WEST END
CHIROPRACTIC & WELLNESS

NEW PATIENT ENTRANCE APPLICATION

Welcome! We are honored you chose us to evaluate your condition. So we may file your insurance forms for you, would you please fill out the personal information below? If you need assistance please inform the front desk person. Thank you!

Personal Information:

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M or F Marital Status: S M D

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Social Security #: _____ E-mail: _____

Employer Name: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Guardian / Spouse / Family Information:

Name: _____ Relationship: _____

Employer Name: _____ Occupation: _____ Phone #: _____

Children:

Name: _____ Age: _____ Sex: M or F Name: _____ Age: _____ Sex: M or F

Name: _____ Age: _____ Sex: M or F Name: _____ Age: _____ Sex: M or F

Name: _____ Age: _____ Sex: M or F Name: _____ Age: _____ Sex: M or F

Patient Informed Consent:

I, _____<print name>_____, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature: _____ **Date:** _____

WEST END
CHIROPRACTIC & WELLNESS

CHIROPRACTIC PATIENT HISTORY

So that we may better understand your unique condition, please complete the following information with regard to your current complaint.

Location:

What Is Your Primary Complaint? _____

What Caused The Onset? _____

When Did It Start? _____/_____/_____

Does the Complaint Radiate or Travel? If so, Where? _____

Timing and Duration:

✓ Since the onset of your complaint how has it been changing? ☐ Getting Better ☐ Not Changing ☐ Getting Worse

✓ How often do you experience this complaint? ☐ Constantly (100%) ☐ Frequently (75%) ☐ Occasionally (50%) ☐ Intermittently (25%)

✓ Does your complaint worsen? If so, When? ☐ Morning ☐ Midday ☐ Night ☐ Sleep ☐ Work ☐ Other: _____

✓ How much has the complaint interfered with your normal work? (including both work outside the home, and housework)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

✓ How much would you say this complaint has affected your social activities?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

Severity:

Use the key below to rate the severity of your pain.

0 = No Pain 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate 6 = Moderate to Severe
7 = Mildly Severe 8 = Severe 9 = Very Severe 10 = Excruciating

Please circle where you rate your pain: 1 2 3 4 5 6 7 8 9 10

Quality:

✓ How would you describe the sensation of your complaint?

☐ Sharp pain ☐ Shooting ☐ Numbness ☐ Tingling

☐ Dull Ache ☐ Burning ☐ Throbbing ☐ Other: _____

Modifying Factors:

✓ What makes your complaint feel worse?

☐ Coughing / Sneezing ☐ Standing ☐ Lifting ☐ Exercising ☐ Bending ☐ Twisting

☐ Pushing / Pulling ☐ Sitting ☐ Walking ☐ Driving ☐ Climbing ☐ Other: _____

Alleviating Factors:

✓ What makes your complaint feel better?

☐ Rest / Sleep ☐ Stretching ☐ Lifting ☐ Exercising ☐ Bending ☐ Twisting

☐ Pain Medication ☐ Ice ☐ Heat ☐ Shower ☐ Walking ☐ Other: _____

Previous Treatment:

Who have you seen for this condition? ☐ Medical Doctor ☐ Physical Therapist ☐ Chiropractor ☐ Other: _____

Have you had Chiropractic care in the past? ☐ Yes ☐ No If so, When? ___/___/___

Risk Factors:

Do you have a pace maker? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No ☐ Maybe

Do you have any metal implants or devices? ☐ Yes ☐ No

History was obtained from: ☐ Patient ☐ Parent ☐ Guardian ☐ Child ☐ Other: _____

Patient / Guardian Signature: _____ Date: _____

Dr: _____

WEST END
CHIROPRACTIC & WELLNESS

SOCIAL AND FAMILY HISTORY

In an effort to provide you with the best care possible, please take a moment to answer the following questions related to your social history, daily activities and family history.

