THE SPINE CENTER

Jaime DiOrio-Phillips, D.C.
7380 W Sahara Ave # 100
Las Vegas, NV 89117
(702) 252-7246 | spinecenterlv.com

PATIENT INFORMATION

Name: _____ Date: _____

Date of birth: _____ Height: _____ Weight: _____ Dominant: ☐ R ☐ L

Address: _____ City: _____ Zip: _____

Cell phone: _____ Text reminders are okay? ☐ Yes ☐ No

Email address: _____ SSN#:_____

Employer: _____ Occupation: _____

INSURANCE

Are you covered by health insurance? ☐ Yes ☐ No (Please provide a copy of our insurance card)

Your car insurance company: _____ Claim filed? ☐ Yes ☐ No

Name of insured on your car policy: _____ Phone: _____

Adjuster: _____ Policy #: _____ Claim #: _____

Medical payment coverge: ☐ Yes ☐ No

Uninsured motorist coverge: ☐ Yes ☐ No (Please provide a copy of our insurance card)

Other party car insurance company: _____

Phone: _____ Claim #: _____

ATTORNEY INFORMATION

Which law firm represents you? _____

Your lawyer's name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

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HEALTH HISTORY

(Check all that apply)

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Aneurysm
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Lumps
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ COVID
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ High Blood pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraines
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ STD
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Ulcers
- ☐ Whooping Cough
- ☐ Other
- _____
- _____
- _____
- _____

Name of your personal M.D. _____ Phone: _____

Are you pregnant? ☐ Yes ☐ No Due date: _____

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Work activities: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

PRIOR INJURIES

Falls: ☐ Yes ☐ No When: _____
Describe: _____

Head Injuries: ☐ Yes ☐ No When: _____
Describe: _____

Broken Bones: ☐ Yes ☐ No When: _____
Describe: _____

Dislocations: ☐ Yes ☐ No When: _____
Describe: _____

Auto Collisions: ☐ Yes ☐ No When: _____
Describe: _____

Work Injuries: ☐ Yes ☐ No When: _____
Describe: _____

Prior Neck/Back Surgeries: ☐ Yes ☐ No When: _____
Describe: _____

Other Surgeries: ☐ Yes ☐ No When: _____
Describe: _____

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MOTOR VEHICLE COLLISION INFORMATION

Patient name: _____
Date of collision: _____

Your vehicle:

Make and Model: _____
Time of accident: ☐ Daylight ☐ Dark
Road conditions: ☐ Dry ☐ Damp ☐ Rain ☐ Snow/Ice
Were you: ☐ Stopped ☐ Slowing ☐ Cruising ☐ Accelerating
☐ Making right turn ☐ Making left turn

Other vehicle:

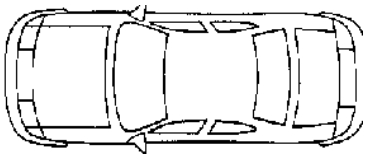
Make and Model of car that hit you: _____
Speed at impact: ☐ 0-5 mph ☐ 5-10 mph ☐ 10-15 mph ☐ 25 mph+

How did the collision occur?

Please describe what happened:

_____
_____
_____

Where was your car hit: Please mark diagram below:

Front  Rear

Was there damage to your vehicle: ☐ Yes ☐ No
Other vehicle: ☐ Yes ☐ No
Please describe damage to your vehicle:
☐ Paint scuffs and scratches ☐ Minor damage ☐ Major damage, but drivable
☐ Major damage, not drivable ☐ Car is a total loss

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At the time of impact, were you:

☐ **Driver** ☐ **Passenger** ☐ **Rear Passenger -** passenger side / driver's side / middle

Seat belted: ☐ Yes ☐ No

Brakes applied: ☐ Yes ☐ No

Air bags deployed: ☐ Yes ☐ No

Was your seat broken: ☐ Yes ☐ No

Did you see or hear the car approaching: ☐ Yes ☐ No

Did you brace for impact: ☐ Yes ☐ No

Were you gripping the steering wheel: ☐ Yes ☐ No

Your head position at time of impact:

☐ Straight ☐ Rotated Right ☐ Rotated Left
☐ Looking in rear view mirror ☐ Looking in side view mirror

Head motion upon impact: ☐ Backward/Forward ☐ Left/Right ☐ Unsure

Your body position at time of impact:

☐ Straight ☐ Rotated Right ☐ Rotated Left
☐ Looking in rear view mirror ☐ Looking in side view mirror

Body motion upon impact: ☐ Backward/Forward ☐ Left/Right ☐ Unsure

Did any part of your body impact anything inside the vehicle:

☐ Head	☐ Upper Back	☐ Right Hip	☐ Left Knee
☐ Chest	☐ Lower Back	☐ Right Leg	☐ Left Foot/Ankle
☐ Left Shoulder	☐ Right Shoulder	☐ Right Knee	☐ Other
☐ Left Arm	☐ Right Arm	☐ Right Foot/Ankle	_____
☐ Left Elbow	☐ Right Elbow	☐ Left Hip	_____
☐ Left Hand/Wrist	☐ Right Hand/Wrist	☐ Left Leg	_____

What did you hit: ☐ Dashboard ☐ Windshield ☐ Side window ☐ Door ☐ Console

Symptoms immediately after the accident:

☐ Dizzy/Dazed	☐ Upset	☐ Weak	☐ Nervous	☐ Headache
☐ Disoriented	☐ Nausea	☐ Vomiting	☐ I was knocked unconscious	

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Pain: Indicate if you experienced any pain **immediately following** the accident. Check all that apply:

☐ Head	☐ Left Shoulder	☐ Right Elbow	☐ Left Hip
☐ Face	☐ Left Arm	☐ Right Hand/Wrist	☐ Left Leg
☐ Neck	☐ Left Elbow	☐ Right Hip	☐ Left Knee
☐ Upper Back	☐ Left Hand/Wrist	☐ Right Leg	☐ Left Foot/Ankle
☐ Mid Back	☐ Right Shoulder	☐ Right Knee	☐ Chest
☐ Lower Back	☐ Right Arm	☐ Right Foot/Ankle	☐ Pelvis

Numbness: Indicate if you experienced any numbness or tingling **immediately following** the accident.

☐ Left Arm	☐ Right Arm	☐ Left Leg	☐ Right Leg
☐ Left Hand	☐ Right Hand	☐ Left Foot	☐ Right Foot

Did the **police or paramedics** arrive at the scene? ☐ Yes ☐ No

☐ Police Only ☐ Paramedics

MEDICAL CARE SINCE COLLISION

Were you transported by ambulance: ☐ Yes ☐ No Hospital: _____

Did you seek medical care on your own: ☐ Yes ☐ No

If yes, where: ☐ ER ☐ Urgent Care ☐ My Family Doctor ☐ Chiropractor

When: ☐ Immediately after accident ☐ Later that day Date: _____

Are you taking any medication: ☐ Yes ☐ No

If yes, name: _____

Any special tests: ☐ X-rays ☐ MRI ☐ CT scan

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SYMPTOMS

Patient _____ **Date** _____ **Date of Injury** _____

Please fill in all symptoms you currently have that you did not have before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" sound with neck movements
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Low Back pain
- ☐ Shoulder Pain ☐ Left ☐ Right
- ☐ Upper Arm Pain ☐ Left ☐ Right
- ☐ Elbow Pain ☐ Left ☐ Right
- ☐ Forearm Pain ☐ Left ☐ Right
- ☐ Wrist Pain ☐ Left ☐ Right
- ☐ Hand Pain ☐ Left ☐ Right
- ☐ Hip Pain ☐ Left ☐ Right
- ☐ Upper Leg Pain ☐ Left ☐ Right
- ☐ Knee Pain ☐ Left ☐ Right
- ☐ Lower Leg Pain ☐ Left ☐ Right
- ☐ Ankle Pain ☐ Left ☐ Right
- ☐ Foot Pain ☐ Left ☐ Right
- ☐ Jaw Pain
- ☐ Clicking in Jaw
- ☐ Pain when chewing
- ☐ Face Pain
- ☐ Chest Pain
- ☐ Stomach Pain
- ☐ Bruise to _____
- ☐ Scrape/Cut to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☐ Numb/Tingling Arm/Hand ☐ Left ☐ Right
- ☐ Numb/Tingling Leg/Foot ☐ Left ☐ Right
- ☐ Weakness Arm/Hand ☐ Left ☐ Right
- ☐ Weakness Leg/Foot ☐ Left ☐ Right

