INTRODUCTION PATIENT CASE HISTORY

Today's Date: ___/___/___

PATIENT INFORMATION

Name: *(First MI Last)* _____ **Preferred Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female **Social Security #:** _____

Home: _____ **Mobile:** _____ **Work:** _____

Email: _____

Preferred Method of Contact: ☐ Text ☐ Email ☐ Phone - *Home, Mobile, or Work* ☐ Other: _____

***Referred By:** *(Name)* _____

☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor ☐ Other: _____

Race & Ethnicity: *(Choose up to 2)*

- ☐ African American or Black
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Decline

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other: _____
- ☐ Decline

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* _____ **Primary Care Physician:** _____

Home: _____ **Mobile:** _____ **Doctor's Phone:** _____

Relationship:

☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

FINANCIAL INFORMATION

Is today's visit the result of an accident?

☐ No ☐ Auto ☐ Work ☐ Other: _____

Will we be working with insurance? ☐ No ☐ Yes *(Details)*

Primary _____ *ID#* _____

Secondary _____ *ID#* _____

Where would you like statements sent?

☐ Self ☐ Other *(Details below)*

Name _____

Address _____

Phone _____ *Email* _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

Major Complaint: _____ **Secondary Complaints:** _____

_____ _____

_____ _____

When did it start? __/__/____ **What happened?** _____

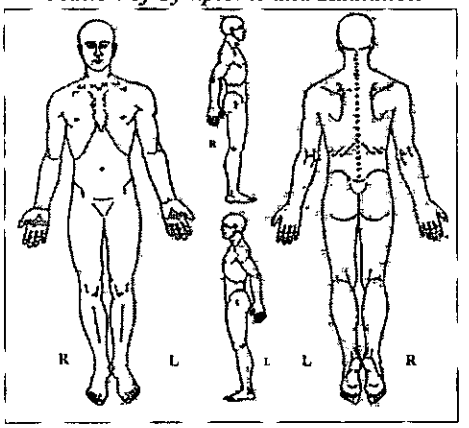
_____

Which daily activities are being affected by this condition? _____

_____

MAJOR COMPLAINT

Location of Symptoms and Radiation



P__ Pain T__ Tender
N__ Numb H__ Hypoesthesia
S__ Spasm

Grade Intensity/Severity:

- ☐ None (0/10)
- ☐ Mild (1-2/10)
- ☐ Mild-Moderate (2-4/10)
- ☐ Moderate (4-6/10)
- ☐ Moderate-Severe (6-8/10)
- ☐ Severe (8-10/10)

Frequency:

- ☐ Off & On
- ☐ Constant

Quality:

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff & Sore
- ☐ Other: _____

Does it radiate?

☐ No ☐ Yes *(Please indicate on drawing)*

Improves with:

- ☐ Ice
- ☐ Heat
- ☐ Movement
- ☐ Stretching
- ☐ OTC Medications: _____
- ☐ Other: _____

Worsens with:

- ☐ Sitting
- ☐ Standing/Walking
- ☐ Lying Down/Sleeping
- ☐ Overuse/Lifting
- ☐ Other: _____

Previous Treatment:

- ☐ None
- ☐ Chiropractor _____
- ☐ Medical Doctor _____
- ☐ Physical Therapy _____
- ☐ ER/Urgent Care _____
- ☐ Orthopedic _____
- ☐ Other: _____

Previous Diagnostic Testing:

- ☐ None
- ☐ X-rays _____
- ☐ MRI _____
- ☐ CT _____
- ☐ Other: _____

***Women:** *Are you pregnant?*

☐ No *Last Menstrual Period* __/__/____

☐ Yes *Due date:* __/__/____

Present Illness Comments.