Social History:

✓ **What Is The Highest Level of Schooling You Have Completed?**
☐ Still in School ☐ Some High School ☐ High School ☐ Some College ☐ College ☐ Graduate School

✓ **What Is Your Current Work Status?**
☐ Employed Full Time ☐ Employed Part Time ☐ Retired ☐ Unemployed ☐ Disabled ☐ Student

✓ **How Often Do You Exercise?**
☐ Never ☐ 1-3 times per month ☐1-2 times per week ☐ 3-4 times per week ☐ daily

✓ **How Would You Rate The Intensity Of Your Exercise?**
☐ Never Exercise ☐ Low Level ☐ Moderate Level ☐ High Level ☐ Competition level

✓ **How Many Hours Do You Sleep Per Night?**
☐ <4 hours ☐ 5-6 hours ☐ 7-8 hours ☐ 8-10 hours ☐ >10 hours

✓ **How Often Do You Eat A Balanced Diet?**
☐ Never ☐ Rarely ☐ Sometimes ☐ Regularly ☐ Always

✓ **How Often Do You Drink Caffeinated Beverages?**
☐ Never ☐ 1-3 Times Per Month ☐ 1-2 Times Per Week ☐ 3-4 Times Per Week ☐ Daily ☐ >2 Per Day

✓ **How Often Do You Smoke Cigarettes?**
☐ Never ☐ Past ☐ 1-3 packs per month ☐ 1-2 packs per week ☐ 3-4 packs per week ☐ >1 pack per day

✓ **How Often Do You Drink Alcohol?**
☐ Never ☐ Past ☐ 1-3 drinks per month ☐ 1-2 drinks per week ☐ 3-4 drinks per week ☐ daily

✓ **Have You Used Illicit / Street Drugs In The Past 6 Months?**
☐ Yes ☐ No

Daily Activities:

So that we may have an idea as to your daily routine please list a few of your daily activities and your favorite hobbies:

_____

_____

✓ **Does Your Current Condition Affect Your Performance In These Activities Or Hobbies?**

☐ Yes ☐ No If So How:_____

Family History Information:

✓ **Please Indicate If Anyone In Your Family Currently Has, Or Has In The Past, Suffered From Any Of The Conditions Listed Below:**

✓ **Arthritis:**
☐Yes ☐ No Whom:_____

✓ **Back Pain:**
☐Yes ☐ No Whom:_____

✓ **Cancer:**
☐Yes ☐ No Whom:_____

✓ **Diabetes:**
☐Yes ☐ No Whom:_____

✓ **Heart Disease:**
☐Yes ☐ No Whom:_____

✓ **High Blood Pressure:**
☐ Yes ☐ No Whom:_____

✓ **High Cholesterol:**
☐ Yes ☐ No Whom:_____

✓ **Osteoporosis:**
☐ Yes ☐ No Whom:_____

✓ **Stroke:**
☐ Yes ☐ No Whom:_____

✓ **Thyroid Conditions:**
☐ Yes ☐ No Whom:_____

Patient / Guardian Signature: _____ Date: _____

Dr: _____

WEST END
CHIROPRACTIC & WELLNESS

PAST AND GENERAL HISTORY

To help us better understand your unique condition please complete the information below related to your past and general history.

Past History: Please Mark Below With an "X"

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition	Past	Present	Allergies
X		Example	X	X	Example		X	Example	X	X	Example
		Angina / Chest Pain			Heart Problems			Seizures			Animal Dander
		Arthritis			HIV			Sleeping Problems			Latex
		Asthma			Irritability			Soreness			Food Allergies
		Back Pain			Joint Stiffness			Speaking Problems			Penicillin
		Balance Problems			Joint Swelling			Spinal Curvature			Pollen
		Broken Bones			Joint Tenderness			Stiffness			Smoke
		Cancer			Loss of Sleep			Stroke / TIA			Grasses
		Chills			Lumps			Tingling			Sulfa Drugs
		Concentration Loss			Masses			Thyroid Problems			Dairy Products
		Diabetes			Memory Loss			Tremors			Perfumes
		Dizziness			Muscle Cramps			Vertigo			Hay
		Fatigue			Muscle Pain			Weakness			Other Please List:
		Fainting			Nervousness			Other Please List:			
		Fever			Night Sweats						
		Gout			Numbness						
		Headaches			Paralysis						

