16705 Square Drive
Marysville, Ohio 43040

Patient Name_____ **DOB:**_____ ☐ **Male** ☐ **Female**

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

SS#/ SIN_____

Email_____ Home Phone_____ Cell Phone_____

Patient's Address_____ City_____ State_____ Zip_____

Employer Name_____

Spouse or Patients' Guardian Name_____ Spouse's Employer_____

How did you hear about us?_____

Emergency Contact_____ Phone_____

Responsible Party

Name of the person responsible for this account_____ Relationship to patient_____

Is the person currently a patient at our office? ☐ Yes ☐ No

Email_____ Home Phone_____ Cell Phone_____

Address_____ City_____ State_____ Zip_____

Driver's License # _____ Date of Birth_____

Do you have Medical Insurance? ☐ Yes ☐ No if yes, complete the following:

Name of the insured_____ Relationship to patient_____

Birthdate_____ SS#/SIN_____ Work Phone_____

Name of Employer_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ ID #_____ Group #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

In case of a medical emergency, if the patient is of school age 15+, it is ok to treat in my absence.

_____ _____

Parent or Guardian Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS Y PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Synergy Medical, Doctor Charita Cooper, Doctor Patrick Cooper, Alana Grabovich CNP, and Lindsay West, CNP** as well as all employees, employers, representatives, and agents thereof (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health Insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with the same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that the Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Providers. A photocopy or scan or this document is to be considered as valid as the original.

Signed this_____ day of _____, 20_____. X_____ (SEAL)
(Patient signature)

X_____(SEAL) X_____
(Signature of Guardian if applicable) (Please print patient name)

Health History

Chief Complaint:_____

History of Present Illness:

Location:_____
(Where is the Pain/ Problem?)

Quality:_____
(Example: Normal vs abnormal color, activity, etc..)

Severity:_____
(How severe is the pain/problem on a scale of 1-10

Duration:_____
(How long have you had this pain/ problem? being the most severe?) When did it start?)

Timing:_____
(Does the pain/problem occur at a specific time?)

Context:_____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms:_____
_____
_____
(What other associated problems have you been having?)

Modifying Factors:_____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Please check all that apply)

- ☐ Anemia
- ☐ Bladder Infection
- ☐ Epilepsy
- ☐ Whooping Cough
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Smallpox
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Arthritis
- ☐ Venereal Disease
- ☐ Stroke Chronic Bronchitis
- ☐ Infectious Mono AIDS & HIV
- ☐ Back Trouble
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Migraine Headaches
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Cancer
- ☐ Polio
- ☐ Glaucoma
- ☐ Hernia
- ☐ Mitral Valve Prolapse
- ☐ Hepatitis
- ☐ Ulcer
- ☐ Kidney Disease
- ☐ Hemorrhoids
- ☐ Bleeding Tendency
- ☐ Asthma
- ☐ Hives or Eczema

Date of Last Chest X-Ray_____

Any Other Disease, (Please List):

_____
_____

Previous Hospitalizations/ Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication: *(include non prescription)*

_____
_____

Drug Allergies, including reaction to them:

_____
_____

Sleep:

Average length of sleep (hours):_____

Does pain affect sleep? ☐ NO ☐ YES

How many pillows do you sleep with? 1 2 3 4

Energy level: ☐ Low ☐ Moderate ☐ Adequate

How has your mood been lately? _____

Patient Social History:

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Drugs: ☐ Never Type/Frequency:_____

Excessive Exposure At home or at work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne Particles ☐ Noise

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling's	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Itching	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5
Muscle Spasm	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands/feet	1 2 3 4 5
Recent Vision Changes	1 2 3 4 5
Loss of Consciousness	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5
Insomnia/difficult sleeping	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian *Date*

Provider's Review

_____ _____

Signature of Provider *Date*

CONSENT TO TREAT

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read below and if you have any questions, please feel free to ask.

