OAK POINT
CHIROPRACTIC

3800 Watt Avenue, Suite 120 Sacramento, CA 95821
Telephone: 916.484.0321 • Fax: 916.481.6830

AUTO ACCIDENT INFORMATION

Please complete the following questionnaire as completely and as accurately as possible. If a question does not apply to you, please write "N/A" (not applicable) next to it. Please print all responses.

Patient Information

Name _____ Today's Date _____

Age _____ Date of Birth _____ Sex ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ Telephone (Cell) _____

E-Mail Address _____ SSN _____ DL # _____

Occupation _____ Employer _____ Years Employed _____

Address _____ City _____ State _____ Zip _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced No. of Children _____

Spouse's Name _____ Telephone _____

Emergency Contact _____ Relationship _____ Telephone _____

Who can we thank for referring you to our office? _____

Auto Insurance & Attorney Information

Name of your Auto Insurance _____ Telephone _____

Address _____ City _____ State _____ Zip _____

Date accident was reported to your auto insurance _____

Group or Policy # _____ Claim # _____

Do you have medical payment (med-pay) coverage on your policy? ☐ Yes ☐ No

Adjuster's Name _____ Telephone _____

Have you retained an attorney regarding this accident? ☐ Yes ☐ No

Attorney's Name _____ Telephone _____

Address _____ City _____ State _____ Zip _____

Accident Details

Date of auto accident _____ Time _____ ☐ AM ☐ PM

Make and model of your vehicle _____ Year _____

Make and model of other vehicle(s) involved _____ Year _____

Were you the ☐ Driver ☐ Front Passenger ☐ Rear Passenger (☐ Left ☐ Middle ☐ Right)

Number of people in your vehicle at the time of the accident ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other _____

Total number of vehicles involved in the accident ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other _____

Total number of impacts to your vehicle ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other _____

The impact to your vehicle occurred from the ☐ Front ☐ Rear ☐ Driver's side
☐ Passenger side ☐ Other _____

Were you on company business at the time of the accident? ☐ Yes ☐ No

If yes, was the accident reported to your employer? ☐ Yes ☐ No

Accident Details, continued

Were you wearing ☐ Lap Belt ☐ Lap and shoulder belt ☐ Neither

Did an airbag deploy? ☐ Yes ☐ No If yes, which airbag(s) were deployed? _____

Location of the accident _____

Please describe, in detail, how the accident happened _____

_____

_____

_____

To the best of your ability, please diagram or draw a picture of the accident

Please describe any damage to the vehicle you were driving _____

_____

Please describe any damage to the other vehicle(s) involved _____

_____

Estimated speed of your vehicle at the time of impact _____ MPH ☐ Stopped

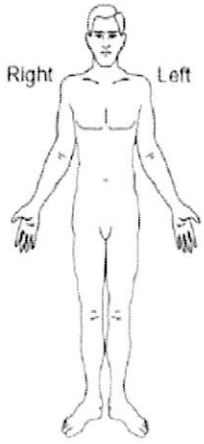
Estimated speed of the other vehicle at the time of impact _____ MPH ☐ Stopped

Did you anticipate the impact? ☐ Yes ☐ No

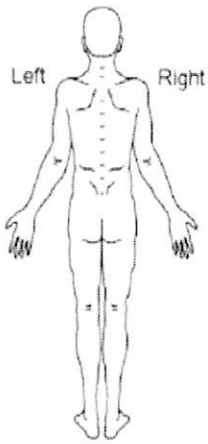
What was the position of your body just before impact? _____

Did you strike anything inside of the vehicle during the accident? ☐ Yes ☐ No

If yes, please indicate the probable item struck on the list below and then draw a line to the region of the body struck using the diagrams below.