Medication and Surgical History:

Surgery	Yes	No	Year	Surgery	Yes	No	Year	Have You Ever Taken:	Yes	No	Year
Tonsils				**Women**				Insulin			
Colon				Breast				Cortisone			
Hernia				Uterus				Thyroid Medication			
Appendix				Ovaries				Male / Female Hormones			
Gall Bladder								Blood Pressure Medication			
Stomach				**Men**				Cholesterol Medication			
Heart				Prostate				Anti-Depressants			
Kidney								Tranquilizers / Sedatives			
								Birth Control			

What Other Supplements, Vitamins or Medications Are You Taking? _____

_____

_____

Injury History:

What, If Any, Major Injuries Have You Had? When? _____

_____

_____

Have You Been Hospitalized? If so, When and Why? _____

_____

_____

Patient / Guardian Signature: _____ Date: _____

Dr: _____

WEST END
CHIROPRACTIC & WELLNESS

ACCIDENT / INJURY QUESTIONNAIRE

Due to your recent Accident / Injury please help us by completing the following questionnaire. For Auto Accidents please complete the second page as well.

Personal Information:

Patient Name: _____ Today's Date: _____

Is this injury related to an Auto Accident? ☐ Yes ☐ No Is this injury related to your work? ☐ Yes ☐ No

Auto / Worker's Compensation Insurance Information:

Insurance Company: _____ Policy Holder: _____

Date of Accident / Injury: _____ Approximate Time of Accident / Injury: ☐ AM ☐ PM

Have you contacted your employer / auto insurance company: ☐ Yes ☐ No Date of Contact: _____

❖ _____ Adjuster's Name: _____ Phone Number: _____ Claim Number: _____

Have you contacted an attorney? ☐ Yes ☐ No Attorney's Name: _____ Attorney's Phone: _____

Description of Accident / Injury:

❖ Please describe the events immediately proceeding, the event causing and the immediate events following the Accident / Injury:

_____

_____

_____

*Additional space on back if necessary

Accident / Injury Related Questions:

Did you lose consciousness? ☐ Yes ☐ No Were you prepared for the event or was it a surprised? ☐ Prepared ☐ Surprised

❖ Did you feel: ☐ Sharp Pain ☐ Shooting Pain ☐ Dull Ache ☐ Numbness ☐ Dizziness ☐ Weakness ☐ Other:

When did your pain / symptoms begin? ☐ Immediately ☐ <1 Hour ☐ <1 Day ☐ <1 Week ☐ <1 Month ☐ >1 Month

Since the Accident / Injury, have your pain / symptoms: ☐ Gotten Worse ☐ Gotten Better ☐ Stayed the same

Have you had the same or a similar condition in the past? ☐ Yes ☐ No How long ago? ☐ <1 Month ☐ <6 Months ☐ 1 Year or more

❖ Did you receive emergency care at the accident site? ☐ Yes ☐ No

Hospital Visit: ☐ Check here if this section is N/A because you did not go to the hospital.

When did you go to the Hospital? ☐ Immediately ☐ <1 Hour ☐ <1 Day ☐ <1 Week ☐ <1 Month ☐ >1 Month

❖ What hospital did you go to? What was the doctor's name?

Were any of the following procedures performed? ☐ X-rays ☐ MRI ☐ CT-Scan

Was a diagnosis made? ☐ Yes ☐ No If so, What was it?

What treatment was performed at the hospital?

Did the doctor prescribe medication? ☐ Yes ☐ No If so, what was it?

Did the doctor make any additional recommendations? ☐ Yes ☐ No

❖ If so, what were they?

For Auto Accident Related Injuries Please Sign Below and Continue To Page 2

Patient / Guardian Signature: _____ Date: _____ Dr: _____

WEST END
CHIROPRACTIC & WELLNESS

ACCIDENT / INJURY QUESTIONNAIRE

This page is to be completed only if you were involved in an auto accident.
This is page 2 of the Accident / Injury Questionnaire.

