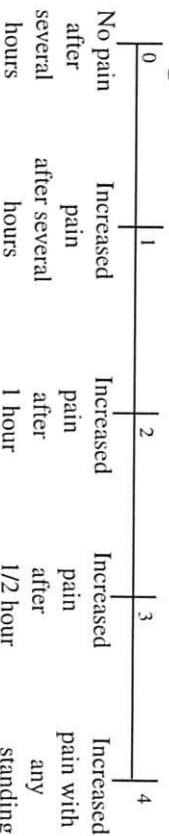
8. Lifting



9. Walking



10. Standing



Name _____ **PRINTED** ID#/SS# _____ Plan ID _____ **Total Score** _____

Signature _____

Date _____

**PARTIAL ASSIGNMENT OF THE CAUSES OF ACTION,
ASSIGNMENT OF PROCEEDS CONTRACTUAL LIEN & AUTHORIZATION**

(Form CLA2017)

Purpose. The purpose of this Assignment is to improve the ability of the Office to collect my Charges directly from various Payers. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to Lovett Chiropractic Pain Relief Clinic; "Payer" shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for any reason; "Proceeds" shall include, without limit, the proceeds from any settlement, judgement, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Medicaid, worker's compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; "Charges" shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony), and Collection Costs incurred by the Office, interest (and penalties on delinquent Charges) to the extent permitted by law, and any other charges incurred by me at the Office; "Collection Costs" shall include, without limit, any pre- and post judgement court costs, filing fees, service of process charges, attorney fees, and any other costs of collection incurred by the office in any effort or action to collect my Charges either from me or from any Payer.

Partial Assignment of the Causes of Action, Assignment of Proceeds, and Contractual Lien. I hereby assign to the Office, Insofar as permitted by law, but only to the extent of my Charges, all of my rights, remedies, and benefits relating to any Payer, including without limit my right to receive Proceeds from any Payer now or in the future, and any and all causes of action that I might have against any Payer now or in the future, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further grant a contractual lien to the Office with respect to my Charges. I further intend for this Agreement to create a secured interest under the applicable Uniform Commercial Code and hereby direct the Office to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such lien. Consistent with these provisions, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the extent of my Charges.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of any Proceeds received by the attorney is to pay my Charges.

Other Disclosure Authorization. I hereby direct all Payers to release to the Office any pertinent information regarding any coverage I may have including without limit the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize and direct the Office to release any information regarding my treatment or pertinent to my case(s), including without limit a copy of my Charges and a copy of this Assignment, to all Payers in order to facilitate collection of my Charges.

Miscellaneous Provisions. Except as provided in this paragraph, this Assignment shall not be modified or revoked without the expressed, written consent of the Office, I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment. I agree that each and every provision of this Assignment is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Assignment be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment shall, nevertheless, remain in full force and effect. This Assignment shall be governed under the laws of the state where the office is located, and is performable in the county where the Office is located. In any action based upon this Assignment, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens as such term is defined by law. I further waive any statute of limitations which may apply in any action based upon this Assignment.

I have read, understood, and agree to the terms of this Assignment.

Patient Name (print): _____

Patient Signature: _____ Date: ____ / ____ / ____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: ____ / ____ / ____