AUTHORIZATION TO GIVE MEDICAL CARE-CONSENT TO TREATMENT:

I hereby voluntarily consent to outpatient care from Synergy Medical encompassing routine diagnostic procedures, physical examination, and medical treatment including (but not limited to) routine laboratory work and administration of medications prescribed by the providers (joint injections, PRP, trigger point injections, regenerative cell medicine). I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by Synergy Medical's medical providers and staff, as is necessary in the medical staff's judgement. I understand that during the course of treatment, health care workers may be exposed to the patient's blood and/or body fluids increasing the risk of contracting Hepatitis B, Hepatitis C and/or HIV. In the event that exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the healthcare worker. I understand that this consent will be valid and will remain in effect as long as I attend the clinic. Please see below for potential risks and side effects.

- Injection: increased pain or discomfort, infection, allergic reactions, numbness, trauma to nerves, fainting, soft tissue swelling, bruising, hematoma formation, collapsed lung, seizures, even remote risk of death or serious disability that exist with any surgical procedure.
- Blood Draw: increased pain or discomfort, infection, numbness, trauma to nerves, fainting, soft tissue swelling, bruising, or hematoma formation.
- Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations, and sprains.
- Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.
- Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

Consent to Evaluate and Treat a Minor:

I, _____being the parent or legal guardian of _____, have read and fully understand the above terms and hereby grant permission for my child to receive treatment with Synergy Medical.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

[ ] No One [ ] Name/Relationship: _____ Phone: _____

May we leave messages regarding your personal healthcare information on an answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgment

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Patient Print Name: _____Signature: _____ Date: _____

Witness Name Print: _____ Signature:_____ Date:_____

Women Only:

To the best of my knowledge, **I am/am NOT** pregnant and (**give my permission/don't give my permission**) to x-ray me for diagnostic interpretation.

Protecting Your Health Information

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPPA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individuals and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need the record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are the victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Upon becoming a patient, we will be entering your name and email into our database and you may receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail, email, or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

Patient/Guardian Signature:_____Date:_____

PHOTO/VIDEO RELEASE FORM

Permission to Use Photograph/Video

I grant Synergy Medical, its representatives and employees the right to take photographs of me and my property in connection with the above identified subject. I authorize Synergy Medical , its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that Synergy Medical may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above:

Signature_____

Printed Name_____

Date_____

Signature, parent or guardian_____

(If under age 18)

Name _____ Date _____

Date of Injury: _____/_____/_____ Where did the injury occur? _____

Please describe the injury in your own words: _____

_____

_____

Was there anything that you think caused the injury? Ex. Wet floor. Please describe: _____

_____

_____

Immediately after the accident, were you: ☐ Conscious ☐ Dazed ☐ Unconscious

If dazed or unconscious, how long? _____

Did anyone witness your injury? ☐ Yes ☐ No Who? _____

Did you report the injury to anyone? ☐ Yes ☐ No Who? _____

Did you go to the hospital? ☐ Yes ☐ No When? _____

If yes, how did you get there? ☐ Ambulance ☐ Other _____

If by ambulance, did attendants place you in a: ☐ Neck Brace ☐ Back Brace ☐ Other _____

Please list any medications or medical supplies given: _____

Did you have X-Rays taken at the hospital? ☐ Yes ☐ No

If you went to the Hospital or Doctor, please list the following:

Doctor or Hospital Name _____ Diagnosis _____

Treatment Received _____

Do you have any future appointments regarding this injury? ☐ Yes ☐ No

If yes, when? _____

What type of work do you do? _____

Requirements? _____

Have you lost any days of work because of the injury? ☐ Yes ☐ No If yes, list dates _____

Have you retained an attorney? ☐ Yes ☐ No Litigation? ☐ Yes ☐ No ☐ Maybe

If yes, please list name and address: _____

Patient Signature: _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____

GUARANTEE OF MEDICAL AND/OR HEALTH BILLS FROM SPECIFIC CLAIM FUNDS AND FIRST PARTY ASSIGNMENT

This Assignment, made effective on the _____ day of _____, 20___, by and between _____(“Patient") and Synergy Medical, and its officers, agents, members, shareholders, subsidiaries, assigns, employees, and directors (collectively referred to as "Clinic");

Witnesseth:

WHEREAS, _____ insurance company insures Patient through a contractual right of uninsured/underinsured-motorist coverage and/or medical-payment coverage and/or health-insurance coverage and/or any other contractual right between Patient and insurance company (“First Party Insurance");