_____

_____

_____

_____

_____

_____

Prescription Medications & Supplements: ☐ None

☐ Yes *(List – Name, dosage, frequency)* _____

_____

_____

_____

_____

Allergies to Medications: ☐ No known drug allergies

☐ Yes *(List - Name and reaction)* _____

_____

_____

_____

_____

PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you *ever* had any of the following? *(Please select all that apply and use comments to elaborate.)*

Illnesses:

- ☐ Asthma
- ☐ Autoimmune Disorder (*Type*) _____
- ☐ Blood Clots
- ☐ Cancer (*Type*) _____
- ☐ CVA/TIA (stroke)
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Other: _____

Injuries:

- ☐ Back Injury
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Falls
- ☐ Other: _____

Hospitalizations: *(Non-surgical with Date)*

_____

_____

Surgeries: *(If yes, provide type & surgery date)*

- ☐ Cancer _____
- ☐ Orthopedic
  - Shoulder – R / L _____
  - Elbow/Forearm – R / L _____
  - Wrist/Hand – R / L _____
  - Hip – R / L _____
  - Knee – R / L _____
  - Ankle/Foot – R / L _____
- ☐ Spinal Surgery
  - Neck: _____
  - Back: _____
- ☐ Other: _____

_____

_____

Medical History Comments

_____

FAMILY HISTORY *(Please mark X to all that apply and use comments to elaborate.)*

☐ Unknown ☐ Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death *(if Deceased)*								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

Family History Comments:

_____

SOCIAL AND OCCUPATIONAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Children: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

Student Status: ☐ Full Student ☐ Part Student ☐ Non-Student

Highest level of Education: ☐ High School ☐ College Grad.

☐ Post Grad. ☐ Other: _____

Employed: ☐ No ☐ Yes (*Occupation*) _____

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Smoking/Tobacco Use: *If current smoker, amount =* _____

☐ Every Day ☐ Some Days ☐ Former ☐ Never

Alcohol Use:

☐ Every Day ☐ Weekly ☐ Occasionally ☐ Never

Caffeine Use:

☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never

Exercise frequency:

☐ Daily ☐ 3-4xs/week ☐ 2-3xs/week ☐ Rarely ☐ Never

Social History Comments. _____

_____

REVIEW OF SYSTEMS

Many of the following conditions respond to chiropractic treatment.

Are you *currently* experiencing any of these symptoms? *(Please select all that apply and use comments to elaborate.)*

Constitutional: *(General)*
- ☐ Fever
- ☐ Fatigue
- ☐ Other: _____
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Joint Pain/Stiffness/Swelling
- ☐ Muscle Pain/Stiffness/Spasms
- ☐ Broken Bones
- ☐ Other: _____
- ☐ *None in this Category*

Neurological:
- ☐ Dizziness or Lightheaded
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Other: _____
- ☐ *None in this Category*

Psychiatric: *(Mind/Stress)*
- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ *None in this Category*

Genitourinary:
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Painful or Irregular Periods
- ☐ Other: _____
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains/Tightness
- ☐ Rapid or Heartbeat Changes
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Other: _____
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Other: _____
- ☐ *None in this Category*

Eyes & Vision:
- ☐ Eye Pain
- ☐ Blurred or Double Vision
- ☐ Sensitivity to Light
- ☐ Other: _____
- ☐ *None in this Category*

Head, Ears, Nose, & Mouth/Throat:
- ☐ Frequent or Recurrent Headaches
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Hearing Loss
- ☐ Sensitivity to Loud Noises
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Other: _____
- ☐ *None in this Category*

Endocrine:
- ☐ Infertility
- ☐ Recent Weight Change
- ☐ Eating Disorder
- ☐ Other: _____
- ☐ *None in this Category*

Hematologic & Lymphatic:
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Swollen Glands
- ☐ Other: _____
- ☐ *None in this Category*

Integumentary: *(Skin, Nails, & Breasts)*
- ☐ Rash or Itching
- ☐ Change in Skin, Hair, or Nails
- ☐ Non-healing Sores or Lesions
- ☐ Change of Appearance of a Mole
- ☐ Breast Pain, Lump, or Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Allergic/Immunologic:
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Other: _____
- ☐ *None in this Category*

Review of Systems Comments:

I have answered these questions to the best of my knowledge and certify them to be true and correct