Vehicle Information

Vehicle Make: _____ Vehicle Model: _____ Vehicle Year: _____

Accident Description

Where did the accident occur (What street or the nearest intersection)? _____

What direction were you traveling? _____

Where were you in the vehicle? ☐ Driver ☐ Front Passenger ☐ Rear Passenger – Driver's ☐ Rear Passenger – Passenger's

Was anyone else in the vehicle? ☐ Yes ☐ No

- If so, Where? ☐ Driver ☐ Front Passenger ☐ Rear Passenger – Driver's ☐ Rear Passenger – Passenger's

Where was your vehicle impacted? ☐ Front end ☐ Front Driver's ☐ Front Passenger's ☐ Driver's Side ☐ Passenger's Side
☐ Rear end ☐ Rear Driver's ☐ Rear Passenger's ☐ Other:

Additional Accident Information

Were you wearing a seatbelt? ☐ Yes ☐ No If so, where? ☐ Shoulder and Lap ☐ Lap only

Did airbags deploy? ☐ Yes ☐ No

- Were you contacted by the airbag? ☐ Yes ☐ No If so, where?

What direction were you facing at the moment of impact? ☐ Forward ☐ Up ☐ Down ☐ Right ☐ Left ☐ Other:

If driving, did your feet slip from the pedals? ☐ Yes ☐ No If so, which pedal? ☐ Brake ☐ Gas ☐ Both

If driving, did your hands slip from the wheel? ☐ Yes ☐ No If so, which hand? ☐ Right ☐ Left ☐ Both

Did any portion of your body contact the interior of the vehicle? ☐ Yes ☐ No

- If so, what and where?

Other Vehicles Involved

☐ Check here if N/A because no other vehicles were involved.

1st Vehicle to contact you was a: ☐ Car ☐ SUV ☐ Minivan ☐ Van ☐ Truck ☐ Motorcycle ☐ Bus ☐ Other:

Where did this vehicle contact you? ☐ Front end ☐ Front Driver's ☐ Front Passenger's ☐ Driver's Side ☐ Passenger's Side
☐ Rear end ☐ Rear Driver's ☐ Rear Passenger's ☐ Other:

2nd vehicle to contact you was a: ☐ Car ☐ SUV ☐ Minivan ☐ Van ☐ Truck ☐ Motorcycle ☐ Bus ☐ Other:

Where did this vehicle contact you? ☐ Front end ☐ Front Driver's ☐ Front Passenger's ☐ Driver's Side ☐ Passenger's Side
☐ Rear end ☐ Rear Driver's ☐ Rear Passenger's ☐ Other:

Patient / Guardian Signature: _____ Date: _____ Dr: _____

INSURANCE SUBMISSION AND PAYMENT AGREEMENT

For our patient's involved in an injury / accident; this form allows us to submit bills and receive payment directly from your insurance company.

Personal Information

Patient Name:	Date of Birth:	Today's Date:
Insurance Company:	Employer:	Claim Number:
SS# / ID #:	Date of Injury / Accident:	

Directions

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to the address below. Or, if my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it to the following address:

West End Chiropractic and Wellness, P.A

1660 Hwy 100 S, Ste 146

St. Louis Park, Mn 55416

Assignment and Release

These payments will be for the professional and medical expense incurred by the patient (your insured), and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to West End Chiropractic and Wellness. I have agreed to pay, in current manner, any balance of the professional service charges over and above this insurance payment.

If checks are made out to me for my account / medical bills at West End Chiropractic, I authorize West End Chiropractic to deposit such checks.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case. Finally, I authorize the doctor(s) to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Patient / Guardian Signature:_____ Date:_____

Witness / Authorized Signature:_____ Date:_____

A photocopy of this Assignment shall be considered as effective and valid as the original.