WHEREAS, Patient was involved in an accident on or about _____ in which he/she was injured and for which he/she has a claim against another person(s) and/or liability insurance carrier(s) (including, but not limited to, "First Party Insurance" or "Third Party Insurance") for causing his/her injuries and/or damages (hereinafter referred to as "Claim");

WHEREAS, to the best of Patient's knowledge, the person(s) who caused the Claim is/are insured by _____ insurance company(ies);

WHEREAS, Patient is entering into this Assignment and Guarantee of Payment voluntarily and without duress;

WHEREAS, Patient acknowledges that he/she has the right and opportunity to seek independent legal counsel to review this Assignment prior to execution; _____ (Patient's initials)

WHEREAS, Patient seeks to have the Clinic provide medical care, treatment, and services as a result of Patient's Claim;

WHEREAS, Clinic agrees to provide medical care, treatment, and services to Patient for the injuries Patient sustained in the accident referred to above; and,

WHEREAS, Patient and Clinic desire to enter into this Assignment and Guarantee of Payment in accordance with the terms contained herein.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, and for other good and valuable consideration, the receipt of which is hereby acknowledged, it is agreed as follows:

1. **Patient hereby personally GUARANTEES payment of the Clinic's fees incurred by Patient to the Clinic for all treatment and other services rendered by the Clinic arising out of the Claim and/or from any proceeds and/or specific funds from Patient's Claim, including, but not limited to, third-party settlement(s), judgment(s), or verdict(s), and/or any first-party benefits, including but not limited to med-pay or other contractual proceeds. Patient affirms that this guarantee constitutes a lawful interest pursuant to Ohio Rule of Professional Conduct 1.15(D).**

I have read and agree to the above guarantee to claim funds:_____

(Signature of Patient) *(Date)*

2. **Patient hereby ASSIGNS, without any right to later revoke, a part of any proceeds from his/her Claim equal to the fees incurred by Patient to the Clinic for all treatment and other services rendered by the Clinic. Patient is <u>not</u> assigning any legal cause of action in the Claim above, but only contractual proceeds. Patient also assigns to the Clinic his/her right to enforce the obligation of any insurance company to pay med pay or other contractual proceeds for any treatment Patient receives in exchange for this assignment of first-party insurance benefits, including med-pay benefits. Prior to settlement or other disposition of the Claim, Patient understands and permits Clinic to pursue payment from any insurance company that insures Patient through a contractual right of uninsured/underinsured-motorist coverage and/or medical-payment coverage and/or health insurance coverage and/or any other contractual right between Patient and insurance company, including medical-payments coverage in an automobile liability policy. Patient also assigns, without any right to later revoke, a part of any available medical-payments coverage equal to fees incurred by Patient to Clinic for all treatment and other services rendered by Clinic.**

I have read and agree to the above guarantee to claim funds:_____

(Signature of Patient) *(Date)*

3. **Patient directs the First Party Insurance Company to include the Clinic's name on all first party insurance contractual draft and/or check payments, including med pay payments. Further, Patient directs the First Party Insurance Company, including medical-payments carrier, to send all med pay payments to the Clinic at <u>16705 Square Drive Marysville, Ohio 43040</u>. Further, Patient authorizes and permits First Party Insurance Company, including Patient's applicable med-pay insurance, to disclose to Clinic the terms and amount of insurance proceeds available, including applicable med pay coverage, under the subject first party insurance contractual policy.**

4. This Assignment and Guarantee and related documents, which Patient has signed in connection with it, state the entire agreement and Patient's complete understanding regarding the Clinic's fees. Patient has not relied on any statements by the Clinic or other information before making this Assignment. Patient understands that he/she remains responsible to Clinic for any Clinic fees not paid out of Patient's First Party Insurance Claim(s).

5. Patient understands that it is Patient's responsibility during treatment to remain aware of his/her cumulative account balance for services rendered. Patient has received a schedule of treatment fees for the Clinic; if Patient has not received a schedule of treatment fees prior to signing this Assignment and Guarantee of Payments, Patient agrees to immediately request one in writing.