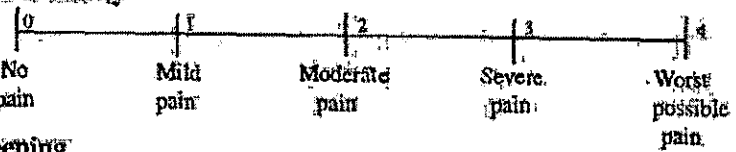
Patient or Guardian Signature _____ Date _____

Functional Rating Index

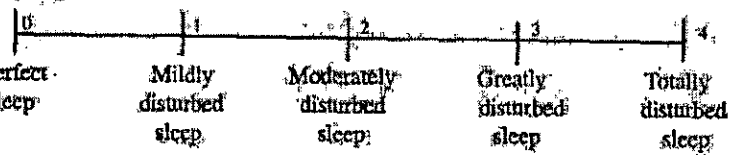
For use with Neck and/or Back Problems only.

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.

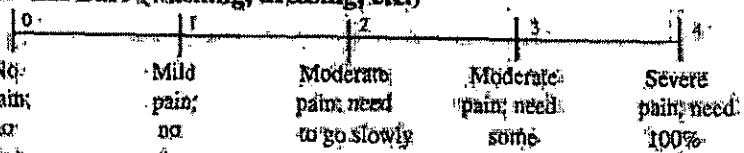
1. Pain Intensity



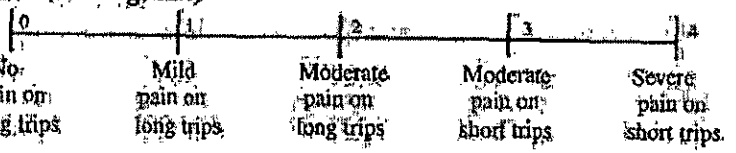
2. Sleeping



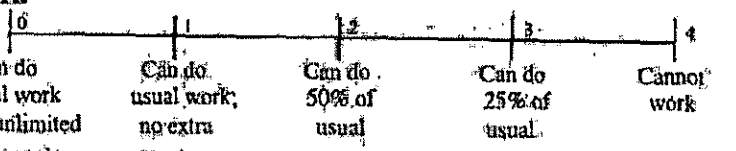
3. Personal Care (washing, dressing, etc.)



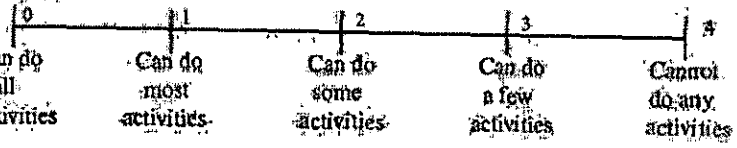
4. Travel (driving, etc.)



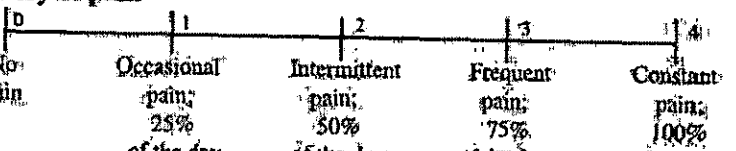
5. Work



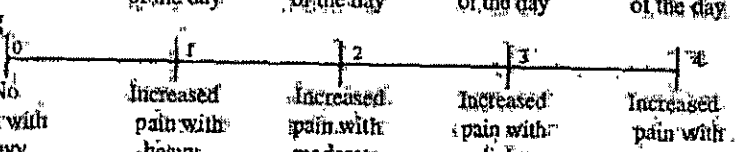
6. Recreation



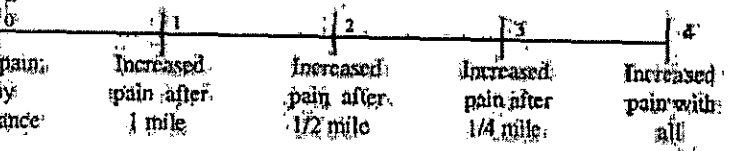
7. Frequency of pain



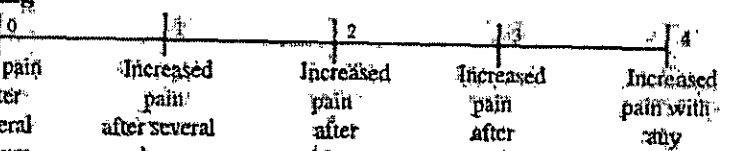
8. Lifting



9. Walking



10. Standing



Signature _____ Date _____

ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI)_____ **Today's Date:** _____