WEST END
CHIROPRACTIC & WELLNESS

CREDIT GUARANTEE

For our patient's involved in an auto accident the following is a definition of our clinic's insurance assignment, and personal balance policy.

Insurance Assignment

Our auto insurance assignment program is designed to render you immediate care and keep you out of pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to 6 months for payment. Please remember, however, that you are ultimately responsible for the payment of your bill. As a prerequisite, we ask that you supply us with the following information:

- Your complete automobile insurance information
- Your family health insurance information

Filing Procedure

- We will submit claims on your behalf to your automobile insurance carrier.
- Any overpayment resulting in credit balances on your account will be refunded promptly at the conclusion of your care.
- At the conclusion of your care, you will be required to make payment arrangements with our billing department. If you should seek legal council at any time during, or after your care, we require that you provide us with your attorney's billing information no later than one week after council is obtained.
- Balances not paid within 6 months of the conclusion of your care may be sent to a collection agency.
- Should settlement be reached prior to your physician dismissal all balances become due immediately and are subject to agreed monthly interest charges.

I agree to the above terms and conditions and authorize you to bill my automobile insurance company. I understand that if payment is not received within 6 months of the termination of my care I may be asked to take responsibility for the remaining balance due to West End Chiropractic.

Patient / Guardian Signature:_____ Date:_____

Witness / Authorized Signature:_____ Date:_____

ASSIGNMENT, LIEN, AND AUTHORIZATION

FOR DIRECT PAYMENTS BY MY PAYERS TO WEST END CHIROPRACTIC & WELLNESS, P.A.

Purpose. The purpose of this Assignment & Lien is to assist the Office in obtaining Proceeds from various Payers for the payment of my Charges. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment & Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to West End Chiropractic & Wellness, P.A., located at 1660 Highway 100 South, Suite 146, St. Louis Park, MN 55416 ; "Assignment & Lien Document," "Assignment & Lien," and "Assignment" shall refer to this document. "Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, adjuster, claims handler, medical examiner, individual reviewer or review entity, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds, either now or in the future, or which may be involved directly or indirectly in determining the obligation to pay or disburse Proceeds, either now or in the future; "Proceeds" shall include without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, the proceeds relating to "health-care-insurance receivables" and "payment intangibles" as such are defined by the applicable Uniform Commercial Code, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare and Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, errors & omissions, and malpractice; "Charges" shall include without limit the full fees for the Office's goods and services (including without limit treatment, diagnostic services, medical equipment, supplies, supplements, narrative reports, photocopies, pre-authorization requests, no-shows, depositions, and testimony, whether rendered before or after the date of this Assignment & Lien), any Collection Costs incurred by the Office, delinquency penalties and interest to the maximum extent permitted under law or at the annual rate of eighteen percent (18%), whichever is greater, and any other charges incurred by me at the Office; "Collection Costs" shall include without limit any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, fees or costs associated with requests for reconsideration, independent reviews, appeals, mediation, arbitration, 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.

Assignment and Lien Terms. I hereby assign to the Office to the extent permitted by law, but only to the extent of my Charges, all of my claims to, rights to, and interests in, Proceeds, whether resolved or unresolved, including without limit ownership rights, which I may have now or in the future relating directly or indirectly to my Charges, condition, or causes of my condition ("Claims to Proceeds"), including without limit any and all causes of action, receivables, payment intangibles, and remedies that I might have against or with respect to any Payer now or in the future, and the right to prosecute, seek, settle, or otherwise resolve such Claims to Proceeds either in my name or in the Office's name and as the Office otherwise sees fit. I agree that this assignment shall be effective as of the date and time the initial cause of my condition occurred. I further intend for this Assignment & Lien to create a security interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to the Office a primary, non-contingent security interest in all of my Claims to Proceeds to the extent permitted by law for the purpose of securing payment of my Charges, the attachment and perfection of which shall relate back to, and be effective as of, the date and time that the initial cause of my condition occurred. I further authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency relating to such security interests, and to make such filings in all relevant jurisdictions as the Office sees fit in its sole discretion. I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my agreement with the Office, such security interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Service Certified Mail. Consistent with these terms, 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 full extent of my Charges. To the extent that any law, including without limit a lien statute, purports to limit, reduce, or modify the distribution of Proceeds in any manner inconsistent with this Assignment & Lien including without limit through the reservation of a portion of the Proceeds exclusively to me, I hereby waive such limits, reductions, or modifications. Such waiver shall not adversely affect or prejudice any rights which the Office may have and elect to exercise under said law.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys who receive(s) Proceeds from one or more Payers, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding such Proceeds, 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 such Proceeds shall be primarily to pay my Charges. If I have a dispute regarding the Charges, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the Office. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney's fees and costs, or other expenses of obtaining Proceeds.