☐ Dashboard
☐ Windshield
☐ Side Window
☐ Steering Wheel
☐ Shifter
☐ Inner door panel
☐ Ceiling
☐ Armrest
☐ Headrest
☐ _____
☐ _____



Patient Name: _____ Date: _____

Accident Medical Treatment

Did you receive any: ☐ Cuts ☐ Bruises ☐ Abrasions

Where? _____ Where? _____ Where? _____

At the time of accident, did you have Loss of consciousness ☐ Yes ☐ No

Loss of bowl or bladder control ☐ Yes ☐ No

Fluid from your ears ☐ Yes ☐ No

Did you have any other unusual experience? ☐ Yes ☐ No

If yes, please explain _____

Were you able to remove yourself from the vehicle? ☐ Yes ☐ No

If no, who assisted you, and how were you removed? _____

Which of the following emergency services responded to the scene? ☐ Highway Patrol

☐ Local Police ☐ Sheriff ☐ Paramedics ☐ Ambulance ☐ Other _____

Was a police report made? ☐ Yes ☐ No If yes, do you have a copy of this report? ☐ Yes ☐ No

Did you receive first aid at the scene? ☐ Yes ☐ No If yes, by whom? _____

If yes, what services were provided? _____

Following the accident, did you go to: ☐ Emergency Room ☐ Doctor's Office

Date of visit: _____

If you checked either of the boxes above, please answer the following questions:

Were you admitted to the hospital for injuries relating to this accident? ☐ Yes ☐ No

Name and Location of Hospital _____

Date Admitted _____ Date Discharged _____

What services were done for you at the hospital? _____

Have you seen any other doctors for injuries relating to this accident? ☐ Yes ☐ No

Name and Location of Doctor's Office(s) _____

What diagnosis were you given by these providers? _____

Did the doctor give you any other special instructions? ☐ Yes ☐ No

If yes, please explain: _____

Which of the following medical services have been provided to you relating to this accident?

☐ Examination Where? _____ Date: _____

☐ Supports / Braces Where? _____ Type _____

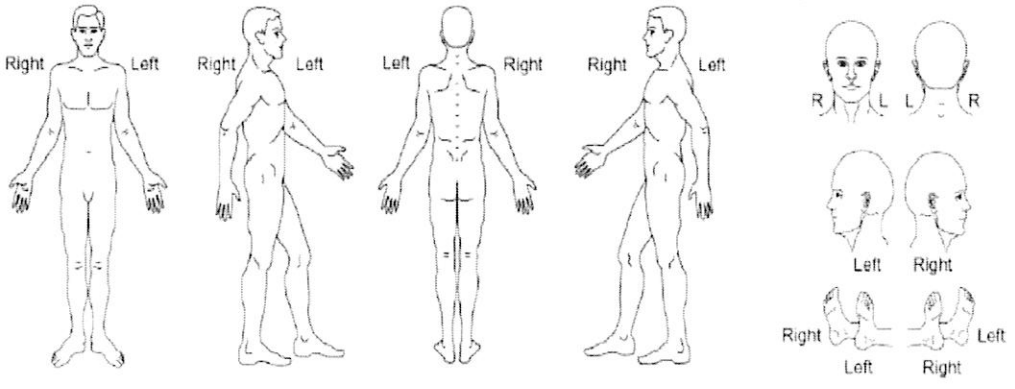
☐ Medication Where? _____ Type: _____

☐ Diagnostic Imaging Where? _____ Type: _____

☐ Other Please Explain:

Accident Medical History

Please mark the diagram below to show where you are experiencing pain and/or discomfort.



Patient Name: _____ Date: _____

Accident Medical History, Cont.

Please describe any health problems that you are experiencing as a result of this accident: _____

_____

_____

Since the accident, has your problem ☐ Improved ☐ Gotten Worse ☐ Not Changed

How often are your symptoms present during the day?

☐ Occasionally 0%-25% ☐ Intermittently 25%-50% ☐ Frequently 50%-75% ☐ Constantly 75%-100%

What makes your condition better? _____

What makes your condition worse? _____

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

Are there any additional activities, <u>not listed above</u>, that you were previously able to perform, but have difficulties performing as a result of this accident? ☐ Yes ☐ No

If yes, please explain: _____

Have you missed any work as a result of this auto accident? ☐ Yes ☐ No

If yes, please explain: _____

Have you had any other serious injury or illness <u>since the auto accident?</u> ☐ Yes ☐ No

If yes, please explain: _____

Medical History

Are you aware of any congenital (from birth) anomalies you may have? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever been placed on disability, even for a brief period of time? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever received an award of permanent disability? ☐ Yes ☐ No

If yes, please explain: _____

Have you been told by a health care professional to permanently refrain from certain physical activities? ☐ Yes ☐ No

If yes, please explain: _____

Do you currently smoke tobacco? ☐ Yes ☐ No How much? _____ How often? _____

Do you currently drink alcohol? ☐ Yes ☐ No How much? _____ How often? _____

Patient Name: _____ Date: _____

Medical History, Cont.

