Wilmington Back & Spine
Dr. Stephen Jensen

299 Main Street
Wilmington, MA 01887
Phone: (978) 988-9588

Personal Information

First _____ M _____ Last _____ Nickname _____ Date _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Gender M/F Marital Status _____ Spouse _____

Date of Birth _____ Emai Address: _____

Height: _____ Weight _____ Employed? Y N Employer Name: _____

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

Children? Y N If yes, number of children? _____ Ages of children: _____

Names of children: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

How did you hear about Wilmington Family Chiropractic? _____

Health Insurance Information

Do you have insurance coverage? ❑ Yes ❑ No

Who Is Responsible for payment/co-payment? ❑ Self ❑ Spouse ❑ Parent ❑ other _____

Insurance Carrier _____ Policy Number _____ Copay _____

Name of Insured, if not self _____ Birthdate of Insured _____ SS# _____

Insured's Employer _____ Address _____

Are you covered by any other insurance? ❑ Yes ❑ No

Insurance Carrier _____ Policy Number _____ Copayment _____

Auto Accident Insurance

Auto Insurance Carrier _____ Policy Number _____

Address _____ City _____ State _____ Zip _____

Insurance Contact _____ Insurance Co. Phone # _____

Date of Accident _____ _____

Name of Insured _____ (whose car was it?)

Patient Relationship to the insured?? ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Reason for the Appointment

Describe your condition(s)/symptoms/pain _____ Date the condition occurred? _____

On a Scale of 1 - 10 with 10 being the worst, circle the pain you currently have:

1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
Neck Pain	Mid Back Pain	Low Back Pain	Headaches	Shoulder Pai

1 2 3 4 5 6 7 8 9 10 (describe other pain and location) _____
Other Pain _____

Attorney Information

Attorney Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Automobile Accident

DESCRIBE THE VEHICLE

Patient's Vehicle Type:
- ❑ Bus ❑ Van ❑ Sport-utility
- ❑ Sports car ❑ Truck
- ❑ Coupe ❑ Station Wagon
- ❑ Sedan ❑ Pick-up truck

Vehicle Size:
- ❑ Compact ❑ Mini
- ❑ Full-Size ❑ Sub-compact
- ❑ Light ❑ Semi
- ❑ Mid-Size

Position in vehicle:
- ❑ Driver ❑ Rear left passenger
- ❑ Front mid passenger ❑ Rear mid passenger
- ❑ Front right passenger ❑ Rear right passenger

DESCRIBE THE ACCIDENT

Action of patient vehicle:
- ❑ Crossing intersection
- ❑ Stopped at intersection
- ❑ Stopped for pedestrian
- ❑ Stopped in traffic
- ❑ Turning right
- ❑ Turning left
- ❑ Traveling speed limit
- ❑ Faster than speed limit
- ❑ Slower than speed limit

Patient's Vehicle was hit:
- ❑ Head-on
- ❑ On the left front
- ❑ On the right front
- ❑ On the left rear
- ❑ On the right rear
- ❑ Was rear-ended
- ❑ Sideswiped on left
- ❑ Sideswiped on right

Patient's Vehicle hit:
- ❑ Other vehicle head-on
- ❑ Left front of other veh.
- ❑ Left rear of other veh.
- ❑ Rt rear of other veh.
- ❑ Rt front of other veh.
- ❑ Rear-ended other veh.
- ❑ Sideswiped other veh on left
- ❑ Sideswiped other veh on right

Damage:
- ❑ Complete
- ❑ Extensive
- ❑ Minimal
- ❑ Moderate

Damage to other Vehicle:
- ❑ Complete
- ❑ Extensive
- ❑ Minimal
- ❑ Moderate

Time of Day
- ❑ Dawn
- ❑ Daylight
- ❑ Dusk
- ❑ Night

Visibility
- ❑ Fair
- ❑ Poor
- ❑ Good

Patient's Vehicle was hit by:
- ❑ A compact car ❑ A pick-up truck
- ❑ A full-sized car ❑ A sport-utility veh.
- ❑ A mid-sized car ❑ A full-sized van
- ❑ A subcompact car ❑ A mini-van
- ❑ A semi-trailer ❑ None of the above
- ❑ A light truck ❑

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- ❑ A compact car ❑ A pick-up truck
- ❑ A full-sized car ❑ A sport-utility veh.
- ❑ A mid-sized car ❑ A full-sized van
- ❑ A subcompact car ❑ A mini-van
- ❑ A semi-trailer ❑ None of the above
- ❑ A light truck

Weather Conditions:
- ❑ Clear ❑ Rainy
- ❑ Cloudy ❑ Snowing
- ❑ Drizzling ❑ Storming
- ❑ Foggy ❑ Sunny

Road Conditions:
- ❑ Dry
- ❑ Damp
- ❑ Wet
- ❑ Iced over
- ❑ Dry with icy patches
- ❑ Snowed over