Symptoms Associated with Injuries

- ☐ Stiffness or limited movement in joint(s)
- ☐ Headaches
- ☐ Muscle spasms/sore muscles
- ☐ Dizziness, lightheaded, woozy feeling
- ☐ Visual disturbances or visionchange
- ☐ Sleep changes/disruption of patterns
- ☐ Pain radiates from one place to another
- ☐ Anxiety or nervous when driving
- ☐ Irregular Heartbeat or uneven pulse
- ☐ Feeling depressed about things
- ☐ I am taking the following medications

_____

Brain/Neuropsych/MTBI/PTSD Symptoms

- ☐ I prefer being alone now(notsocializing)
- ☐ I am sleepy, tired during day or doze off easily
- ☐ Upset stomach, nausea, heartburn or vomiting
- ☐ Difficulty concentrating, mind wanders easily
- ☐ I get overwhelmed easily
- ☐ Mood swings, happy one moment then sad
- ☐ Agitation (can't sit still, need to move around)
- ☐ Sadness, tearful episodes, crying easily
- ☐ Blurry vision, had to get or change glasses
- ☐ Asking people to repeat things or hearing problem
- ☐ I make wrong turns driving or can't remember time
- ☐ I get confused easily or cannot multi-task anymore
- ☐ I have difficulty finding some words when talking
- ☐ Bright lights bother me
- ☐ I cannot pay attention as long as before
- ☐ I am eating more or less than normal
- ☐ Room spins, lightheaded or woozy feeling
- ☐ Balance problems
- ☐ I feel like my head is "Foggy"
- ☐ I have forgotten computer passwords or ATM PIN
- ☐ I have to re-read things to understand what I read
- ☐ My thinking is slowed down
- ☐ Difficulty with adding/subtracting numbers
- ☐ Fear I will never be the same again
- ☐ Difficulty learning new things
- ☐ Difficulty understanding what people say to me
- ☐ Difficulty remembering or memory problems
- ☐ Cannot take on any more responsibility
- ☐ I can't make decisions as quickly as before
- ☐ Loss of libido or lack of sexual desire
- ☐ I do not feel as confident of my abilities
- ☐ I get panic attacks, fast heartbeat, nervous
- ☐ I am more irritable than usual
- ☐ Some food or drink tastes "Funny" to me now
- ☐ I get frustrated very easily
- ☐ Difficulty planning my life or organizing my work
- ☐ Flashbacks or frightening thoughts about accident
- ☐ I have had bad dreams about the accident
- ☐ I avoid places & objects that remind me about it
- ☐ I feel emotionally numb-no interest in my hobbies
- ☐ I'm feeling strong guilt, worry or depression
- ☐ I am having trouble remembering the accident
- ☐ I am easily startled since the accident-"jumpy"
- ☐ I feel tense or "on edge" most of the time
- ☐ I am having difficulty sleeping
- ☐ I get angry easily or even yell at people now

Patient Signature _____ **Dr. Signature** _____

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Patient Name: _____

DOB: _____ **Age:** _____

Date: _____ **ID/MR #** _____

A. INJURY CHARACTERISTICS: Date/Time of Injury _____ **Reporter:** ☐ Patient ☐ Parent ☐ Spouse ☐ Other_____

1. Injury Description _____

_____

1a. Is there evidence of a forcible blow to the head (direct or indirect)? ☐ Yes ☐ No ☐ Unknown

1b. Is there evidence of intracranial injury or skull fracture? ☐ Yes ☐ No ☐ Unknown