Had	Have	
☐	☐	AIDS
☐	☐	Alcoholism
☐	☐	Allgeriges
☐	☐	Arteriosclerosis
☐	☐	Cancer
☐	☐	Chicken Pox
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Glaucoma
☐	☐	Goiter
☐	☐	Gout
☐	☐	Heart Disease
☐	☐	Hepatitis
☐	☐	HIV Positive
☐	☐	Malaria
☐	☐	Multiple sclerosis
☐	☐	Mumps
☐	☐	Polio
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Sexualy Transmitted Disease
☐	☐	Stroke
☐	☐	Tuberculosis
☐	☐	Typhoid Fever
☐	☐	Ulcer
☐	☐	Other: _____

_____

Have you ever...

- ☐ Had a fracured or broken bone
- ☐ Had a spine or nerve disorder
- ☐ Been knocked unconscious
- ☐ Used a crutch or other support
- ☐ Used neck or back bracing
- ☐ Received a tattoo
- ☐ Had a body piercing

Surgical Interventions

- ☐ Appendix Removal
- ☐ Bypass Surgery
- ☐ Cosmetic Surgery
- ☐ Eye surgery
- ☐ Hysterectomy
- ☐ Pacemaker
- ☐ Tonsilectomy
- ☐ Vasectomy
- ☐ Elective Surgery: _____
- ☐ Other: _____

_____

Family History

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Problems and/or Stroke
- ☐ High Blood Pressure
- ☐ Rheumatoid Arthritis

Please list any medications that you are currently taking, either in relationship to this accident or any other medical condition: _____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please explain: _____

Please list any additional health information that you believe the doctor should know, and was not mentioned above: _____

_____

_____

I understand and agree that health and accident insurance policies are an arrangement between myself and an insurance carrier. Futhermore, I understand that Oak Point Chiropractic & Wellness Center will prepare any necessary reports and forms to assist me in obtaining collection from the insurance company and that any amount authorized to be paid directly to Oak Point Chiropractic & Wellness Center, will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also agree that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