6. Patient understands that this is an express contract to pay for the services rendered by the Clinic. Patient agrees to pay his/her account balance in full and/or directs its payment from the Claim proceeds. If Patient disputes his/her account balance or treatment rendered, Patient agrees that his/her remedy will be to resolve the dispute with a separate action from the Claim.

<u>NOTICE:</u> PATIENT HEREBY NOTIFIES AND DIRECTS <u>ANY AND ALL FIRST PARTY INSURANCE COMPANIES, THIRD-PARTY ADMINISTRATORS, ATTORNEYS, OTHER PERSONS, AND/OR OTHER ENTITIES WHO HOLD OR LATER MAY HOLD ANY PROCEEDS FROM PATIENT'S CLAIM</u> THAT CLINIC NOW HAS A <u>LAWFUL INTEREST</u> (AS THAT TERM IS USED AND APPLIED IN RULE 1.15(d) OF THE OHIO RULES OF ATTORNEY PROFESSIONAL CONDUCT) IN SAID PROCEEDS BY WAY OF THIS WRITTEN AGREEMENT GUARANTEEING PAYMENT FROM THE SPECIFIC FUNDS DESCRIBED ABOVE, AND PATIENT HEREBY DIRECTS YOU TO PROMPTLY DELIVER AND PAY THE CLINIC THE MONIES COLLECTED FROM THE FIRST-PARTY INSURANCE AND/OR THIRD PARTY SETTLEMENT(S), JUDGMENT(S), AND/OR VERDICT(S), EQUAL TO THE FEES INCURRED BY THE PATIENT FOR CARE AND TREATMENT, UNLESS THE CLINIC EXPRESSLY CONFIRMS PRIOR PAYMENT OF IT IN WRITING.

7. Ohio law governs this Assignment. Jurisdiction shall be in Ohio, and the venue shall lie in the county, which the Clinic is located, unless otherwise required by applicable law. As a result of this Assignment and Guarantee of Payment from the specific funds and/or property referenced above, Rule 1.15 of the Ohio Rules of Professional Conduct applies to any and all funds held by the patient's attorney related to Patient's Claim. If any of the provisions of this Assignment and/or Guarantee of Payment from the specific funds and/or property referenced above are deemed not binding by a court of competent jurisdiction, then it is agreed that the other remaining provisions of this entire agreement shall be construed as legal, valid, and/or enforceable.

8. Patient authorizes the Patient's applicable attorney to issue a letter of protection to the Clinic in order to protect the Clinic's outstanding professional bills that remain unpaid after payments are received from the Patient's First Party Insurance Carrier and/or from any third-party settlement(s), judgment(s), or verdict(s) as additional consideration for the services provided by the Clinic and/or for the Clinic delaying collections of the services owed by the patient.

9. **PATIENT ACKNOWLEDGES AND UNDERSTANDS THAT HE/SHE HAS NOW GIVEN AWAY A PART OF ANY PROCEEDS FROM HIS/HER CLAIM FOR WHICH THE CLINIC NOW HAS A LAWFUL INTEREST. IF PATIENT RECEIVES ANY PROCEEDS FROM HIS/HER CLAIM UNDER THIS ASSIGNMENT, PATIENT AGREES TO IMMEDIATELY DETERMINE IF THE CLINIC HAS BEEN SEPARATELY PAID IN FULL. UNLESS THE CLINIC EXPRESSLY CONFIRMS FULL PAYMENT IN WRITING, PATIENT ACKNOWLEDGES AND UNDERSTANDS THAT ANY USE BY PATIENT OF THESE PROCEEDS CONSTITUTES A TAKING OR CONVERTING MONEY THAT IS THE PROPERTY OF THE CLINIC.**

10. EVEN THOUGH THE CLINIC FIRST REQUESTED THAT PATIENT IS ONLY PERSONALLY GUARANTEEING PAYMENT FROM SPECIFIC FUNDS FROM THE PATIENT'S CLAIM, PATIENT FURTHER AGREES, NOTWITHSTANDING ANY CLAIM PAYMENTS, PATIENT UNEQUIVOCALLY **PERSONALLY GUARANTEES** PAYMENT TO CLINIC REGARDLESS OF THE OUTCOME OF ANY LEGAL ACTION, CLAIM, AND/OR FINAL DETERMINATION. PATIENT INSTRUCTS AND/OR WILL INSTRUCT HIS/HER ATTORNEY AND/OR INSURANCE COMPANY TO RELEASE ANY AND ALL INSURANCE FUNDS TO FULFILL PATIENT THE CLINIC.