1c. Location of Impact: ☐ Frontal ☐ Lft Temporal ☐ Rt Temporal ☐ Lft Parietal ☐ Rt Parietal ☐ Occipital ☐ Neck ☐ Indirect Force

2. Cause: ☐ MVC ☐ Pedestrian-MVC ☐ Fall ☐ Assault ☐ Sports (specify)_____ Other_____

3. Amnesia Before (Retrograde): Are there any events just BEFORE the injury that you/ person has no memory of (even brief)? ☐ Yes ☐ No Duration

4. Amnesia After (Anterograde): Are there any events just AFTER the injury that you/ person has no memory of (even brief)? ☐ Yes ☐ No Duration

5. Loss of Consciousness: Did you/ person lose consciousness? ☐ Yes ☐ No Duration

6. EARLY SIGNS: ☐ Appears dazed or stunned ☐ Is confused about events ☐ Answers questions slowly ☐ Repeats Questions ☐ Forgetful (recent info)

7. Seizures: Were seizures observed? ☐ Yes ☐ No Detail _____

B. SYMPTOM CHECK LIST* Since the injury, has the person experienced any of these symptoms any more than usual today or in the past day? Indicate presence of each symptom (0=No, 1=Yes).

PHYSICAL (10)	0	1	COGNITIVE (4)	0	1	SLEEP (4)	0	1	N/A
Headache	☐	☐	Feeling mentally foggy	☐	☐	Drowsiness	☐	☐	☐
Nausea	☐	☐	Feeling slowed down	☐	☐	Sleeping less than usual	☐	☐	☐
Vomiting	☐	☐	Difficulty concentrating	☐	☐	Sleeping more than usual	☐	☐	☐
Balance problems	☐	☐	Difficulty remembering	☐	☐	Trouble falling asleep	☐	☐	☐
Dizziness	☐	☐	**COGNITIVE Total (0-4)**	_____		**SLEEP Total (0-4)**	_____		
Visual problems	☐	☐	**EMOTIONAL (4)**						
Fatigue	☐	☐	Irritability	☐	☐				
Sensitivity to light	☐	☐	Sadness	☐	☐				
Sensitivity to noise	☐	☐	More emotional	☐	☐				
Numbness/Tingling	☐	☐	Nervousness	☐	☐				
PHYSICAL Total (0-10) _____			**EMOTIONAL Total (0-4)**	_____					
(Add Physical, Cognitive, Emotion, Sleep totals) Total Symptom Score (0-22)	_____								

Exertion: Do these symptoms worsen with:
Physical Activity ☐ Yes ☐ No ☐ N/A
Cognitive Activity ☐ Yes ☐ No ☐ N/A

Overall Rating: How different is the person acting compared to his/her usual self?
Normal 0 1 2 3 4 5 6 Very Different

C. RISK FACTORS for Protracted Recovery (check all that apply)

Concussion History? Y ☐ N ☐	**Headache History?** Y ☐ N ☐	**Developmental History**	**Psychiatric History**
Previous # 1 2 3 4 5 6+	☐ Prior treatment for headache	☐ Learning disabilities	☐ Anxiety
Longest symptom duration Days___ Weeks___ Months___ Years___	☐ History of migraine headache ☐ Personal ☐ Family _____	☐ Attention-Deficit/ Hyperactivity Disorder	☐ Depression ☐ Sleep disorder
If multiple concussions, less force caused reinjury? Yes ☐ No ☐	_____	☐ Other developmental disorder_____	☐ Other psychiatric disorder _____

List other comorbid medical disorders or medication usage (e.g., hypothyroid, seizures) _____

_____

D. RED FLAGS for acute emergency management: Refer to the emergency department with sudden onset of any of the following:

- Headaches that worsen
- Seizures
- Focal neurologic signs
- Looks very drowsy/ can't be awakened
- Repeated vomiting
- Slurred speech
- Can't recognize people or places
- Increasing confusion or irritability
- Weakness or numbness in arms/legs
- Neck pain
- Unusual behavioral change
- Change in state of consciousness