_____ _____

Print Patient Name Date

_____

Signature

Patient Name: _____ 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

The Neck Disability Index Questionnaire

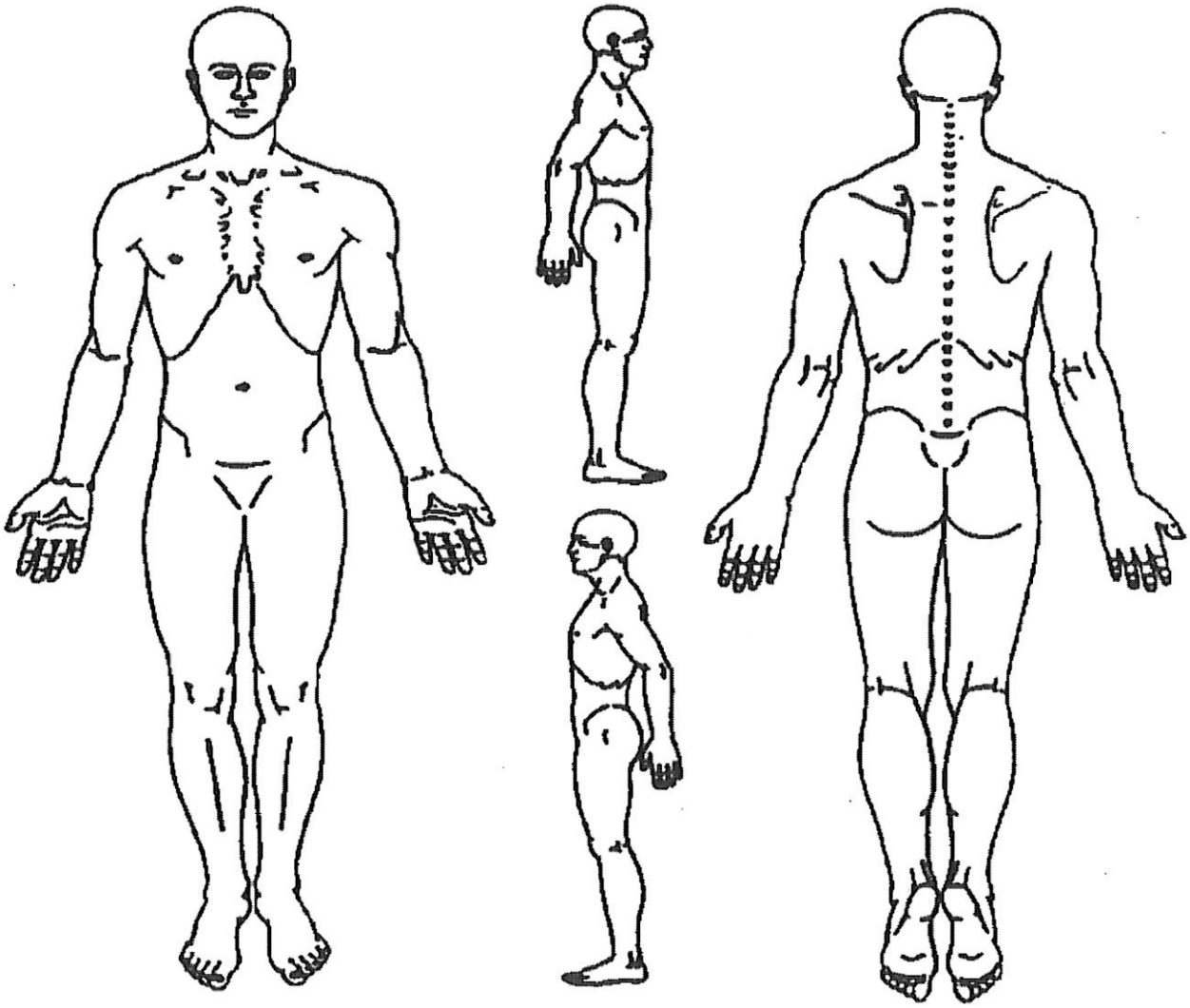
Name (Please Print): _____ Date: _____

How long have you had neck pain? _____ years _____ months _____weeks

Is this you first episode of neck pain? _____ yes _____ no

Use the letters below to indicate the type and location of your sensations right now

Key:	A = Ache	B = Burning	N = Numbness
	P = Pins & Needles	S = Stabbing	O = Other