_____

Signature of Patient *Date*

IN WITNESS WHEREOF, the parties hereto have caused this Assignment and Guarantee of Payment from the specific funds described above to be executed and effective as of the date first written above.

PATIENT	**Synergy Medical**
Signed:_____	_____
Print Name:_____	By:_____
Signature of Parent/Legal Guardian:	Title:_____
_____	Date:_____

Payment For Treatment and Related Expenses

I have been injured. If my automobile insurance has medical payments coverage, I authorize this Clinic to bill this insurer and I will submit a claim with my insurer for this Clinic's treatment fees. Even if no other person is at fault for my injuries caused by an accident, I agree to sign this Clinic's Assignment and related documents, and will provide any information required by the Clinic. I realize that any money which I receive from my automobile insurer for this Clinic's treatment fees (including under or uninsured motorists coverage proceeds) must be immediately paid over to this Clinic.

If I believe that one or more persons are at fault for causing my injuries in an accident, I agree to sign this Clinic's Assignment and related documents, and will provide any information required by the Clinic.

I understand that my automobile insurer, or an insurer representing someone I believe to be at fault for causing my injuries, or that persons' attorney, or an attorney representing me in a claim for injuries, may request reports, copies of records, may require a physician from this Clinic to provide deposition testimony or testimony in court, or other information. I understand and agree that I am financially responsible to this Clinic to pay the Clinic's costs for these items, and that the Clinic may request payment in advance for some or all of these items, even if this Clinic's Assignment states otherwise.

I understand and agree that all of my records, including X-rays, are permanent records of this Clinic. I authorize the release of any information relevant to my treatment, including information regarding treatment fees, to insurers and attorneys who are involved with my claim and their respective representatives. I understand that the Clinic may require any recipient of such information to comply with applicable federal, state, and/or local law prior to and during receipt of such information.

I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT.
THIS DOCUMENT IS MADE A PART OF THE ASSIGNMENT
I HAVE SIGNED IN FAVOR OF THE CLINIC.
I HAVE RECEIVED A COPY OF THIS DOCUMENT.

_____ _____

(Signature of patient) *(Date)*

_____

(print or type patient name)

_____

(Signature of Parent or Legal Guardian)

IMPORTANT ACKNOWLEDGEMENT BY PATIENT WHO HAS SIGNED A PERSONAL INJURY PROCEEDS ASSIGNMENT

Please read and initial on the line provided beside each statement.

_____ I understand this Assignment, and how it will affect my prospective settlement proceeds. I know that the Clinic is starting treatment in reliance that I understand the Assignment. I received a copy of the Assignment.

_____ I understand that I cannot cancel or terminate the Assignment, and will not permit any attorney for me to attempt to do this.

_____ I understand that this Clinic is entitled to its treatment fees first out of any and all settlement proceeds.

_____ If I believe the prospective settlement from an insurance company will not be enough to cover my damages and this Clinic's treatment fees, I realize that I will owe any balance to this Clinic for my treatment. I can choose to continue treatment, or can consult with my chiropractic physician at this Clinic about decreasing or terminating treatment prior to reaching Maximum Medical Improvement.

_____ I state that I am not currently a debtor in a pending Chapter 7 or Chapter 13 Bankruptcy Proceeding.

_____ I understand that this Assignment and the related documents that I have signed are for the purpose of protecting the Clinic's rights, and that they are not intended or designed to provide legal assistance to or for me.

Alana Grabovich, CNP ● Lindsay West, CNP ● Charita N.Cooper, DC CACCP ● Patrick S. Cooper, DC CCEP

When it comes to your health, chiropractors and medical doctors should be working together for your benefit!

I agree! I give you permission to inform my primary care physician of my condition, treatment and expected/actual response to care at this office.

Patient/Guardian Signature:_____

Name (Please Print):_____

Primary Care Physician:_____

Physician's Address/Phone:_____

_____