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- **Was anyone else in the vehicle with you?** ☐ No ☐ Yes - *(Number of people)* _____
- **You were?** ☐ Front seat – *Driver / Passenger* ☐ Rear Seat - Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row
- **Name of Driver**, *if not self*: _____ **Name of Driver of other vehicle:** _____
- **Did airbags deploy?** ☐ No ☐ Yes **Did Police arrive?** ☐ No ☐ Yes **Using Seatbelt?** ☐ No ☐ Yes
- **Did you strike the windshield or object in car?** ☐ No ☐ Yes - *(Describe)* _____
- **Were you knocked unconscious?** ☐ No ☐ Yes *(How long?)* _____
- **Where was your vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Where was the other vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Your Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:** _____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____
- **Other's Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:** _____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: _____ **Occupation:** _____ **Claim #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Contact Person: _____ **Phone:** _____ **Email:** _____

GENERAL ACCIDENT/INJURY INFORMATION – *(PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)*

Date of Accident: __/__/____ **Time:** __:__ AM / PM

Please describe the accident in as much detail as possible? _____

_____

_____

_____

Before the accident/injury:

- **Have you ever had any complaints in the involved area before?** ☐ No ☐ Yes
  - *If yes* - **Were they present at the time of the accident/injury?** ☐ No ☐ Yes
    - *If yes* - **Summarize these complaints prior to the accident:** _____
- **Were you capable of performing all of your work activities without restriction?** ☐ No ☐ Yes

At the time of the accident/injury:

- **Did you feel pain immediately after the accident?** ☐ No ☐ Yes ☐ Later that day ☐ Next day ☐ When? _____
- **Were you taken anywhere after the accident?** ☐ No ☐ Yes ☐ Later that day ☐ Next day ☐ When? _____
  - *If yes*, **How?** _____ **Where?** _____
  - *If yes*, **Did you receive treatment?** ☐ No ☐ Yes - *(Describe)* _____

Since the accident/injury:

- **Are your symptoms:** ☐ Improving? ☐ Getting Worse? ☐ The Same?
- **Are your work activities restricted as a result of this accident/injury?** ☐ No ☐ Yes - *(How?)* _____
- **Have you missed any work since this accident?** ☐ No ☐ Yes - *(Dates?)* _____
- **Have you retained an Attorney?** ☐ No ☐ Yes - **Name:** _____ **Phone:** _____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

Patient No: _____

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME(Please Print):_____ DATE: _____