Disclosure Directives. I hereby direct each and every Payer to immediately release to the Office any Pertinent Information relating to (a) any coverage I may have and (b) any Proceeds Determination by the Payer relating to the Office's Charges. "Pertinent Information" shall include without limit the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information" shall also include without limit copies of all documents, records, and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny, or delay payment of any Proceeds relating to the Office's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or for me by the Office to all Payers, including without limit a copy of my Charges and a copy of this Assignment & Lien, unless otherwise agreed to in writing.

Miscellaneous. Except as provided in this paragraph, this Assignment & Lien 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 & Lien. I agree that each and every provision of this Assignment & Lien is reasonably necessary. However, should any provision of this Assignment & Lien 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 & Lien shall, nevertheless, remain in full force and effect. This Assignment & Lien 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 & Lien, 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 inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment & Lien.

I have read, understood, and agree to the terms of this Assignment & Lien.
Patient Name (print):

_____

Patient Signature: _____

Date: _____/_____/_____

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

_____

Parent/Guardian Signature: _____

Date:_____/_____/_____

NOTICE OF DOCTOR'S LIEN

For our patient's involved in an injury / accident with an attorney; this form allows us to submit bills to and if necessary receive direct payment from your attorney. This also protects our fees and assures your bills are paid first.

Attorney Contact Information

Attorney's Name: _____

Attorney's Firm's Name: _____

Attorney's Address: _____

Attorney's City, State Zip: _____

Clinic Contact Information

Doctor's Name: _____

Clinic's Name: **West End Chiropractic and Wellness**

Clinic's remit Address: **1660 Hwy 100 S, Suite 146**

Clinic's remit City, State Zip: **St. Louis Park, Mn 55416**

Medical Reports and Doctor's Lien's

I do hereby authorize West End Chiropractic and Wellness to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to West End Chiropractic and Wellness such sums as may be due and owing them for medical services rendered me by reason of this accident and by reason of any other bills that are due their office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor.

I hereby further give a lien on my case to said doctor against any and all proceeds of any 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 fully understand that I am directly and fully responsible to said doctor for all medical benefits, including major medical, submitted by them for services rendered me and that this Agreement is made solely for said doctor's additional protection and in consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

❖ Patient / Guardian Signature:_____ Date:_____

❖ Witness / Authorized Signature:_____ Date:_____

Attorney Acknowledgement

The undersigned being the attorney for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named. The undersigned attorney's signature must be accompanied by patient's signature (above) otherwise this lien will be void.

❖ Attorney's Signature:_____ Date:_____

This office holds an assignment / lien on this case for services rendered. Any settlement of this claim without honoring this assignment / lien will cause you to be responsible to this office for payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Please return this form to the Office Remit address listed above within 5 business days.

SUMMARY OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FOR PHI RELEASE

Privacy Policy:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) and specifically its Privacy Rule, I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that my PHI can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers that may be involved in my treatment directly or indirectly.
- Obtain payment or reimbursement from health coverage programs or others.
- Conduct normal healthcare business operations including routine aspects of operating a health related practice or business.

Acknowledgement and Consent:

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the creation, uses and disclosures of my PHI. I understand that West End Chiropractic has the right to change its Notice of Privacy Practices from time to time an that I may contact the Privacy Officer for West End Chiropractic at or through the address listed below to obtain a current copy of the Notice of Privacy Practices.