DESCRIBE MOMENT OF IMPACT

Body Position at impact:
- ❑ Leaning forward
- ❑ Slouched down in seat
- ❑ Straight
- ❑ Turned left
- ❑ Turned right

Direction Body was thrown:
- ❑ backward then forward ❑ about the vehicle
- ❑ forward then backward ❑ outside the vehicle
- ❑ to the left ❑ under the vehicle
- ❑ to the right

Head Position at impact:
- ❑ Straight
- ❑ Tilted forward
- ❑ Turned left
- ❑ Turned right

Direction head thrown:
- ❑ backward then forward
- ❑ forward then backward
- ❑ side to side

Type of Passive Restraint:
- ❑ Lap belt
- ❑ Shoulder belt
- ❑ Shoulder-lap belt

Did airbag deploy?
- ❑ Yes
- ❑ No

Position of Headrests:
- ❑ In the high position ❑ In the middle position
- ❑ In the low position ❑ Not installed

Did you brace for impact?
- ❑ Yes
- ❑ No

Post-Injury

WHAT HAPPENED IMMEDIATELY AFTER THE ACCIDENT?

Initial reaction (mark all that apply)
- ❑ Confused
- ❑ Dazed
- ❑ Distressed
- ❑ Dizzy
- ❑ Frightened
- ❑ Light-headed
- ❑ Nervous
- ❑ Shaken
- ❑ Upset
- ❑ Weak

After the accident, in which body areas did you experience pain? (mark all that apply)
- ❑ Head ❑ Neck ❑ Left shoulder ❑ Right shoulder ❑ Left arm ❑ Right arm ❑ Left elbow ❑ Right elbow ❑ Left forearm ❑ Right forearm
- ❑ Left wrist ❑ Right wrist ❑ Left hand ❑ Right hand ❑ Chest ❑ Rib cage ❑ Upper back ❑ Mid back ❑ Abdomen ❑ Lower back
- ❑ Pelvis ❑ Left buttock ❑ Right buttock ❑ Left leg ❑ Right leg ❑ Left hip ❑ Right hip ❑ Left thigh ❑ Right thigh ❑ Left knee
- ❑ Right knee ❑ Left shin ❑ Right shin ❑ Left ankle ❑ Right ankle ❑ Left foot ❑ Right foot

Did you lose Conciousness?
- ❑ Yes
- ❑ No
- ❑ Unsure

Destination after injury (choose one)
- ❑ Work ❑ Hospital
- ❑ Home ❑ Clinic
- ❑ School ❑ Doctor

Any emergency care?
- ❑ Bandages
- ❑ Bracing
- ❑ CPR
- ❑ Neck Collar
- ❑ Splinting

Who drove you?
- ❑ Self
- ❑ Friend
- ❑ Ambulance
- ❑ Family member

Please indicate any lacerations (cuts) resulting from the accident (mark all that apply)
- ❑ Head ❑ Neck ❑ Left shoulder ❑ Right shoulder ❑ Left arm
- ❑ Right arm ❑ left elbow ❑ right elbow ❑ Left forearm ❑ Right forearm
- ❑ Left wrist ❑ Right wrist ❑ Left hand ❑ Right hand ❑ Chest
- ❑ Rib cage ❑ Upper back ❑ Mid back ❑ Abdomen ❑ Lower back
- ❑ Pelvis ❑ Left buttock ❑ Right buttock ❑ Left leg ❑ Right leg
- ❑ Left hip ❑ Right hip ❑ Left thigh ❑ Right thigh ❑ Left knee
- ❑ Right knee ❑ Left shin ❑ Right shin ❑ Left ankle ❑ Right ankle
- ❑ Left foot ❑ Right foot

TREATMENTS ADMINISTERED AFTER THE ACCIDENT

Were you admitted to a hospital?
- ❑ Yes
- ❑ No

Name of Hospital/Clinic: _____
Examining Physician: _____
Date of Visit: _____
Date of Discharge:

Were any X-Rays taken? (mark all that appl Y N (Please circle one)
If yes, what body region? _____

Were any CAT scans performed? (mark all that appl Y N (Please circle one)
If yes, what body region? _____

Were any MRI scans performed? (mark all that apply Y N (Please circle one)
If yes, what body region? _____

Were you given a diagnosis of this injury? _____

Treatments Administered
- ❑ Adjustments
- ❑ Bandages
- ❑ Brace
- ❑ Cast
- ❑ Collar
- ❑ Hot Packs
- ❑ Ice Packs
- ❑ Injection
- ❑ Splint
- ❑ Support
- ❑ Surgery
- ❑ Muscle Relaxants
- ❑ Oral medication
- ❑ Sutures
- ❑ Topical Antiseptic