E. Diagnosis (ICD): ☐ Concussion w/o LOC 850.0 ☐ Concussion w/ LOC 850.1 ☐ Concussion (Unspecified) 850.9
☐ Other (854) _____ ☐ No diagnosis

F. Follow-Up Action Plan: Complete ACE Care Plan and provide copy to patient/family.

☐ **No Follow-Up Needed** ☐ **Physician/Clinician Office Monitoring:** Date of next follow-up _____

☐ **Referral:** ☐ Neuropsychological Testing
☐ Physician: ☐ Neurosurgery ☐ Neurology ☐ Sports Medicine ☐ Physiatrist ☐ Psychiatrist ☐ Other
☐ Emergency Department

ACE Completed by: _____

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OFFICE POLICIES

The Spine Center has made a copy of the Notice of Privacy Practices available to me at my request. I understand I have right to review the Privacy Practices prior to signing this document. This Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in treatment, payment of bills or in the performance of health care operations of Chiropractic and wellness.

The Spine Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy of these forms by calling the office and requesting a revised copy be sent to me in the mail or ask for one at the time of my next appointment. I have the right to revoke this consent, in writing, except to the extent that The Spine Center has taken action in the reliance on this consent.

Initial _____

I understand that The Spine Center may leave a massage on my answering machine and or with a third party regarding limited protected health information, pending appointments, and the time or place of my scheduled appointments, or other healthcare related communications.

I give the following persons access to the use or disclosure of my health information:

_____

I give the spine center permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor/technician privately at any time I may ask for a private room.

Initial _____

The Spine Center will maintain your medical records for five years after your last date of service. Once five years have passed your medical record will be destroyed in a manner currently meeting federal regulations.

Initial _____

In an effort to avoid missed appointments, you will receive an automated reminder of your appointment the day prior to your appointment. Any appointment canceled or missed with less than 24 hours notice will be billed for a missed appointment. The missed appointment fee of $25.00 must be paid to/or at the same time of your next appointment. This amount is not eligible for insurance billing and is the responsibility of the patient.

Initial _____

*MINOR CONSENT

(Minor is anyone under 18 years old at the time of care)

I am the parent, guardian, or personal representative of _____ (child's name) and there are no court orders now in effect that prohibit me from singing this consent. I do hereby request and authorize The Spine Center and the staff to perform necessary services for the child named above, including but not limited to x-rays and treatments which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. I agree to hold The Spine Center free and harmless from any claim and/or suits from damages or complications which may result from such treatment.

Print Child's Name_____

Parent or Guardian's Signature_____ **Date** _____

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OFFICE POLICIES

Our office is pleased to accept your health insurance as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you whenever we can. However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance. If you carrier has a "network" of providers, it is your responsibility to make sure we are in network. Your insurance should pay within 30 days. If your insurance has not paid within 60 days you must pay the balance due and be reimbursed by your insurance company when and if it pays. There will be an interset charge of 7% per annum (year) charged on all unpaid balances over 60 days. We will bill your insurance weekly as long as you are receiving chiropractic care with our office. Once we have received a check from your insurance company you will be billed for any differences in payment. Cash patients will at the time of service. Our office does not not guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied you are responsible for the full amount of your bill. Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. Auto injury policies will be billed as the primary medical coverage if you have been in an auto accident. Once your policy is exhausted to you may either go thru an attorney or pay for your following treatment as you go. if you are represented by an attorney, you must sign a doctor's lien that will be forwarded to your attorney. Please be advised that you are responsible for your bill regardless of the circumstances. There will be a $25.00 charge on all returned check fee. Patient is responsible for all charges and commissions that may be assessed from a collation agency due to unpaid balances. Patient further agrees to pay interest rate of 2% per month, 24% per year from the first date the account becomes delinquent of 60 days.