I also understand that I may request in writing that you restrict how my PHI is used or disclosed to carry out treatment, payment or healthcare operations. However, I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I further agree that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Privacy Officer Contact Information:

The privacy officer for West End Chiropractic may be contacted by mail by writing: Attn: 1660 Hwy 100 S, Ste 146 St. Louis Park, Mn 55416.

Office Use Only:

The following is practice documentation of our good faith effort to obtain acknowledgement of the above. Patient's acknowledgement of this notice could not be obtained due to the following situation:

- ☐ Patient Refused to Sign.
- ☐ Communication Barrier Prohibited Obtaining Acknowledgement.
- ☐ Emergency Circumstances
- ☐ Other: _____

Signature of Practice: _____ Date: _____

Patient Name (Please Print): _____

Patient / Guardian Signature: _____ **Date:** _____

WEST END
CHIROPRACTIC & WELLNESS

OFFICE POLICY

The following is a summary of our clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issue; regaining and maintaining your health. We are happy to answer any questions you have regarding your account.

Payment Policy:

- **Auto Accident and Workers Compensation:** If the incident is properly documented and the necessary forms and liens are signed, you are not required to pay for services on the day they are rendered and we will make efforts to file your services with your insurance provider for you. You are still responsible for all charges on your account. Any balance billed from our office deemed 'patient responsibility' exceeding 90 days past due will be assessed a 10.00% interest charge.

- **For patients with insurance:** West End Chiropractic will file your insurance claim for you, and will attempt to verify coverage of services to be performed. We will review this information with you and explain what services (if any) are not covered that you will be responsible for. You are responsible for the balance on your account for any professional services rendered if your insurance denies coverage. Any balance billed from our office deemed 'Patient Responsibility' exceeding 90 days past due will be assessed a 10.00% interest charge. Payment plans are available, but you must contact our office to setup these plans. Additional Notes about insurance coverage:

    - Copays are due at the time of service.
    - You may be responsible for a Deductible Amount. This amount is deemed 'patient responsibility'. Our office will bill you for this amount following our offices receipt of an 'Explanation Of Benefits' (aka EOB) from your insurance company.
    - You may be responsible for a Coinsurance Amount. (aka % Responsibility) Our office will bill you for this amount following our offices receipt of an Explanation Of Benefits (aka EOB) from your insurance company.
    - You may choose to make payments in advance of receiving a bill for any amount considered patient responsibility.

- **For patients without insurance:** You have the option of paying in full on the date of service, paying in advance for your services or receiving a bill from our office. Discounts apply for payment in advance and payment made on the same day. You are responsible for the balance on your account for any services rendered. Any balance billed from our office deemed 'Patient Responsibility' exceeding 90 days past due will be assessed a 10.00% interest charge.

Appointment Cancelation:

In order for us to better serve our growing number of patients, we ask that you please call if you will be late or unable to keep your scheduled appointment.

Emergency / After Hours Calls:

In case of an emergency you may contact our office during normal business hours for an appointment.

Massage Policies:

- **Cancelation Policy**: If you cannot make your appointment we ask that you please contact our office 24 hours in advance to cancel. If your appointment is not cancelled 24 hours in advance it will be considered a 'No Show' and you will be subject to our 'No Show Policy.'
- **No Show Policy**: If you fail to cancel your appointment according to the cancelation policy you are considered a 'No Show' and will be unable to schedule your next appointment without providing payment in advance. If you fail to redeem this appointment time or fail to cancel according to the 'Cancelation Policy' you will surrender your payment for this appointment.
- **Refusal of Service Policy**: We reserve the right to refuse to provide services to any person at anytime. Should you be denied service you will be reimbursed for any unused services that have been paid in advance.

By signing below I acknowledge having received and read the above 'Office Policy.' I hereby agree to the terms and conditions outlined above.

Patient Name (Please Print): _____

Patient / Guardian Signature: _____ **Date:** _____