OVER PLEASE

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

The Back Disability Index Questionnaire

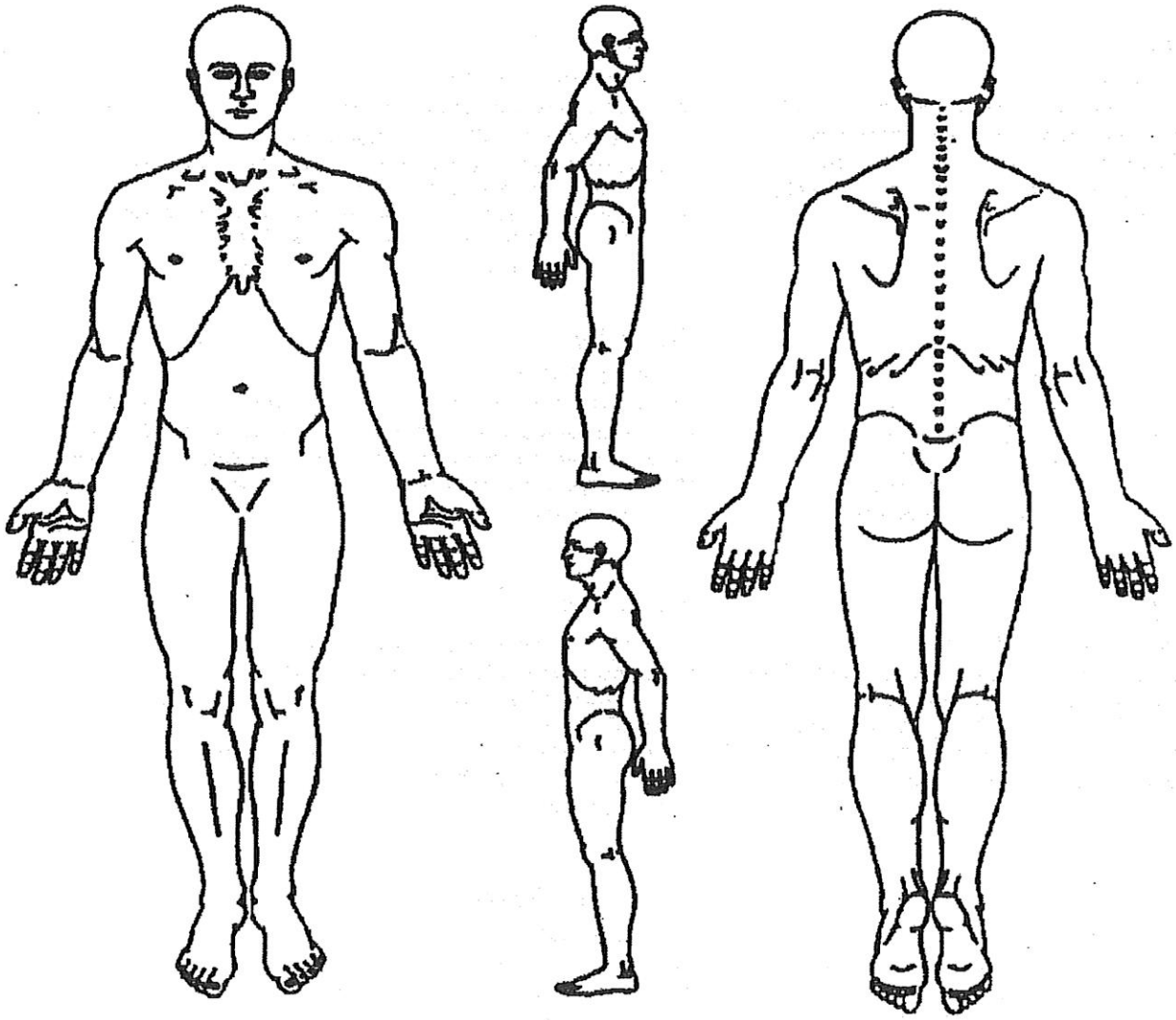
Name (Please Print): _____ **Date:** _____

How long have you had back pain? _____ years _____ months _____ weeks

Is this your first episode of back pain? _____ yes _____ no

Use the letters below to indicate the type and location of your sensations right now

Key:	**A = Ache**	**B = Burning**	**N = Numbness**
	P = Pins & Needles	**S = Stabbing**	**O = Other**



OVER PLEASE

OAK POINT
CHIROPRACTIC

3800 Watt Avenue, Suite 120 Sacramento, CA 95821

Telephone: 916.484.0321 • Fax: 916.481.6830

INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic and extern preceptees (final licensure pending) who now or in the future treat me while employed by, working or associated with, or serving as back-up doctor for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____
Printed Name of Patient

_____ _____
Signature of Patient or Representative Date

_____ _____
Witness to Patient's Signature Date

_____ _____
Translated By Date

Names of Treating Chiropractors:
Michael P. Simmons, D.C.
Steven M. Simmons, D.C.
Nicolas Muhn, D.C.

Oak Point Chiropractic & Wellness Center
3800 Watt Avenue, Suite 120
Sacramento, CA 95821

REV. 11/22/2018 RM

OAK POINT
CHIROPRACTIC

3800 Watt Avenue, Suite 120 Sacramento, CA 95821

Telephone: 916.484.0321 • Fax: 916.481.6830

NOTICE OF PRIVACY PRACTICES

Oak Point Chiropractic and Wellness Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please notify us for a personal conference in person or by telephone within two working days.