Initial _____

I hereby request and consent to the performance of chiropractic care by The Spine Center and their staff. I have had the opportunity to discuss with the doctor and his staff the purpose and benefits of chiropractic treatment. Through chiropractic adjustments and treatments are usually beneficial an seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include but are not limited to: fractures, disc injuries, strokes, bruising, dislocations, and sprains. I understand that I may be receiving the following treatment: HOT/COLD THERAPY, MINERAL ICE(OR LIKE SUBSTANCE), ULTRASOUND, EMS, MANUEL/FLEXION TRACTION, TRIGGER POINT THERAPY, VIBRATORY/DEEP TISSUE MASSAGE, TENS, THERAPEUTIC EXERCISES, LIFESTYLE AN DERGONOMIC INSTRUCTIONS, SPINAL ADJUSTMENT, JOINT MOBILIZATION TECHNIQUES, POSTURAL CORRECTION, NUTRITIONAL SUPPLEMENTATION, DIETARY RECOMMENDATIONS, X- RAYS, MECHANICAL TRACTION, AND LASER THERAPY. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that i have requested and authorized. I have had the opportunity to read this form and ask questions. My question have been answered to my satisfaction. I consent to the proposed treatment.

Initial _____

I certify I have read and understand all the information provided by The Spine Center. I certify the information provided by me is true and correct to the best of my knowledge.

Print Name _____

Signature of Patient or Legal Guardian of Minor _____ **Date** _____

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MEDICAL LIEN

I, the undersigned patient (or Legal guardian of minor), grant to The Spine Center (hereafter "medical facility") a lien upon the recovery of any and all proceeds from any source obtained through settlement, judgment, for any medical services rendered to me or the minor, for treatment of injuries sustained or the exacerbation of any medical condition(s) (hereafter "treatment") that I or the minor have indicated, believe or did in fact arise out of an incident that occurred on or about the date set forth below (hereafter "incident"). I further authorize the medical facility to furnish my attorney with a full report of the examinations, diagnoses, treatments, prognoses, as well as billings for treatment from this incident. I hereby notify and authorize you, my attorney, to pay directly to the medical facility to the unpaid amount due for services rendered.

I understand that apart from this lien, I am directly and fully responsible to the medical facility for all medical bills submitted by it for services rendered, even for bills incurred for the minor (as indicated below) who may reach the age of majority, for which I may be required to make a lump sum or periodic payments, at the election of the medical facility. This lien is made solely for said medical facility's additional protection, and in consideration of its awaiting payment. Except as otherwise provided below, I intend for this lien to continue until all charges have been satisfied. I agree that the statute of Limitations of my obligation to pay is tolled and does not begin to run while the medical facility is awaiting payment by way of this lien. I further understand that the payment of services is not contingent upon any settlement, judgment, or verdict that the minor or I may eventually recover.

Except as provided below I agree never to rescind this lien, and I do not grant any attorney that may represent the minor or me the right to rescind it. However, if my first attorney does not promptly sign, acknowledge and return this lien to the medical facility within 10 (ten) days of receipt of this lien, or if the first attorney for any reason (e.g., withdraws, resigns, is released by me, or substituted by another attorney) no longer represents me or the minor child for injuries arising from this incident, then the Irrevocable Assignment of Proceeds that I have signed with this medical facility supersedes this lien and takes immediate effect when the modification occurs. I agree to promptly notify medical facility of any change of my address or change or addition of attorney(s).

To my attorney: Please acknowledge this medical lien by signing below and returning it to the medical facility's office.

Date of Incident: _____ **Print Name** _____

Date: _____ _____

Signature of Patient or Legal Guardian of Minor

I, the undersigned attorney, state that I am the attorney of record for the this patient; I acknowledge that I am in receipt of this lien; and I agree to observe its terms by withholding the sums from any settlement, judgment or verdict that are owed to the medical facility, for their compensation or benefit. I also agree to promptly (1) notify the medical facility if I discontinue representation of this patient/client, and to (2) provide any subsequent attorney of the patient for this incident a copy of this lien, along with all of the medical facility's records and billings in my or my law firm's possession. In the event this lien is litigated, the prevailing party will be awarded attorney's fees and costs.

Attorney Name _____ **Attorney Signature** _____

Attorney Phone Number _____ **Attorney Address** _____

Please sign, date and return one copy to medical facility's office within 10 days after receipt. Also keep one for your records.