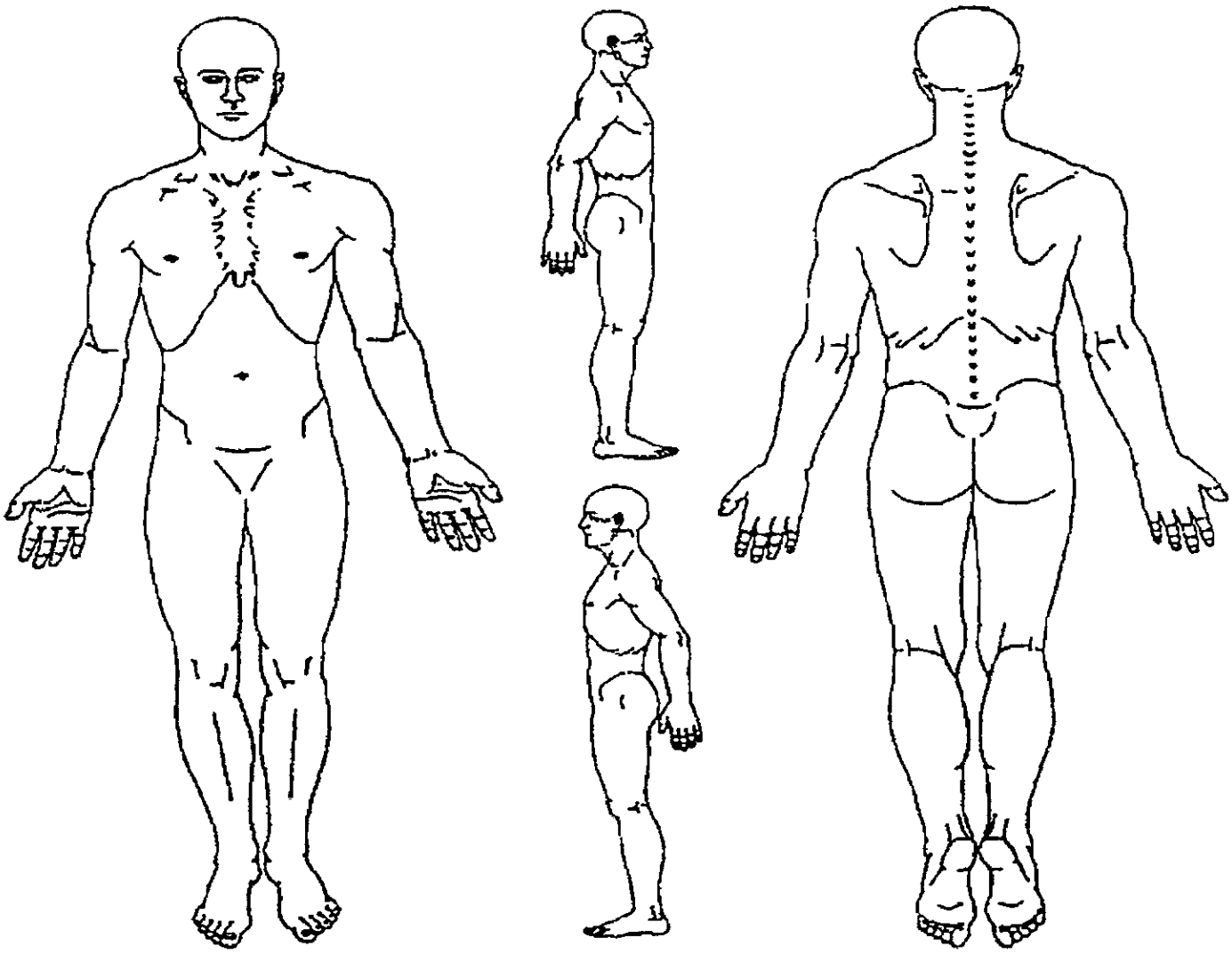
HOW LONG HAVE YOU HAD LOW BACK PAIN? ___YRS ___ MTHS ___ WKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? ___ YES ___ NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY: **A**= ACHE **B**= BURNING **N**= NUMBNESS
P= PINS & NEEDLES **S**= STABBING **O**= OTHER



REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1- Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2- Personal Care

A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3- Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

SECTION 4- Walking

A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than ½ mile.
D Pain prevents me from walking more than ¼ mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

SECTION 5- Sitting

A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more then ½ hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

SECTION 6- Standing

A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than ½ hour without increasing pain.
E I cannot stand for longer than ten minutes without increasing pain.
F I avoid standing, because it increases the pain straight away.

SECTION 7- Sleeping

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than one-quarter.
D Because of pain, my normal night's sleep is reduced by less than one-half.
E Because of pain, my normal night's sleep is reduced by less than three quarters.
F Pain prevents me from sleeping at all.