This notice is effective as of April 14, 2003.

I have read the Privacy Notice and understand my rights contained in the Notice.

By way of my signature, I provide Michael P. Simmons, D.C., Steven M. Simmons, D.C., Nicolas Muhn, D.C., and Oak Point Chiropractic, with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

OAK POINT
CHIROPRACTIC

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Telephone: 916.484.0321 • Fax: 916.481.6830

PERSONAL LIEN
FOR OAK POINT CHIROPRACTIC AND WELLNESS CENTER

PATIENT: _____

DATE OF ACCIDENT: _____

I, the undersigned, understand that this is a personal lien with Dr._____, D.C. I attest that I have not retained an attorney in regards to the accident in which I was recently involved. I also agree that in the event I retain an attorney I will promptly furnish Oak Point Chiropractic and Wellness Center with said attorney's name.

I, the undersigned, agree to pay my account each month until my account is paid off in full, I will be liable for the balance and any court costs that the doctor incurs to recover the balance. However, if the case does not settle within 90 days of release of my care from this accident, I will pay the account in full, or continue to make arrangements for monthly payments until my case settles.

I hereby agree that I will pay directly to said doctor such sums as may be due and owing him/her for chiropractic/medical services rendered me both by reason of this accident and/or by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor.

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

I fully acknowledge this letter by signing below. I have been advised that if I do not cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to pay on my account and keep it on a current basis.

Dated: _____ Patient's Signature: _____

Dated: _____ Witnessed: _____

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CHIROPRACTIC

3800 Watt Avenue, Suite 120 Sacramento, CA 95821
Telephone: 916.484.0321 • Fax: 916.481.6830

INSURANCE ASSIGNMENT & LIEN

Patient: _____

Claim #: _____

Date of Injury: _____

I hereby authorize and direct _____ Insurance Company to pay Dr. _____ such sums as may be due and owing for chiropractic services rendered me by reason of this accident, and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further request that payment be made directly to said doctor which would otherwise be paid to myself, as the result of all charges incurred for injuries in connection therewith.

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

Please acknowledge your agreement to this request by signing below and returning the original in the envelope provided within 5 days from receipt.

_____ _____

Date Patient's Signature

_____

Witness Signature

The undersigned insurance company does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said doctor above, and make payment payable directly to said doctor.

_____ _____

Date Signature of Insurance Company Representative

_____

Print Name

_____

Insurance Company Name

NOTICE OF DOCTOR'S LIEN

TO: Attorney: _____

_____

_____

FROM:
Oak Point Chiropractic & Wellness Center
3800 Watt Avenue, Suite 120
Sacramento, Ca 95821
Ph: (916) 484-0321 Fax: (916) 481-6830

RE: Medical Reports and Doctor's Lien

Patient Name: _____

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay said doctor such sums as may be due and owing him/her for medical services rendered me by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And 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 a result of the injuries which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this manner, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly responsible to said doctor for all medical and/or surgical benefits, including major medical, submitted by him/her for service rendered me and that this agreement is made solely for said doctor's additional protection. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorney's fees, and/or courts costs will be added to the total amount due.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but my declare the entire balance due and payable.

Date: _____

Dated: _____ Patient Signature: _____

Witness: _____ Address: _____

ACKNOWLEDGEMENT OF ATTORNEY

The undersigned being attorney of record for the above patient does hereby agree to observe all the 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 named above. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to this office for payment. The prevailing party in any litigation resulting from enforcement of this lien shall be entitled to actual attorney's fees and court costs.

Date: _____ Attorney's Signature: _____

Attorney: Please date, sign and return one copy to above doctor's office at once.
Keep one copy for your records.

NOTICE OF DOCTOR'S LIEN

TO: Attorney: _____

_____

_____

FROM:
Oak Point Chiropractic & Wellness Center
3800 Watt Avenue, Suite 120
Sacramento, Ca 95821
Ph: (916) 484-0321 Fax: (916) 481-6830

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Date: _____ Attorney's Signature: _____

Attorney: Please date, sign and return one copy to above doctor's office at once.
Keep one copy for your records.

REV. 05/01/2018 RM