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Patient Name: _____

DOB _____ SSN (last four): _____ DL State and No. _____

Insurance Company: _____

Claim No(s).: _____ Date of Incident _____

ASSIGNMENT OF PROCEEDS

I, the undersigned Patient (or as legal guardian of the minor Patient), (also referred to below as "Patient") of The Spine Center ("Medical Provider"), without assigning any cause of action to this Medical Provider, unconditionally and irrevocably assign the proceeds of any settlement, judgment or verdict, up to the full amount of the unpaid medical services rendered by Medical Provider to Patient relating to the Date of Incident. I authorize these proceeds to be paid directly to the Medical Provider's attorney, the law firm of CRAIG K. PERRY & ASSOCIATES, located at 3450 W. Cheyenne Ave., Suite 400, North Las Vegas, Nevada 89032. I understand and agree that said law firm is authorized to contact the Insurance Company and me on behalf of the Medical Provider, to obtain information concerning the facts and status of Patient's case (e.g., completion of care, settlement status, insurance company information, etc.). Payment to a Patient, if a minor, shall be made by way of a minor's compromise, as required by law. The total amount owed, when it becomes a sum certain, will be provided to Insurance Company from one or more of the following sources: Patient, Medical Provider or attorney.

Upon execution of this agreement, I authorize and direct the Medical Provider or its attorney, to furnish the Insurance Company with all reports, findings, interpretations, impressions, treatments, diagnoses, and/or diagnostic studies that Medical Provider may perform or order for Patient received relating to the Date of Incident.

I fully understand that this assignment of proceeds is contingent upon the outcome of my claim or case, and if there is no recovery from the Insurance Company, or if less than the full amount is assignable to the Medical Provider then this assignment will not satisfy my obligation to pay the Medical Provider in full for services rendered. I fully understand that I remain directly and fully responsible to Medical Provider for all unpaid balances of medical bills associated with the services rendered to Patient, whether or not there is any financial recovery from the Insurance Company or other source. I agree that the statute of limitations for the Medical Provider to take action for the collection of any unpaid balance commences (1) six years after it is determined that this assignment of proceeds will not satisfy the amount owed or (2) six years after day of Patient's or Patient's parent/legal guardian's last payment towards the amount owed, whichever is later. The balance owed will accrue interest at the rate of 18 percent per annum from the date of the statute of limitations begins to run. Collection fees shall be the responsibility of the Patient.

If Patient does not initially retain an attorney, but later decides to retain one, then I agree to promptly (1) furnish Medical Provider with the attorney's contact information, and (2) notify Patient's attorney concerning existence of this Assignment of Proceeds. In the event that the Patient is paid by way of settlement, judgment or verdict, Patient agrees not to accept any money from either the Insurance Company or Patient's attorney from any of the proceeds that have been assigned to the Medical Provider. Medical Provider shall be paid in full out of the first proceeds of any money paid by Insurance Company or Patient's attorney.

Date: _____ **Print Name of Patient:** _____

_____

Signature of Patient or Legal Guardian of Minor Patient

Medical Provider acknowledges that the law firm of **CRAIG K. PERRY & ASSOCIATES** is the Medical Provider's attorney and grants the law firm limited power of attorney to enforce this Assignment of Proceeds, and to receive, endorse and deposit into its trust account any funds received.

Date: _____ **Authorized Representation of Medical Provider:** _____

THE SPINE CENTER

Jaime DiOrio-Phillips, D.C.
7380 W Sahara Ave # 100
Las Vegas, NV 89117
(702) 252-7246 | spinecenterlv.com

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Patient Name (printed) _____ **DOB** _____

I authorize any physician, dentist, chiropractor, hospital, pharmacist, medical professional,health care provider, insurance company, worker compensation provider, or employerto disclose allinformation about past and present medical care, history, physical condition, and injuriesincluding itemized statementsto The Spine Center.

I agree that this authorization will remain valid up to one year of the signed date, unless revokedby delivery of written notice to The Spine Center.