SECTION 8- Social Life

A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests.
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9- Traveling

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10- Changing Degree of Pain

A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

Comments:_____

Patient Signature: _____ Date: _____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

NAME(Please Print):_____ _ DATE: _____

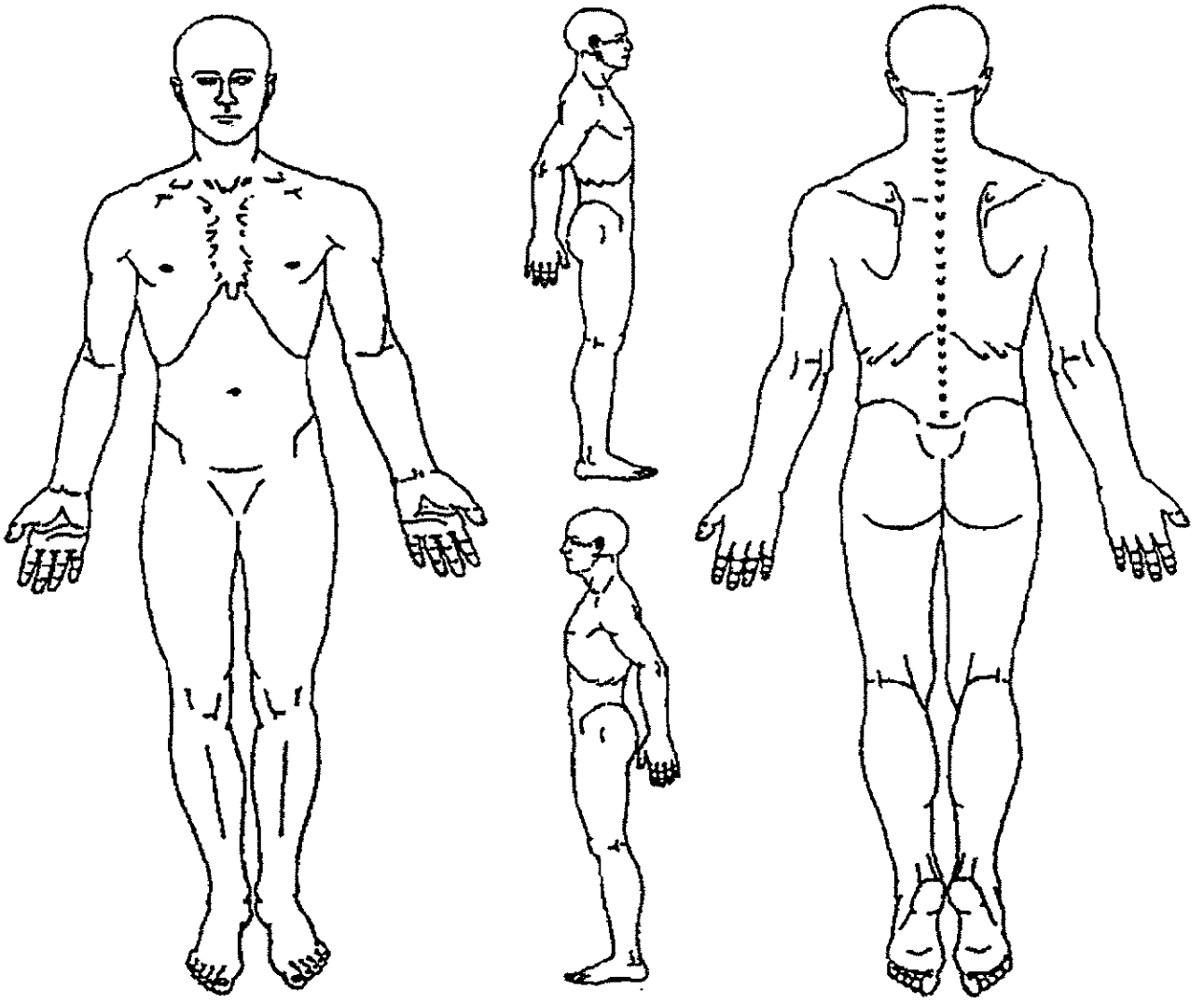
HOW LONG HAVE YOU HAD NECK PAIN? ___YEARS ___ MONTHS ___ WEEKS

IS THIS YOUR FIRST EPISODE OF NECK PAIN? ___ YES ___ NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY: **A**= ACHE **B**= BURNING **N**= NUMBNESS
P= PINS & NEEDLES **S**= STABBING **O**= OTHER



NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please read: This questionnaire is designed to enable us to understand how much your NECK pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1- Pain Intensity
A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain comes is very severe.
F The pain is the worst imaginable at the moment.