I hereby designate the above named company and its claims personnel as my designatedrepresentative, pursuant to NCGS Sec 90-411 for the purpose of obtaining copies of my medical records,the production of which is authorized herein. It is specifically my intent that this designation provide to the company named above the benefit of the maximum fees established in NCGS Sec 90.41.

I understand that I (or my representative) am entitled to receive a copy of this authorization. Aphotocopy of this form may be accepted asthe original.

I (or the patient named above) have received health care treatment from the following providers:

Provider Name _____ **Phone** _____

Provider Name _____ **Phone** _____

Insurance Company _____ **Phone** _____

Requesting:

☐ Entire File ☐ Related to MVA on _____ ☐ Diagnostic Tests

☐ Progress Notes ☐ Auto Insurance Declaration Page

Please send records to:

The Spine Center
7380 W Sahara Ave #100
Las Vegas, NV 89117
Phone # (702) 252-7246
Fax # (702) 251-9650

_____ _____

Signature of Patient or Person Authorized to Act on Patient's Behalf **Date**

THE SPINE CENTER

Jaime DiOrio-Phillips, D.C.
7380 W Sahara Ave # 100
Las Vegas, NV 89117
(702) 252-7246 | spinecenterlv.com

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Patient Name (printed) _____

DOB _____ **Date of Injury:** _____

I authorize any physician, dentist, chiropractor, hospital, pharmacist, medical, professional, health care provider, Insurance company, worker, compensation provider or employer to disclose all information about past and present medical care, history, physical condition, and injuries including itemized statements to Complete Injury Mangemnent for the purpose of review and evaluation in connection with a legal claim.

I agree this authorization will remain valid until the conclusion of my claim. I understand I have the right to revoke this authorization at any time and must do so in writing.

I understand I am entitled to a copy of this authorization. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand signing this authorization may not condition treatment, payment, enrollment or eligibility for benefits.

_____ _____

Name of Healthcare Provider/Physician/Facility **Phone**

Please send records to:

Complete Injury Management
7380 West Sahara Avenue, Suite 110
Las Vegas, NV 89117
Phone # (702) 227-4878
Fax # (702) 272-2013

_____ _____ _____

Signature of Patient or Legal Representative **Relationship to Patient** **Date**

THE SPINE CENTER

Jaime DiOrio-Phillips, D.C.
7380 W Sahara Ave # 100
Las Vegas, NV 89117
(702) 252-7246 | spinecenterlv.com

HEALTH INSURANCE WAIVER

I hereby direct you, as my medical provider, not to bill or utilize my personal health insurance for any of the treatment rendered by you and your office for injuries sustained in the incident for which I am now seeking treatment.

I believe, and have told you as my provider, that the incident was not my fault. I do not wish to be penalized in any manner for someone else's wrongdoing. My health insurance rights may be adversely affected, such as limiting my total number of office visits to a yearly maximum and if I use them for the injuries from this incident, I will lose that insurance entitlement for future office visits. Or, I do not wish to be responsible for any co-pays, deductibles or non-covered services for these same reasons. I desire, and choose, to preserve my health insurance visits and co-pays or deductibles for any similar future medical care where I can then choose to use my healthcare coverage.

Consequently, while you are allowed to bill my auto med-pay policy if med-pay is available, you are instructed not to bill my healthcare insurance. This directive is effective immediately and covers me from the date of my first visit with your office related to this incident, and continues until the conclusion of my treatment for these injuries. I make this directive voluntarily, of my own preference and without any coercion or duress of any kind by you or your staff members.

I understand that by choosing this option, I agree that I shall not rescind this directive once given unless that rescission is given in writing by me within fourteen (14) calendar days of signing this directive. Otherwise, you, as my medical provider, would likely be past the time deadline for the submission of my bills for payment to my health insurer, or I would be creating other problems for the payment of your services under my healthcare plan. I will be solely responsible to notify any attorney I now or later retain of this directive. In the event of any litigation arising under this directive, the prevailing party shall be entitled to recover their reasonable attorney's fees and costs. Venue for any litigation arising out of this incident shall be where the medical services were provided.

Print Patient Name _____ **Date** _____

Patient Signature _____