SECTION 2- Personal Care (Washing, Dressing, etc.)
A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3- Lifting
A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can only lift very light weights, at the most.
F I cannot lift or carry anything at all.

SECTION 4- Reading
A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5- Headaches
A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6- Concentration
A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentration when I want to.
E I have a great tdeal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7- Work
A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8- Driving
A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9- Sleeping
A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless.)
C My sleep is mildly disturbed (1-2 hours sleepless.)
D My sleep is moderately disturbed (2-3 housrs sleepless.)
E My sleep is greatly disturbed (3-5 hours sleepless.)
F My sleep is completely disturbed (5-7 hours sleepless.)

SECTION 10- Recreation
A I am able to engage in all recreational activities, with no neck pain.
B I am able to engage in all recreational activities, with some neck pain.
C I am able to engage in most, but not all recreational activities because of neck pain.
D I am able to engage in a few of my usual recreation al activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

Comments:_ _____

Patient Signature: _____ Date: _____

BACK & NECK Pain Center

Dr. James B. Doty
Chiropractic Physician

ASSIGNMENT, AUTHORIZATION AND LIEN

To Whom It May Concern:

I hereby authorize and direct_____my insurance company, and/or my attorney, to pay directly to James B. Doty, DC., 3730 S Noland Rd, Independence, MO 64055 such sums as may be due and owing this Office and Assignee for services rendered the undersigned by reason of accident or illness, and by reason of any other bills that are due or may become due, and to withhold such sums from any disability benefits, including but not limited to foundation grants, governmental or agency benefits, medical payment benefits, no fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse the undersigned or from any settlement, judgment or verdict on my behalf as may be necessary to adequately provide for any financial obligations owed this Office and Assignee.

The parties further agree that, in the event my insurance company obligated to make payments to me upon the charges made by this Office and Assignee for its services refuses to make such payments, this agreement is to act as an assignment of the undersigned rights and benefits to the extent of the Office's services provided; therefore, I hereby assign and transfer to this Office and Assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize this Office and Assignee to prosecute said cause of action either in my name or in the Assignee's name and further I authorize this Office and Assignee to compromise, settle or otherwise resolve said claim of cause of action as they see fit.

I hereby further give a Lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by said Office and Assignee. The undersigned patient and Assignee further agree that the Assignee's right for payment from the undersigned patient shall be tolled by any state of limitation until a reasonable time has lapsed after either negotiations or litigation between third parties and the undersigned patient are resolved.

It is further agreed that the undersigned patient shall remain personally responsible for the total amounts due this Office and Assignee for its services. The undersigned further understands and agrees that this Assignment, Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

Patients or Authorized Person signature: I authorize the release of any medical or other information necessary to process claims, billings, or to obtain payment. I also request payment of governmental benefits of the party who accepts assignment. Insured or authorized persons signature: I authorize payment of medical benefits to the undersigned physician or supplier for services rendered. I also agree to pay any collection fees, attorney fees, court fees or any other fees associated with collecting fees for services rendered by James B. Doty, D.C., his staff or facility. I hereby acknowledge receipt of goods and services a s received pertinent to my history, in the amount of the total hereon.

I authorize James B. Doty and or his Office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, and Authorization. I agree that the above mentioned Office be given Power of Attorney to endorse/sign my name to any and all checks for payment of any indebtedness owed this Office and Assignee. I hereby acknowledge that this Assignment, Authorization and Lien can not be rescinded

PATIENT PRINTED FIRST AND LAST NAME

PATIENT DATE OF BIRTH

SIGNATURE OF PATIENT OR AUTHORIZED PERSON

DATE

SIGNATURE OF WITNESS

DATE

HIPAA Notice of Privacy Practices

BACK & NECK PAIN CENTER
3730 SOUTH NOLAND ROAD
INDEPENDENCE MO 64055
816/833-1232

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you in writing of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Patient Name:_____ Date _____

Signature of Patient or Parent/Guardian _____