Recommendations
- ❑ No further care required
- ❑ Refer to Plastic Surgeon
- ❑ Refer to Chiropractor
- ❑ Refer to General Practitioner
- ❑ Refer to General Surgeon
- ❑ Refer to Internist
- ❑ Refer to Neurologist
- ❑ Refer to Orthopedist
- ❑ Refer to Physical Therapist
- ❑ See Physician if symptoms persist
- ❑ Time off work
- ❑ Undergo observation
- ❑ Heat therapy
- ❑ Cervical Collar
- ❑ Orthopedic shoes
- ❑ Rest
- ❑ Ice packs
- ❑ Other _____

Medications Prescribed
- ❑ Antibiotic
- ❑ Anti-Inflammatory
- ❑ Anxiety medications
- ❑ Herbs
- ❑ Muscle Relaxants
- ❑ Over-the-Counter Medications
- ❑ Pain Killers
- ❑ Other: _____

Treatment and Diagnostic History

Diagnostic Testing (X-ray, MRI, EMG, etc.)	Body Area	Date	Facility	Finding

Diagnostic tests that have been performed for the current chief complaint include:

Prior Physician: _____ **Date of 1st Visit:** ___/___/___
Date of Last Visit: ___/___/___

Physician's Diagnosis: _____

Treatment Recommended by Prior Physician (mark all that apply)
- ❑ Adjustments
- ❑ Bed Rest
- ❑ Heat
- ❑ Ice
- ❑ Immobilization
- ❑ Massage
- ❑ Physical Therapy
- ❑ Rehabilitation
- ❑ Analgesics
- ❑ Anti-Biotics
- ❑ Anti-Inflammatories
- ❑ Muscle Relaxants
- ❑ Nerve Blocks
- ❑ Sedatives
- ❑ Trigger Point Injections
- ❑ Surgery

Treatment Results (mark one)
- ❑ Plan was not followed
- ❑ Had some success
- ❑ Aggravated the conditic
- ❑ Relieved the condition
- ❑ Offered no relief or benefit

Social History

Marital Status?
- ❑ Married
- ❑ Divorced
- ❑ Single
- ❑ Separated
- ❑ Widowed

# of Children?
- ❑ No children
- ❑ 1 child
- ❑ 2 children
- ❑ 3 children
- ❑ 4 children
- ❑ 5 children
- ❑ 6 children
- ❑ 7 children
- ❑ 8 children
- ❑ 9 children
- ❑ 10 children

How often do you exercise?
- ❑ never
- ❑ rarely
- ❑ occasionally
- ❑ regularly

Hand of Dominance?
- ❑ Left
- ❑ Right
- ❑ Ambidextrous

Hours of Sleep per night?
- ❑ 1 hour
- ❑ 2 hours
- ❑ 3 hours
- ❑ 4 hours
- ❑ 5 hours
- ❑ 6 hours
- ❑ 7 hours
- ❑ 8 hours
- ❑ 9 hours
- ❑ 10 or more

Participation in Sports Activities?
- ❑ very frequently
- ❑ often
- ❑ somewhat often
- ❑ occasionally
- ❑ infrequently
- ❑ almost never
- ❑ never

Involvement in Hobbies?
- ❑ very frequently
- ❑ often
- ❑ somewhat often
- ❑ occasionally
- ❑ infrequently
- ❑ almost never
- ❑ never

Have you traveled internationally?
- ❑ never
- ❑ recently
- ❑ occasionally
- ❑ in the past

How often do you eat a well-balanced diet?
- ❑ never
- ❑ rarely
- ❑ occasionally
- ❑ usually
- ❑ always

Do you consider yourself overweight?
- ❑ yes
- ❑ no

How many pounds overweight?
- ❑ 5
- ❑ 10
- ❑ 15
- ❑ 20
- ❑ 25
- ❑ 30
- ❑ 35
- ❑ 40
- ❑ 45
- ❑ _____

Highest level of education achieved?
- ❑ Did not graduate
- ❑ earned a GED
- ❑ graduated HighSchool
- ❑ Associates Degree
- ❑ Bachelor's Degree
- ❑ Masters Degree
- ❑ PhD or Doctorate

Years of Education after High School?
- ❑ _____

Learning Disabilities?
- ❑ yes
- ❑ No
- ❑ unknown

Alcohol Consumption?
- ❑ does not drink alcoholic beverages
- ❑ drinks alcoholic beverages rarely
- ❑ drinks alcoholic beverages occasionally
- ❑ drinks alcholic beverages frequently
- ❑ drinks alcoholic beverages often
- ❑ usaully only drinks alcoholic beverages on the weekends

Recreational Drug Use? (optional)
- ❑ never
- ❑ occasionally
- ❑ often
- ❑ in the past

How often do you drink beverages with caffeine?
- ❑ never
- ❑ less than 1 caffeinated beverage per day
- ❑ 1-2 caffeinated beverages per day
- ❑ 2-3 caffeinated beverages per day
- ❑ 3-4 caffeinated beverages per day
- ❑ 4-5 caffeinated beverages per day
- ❑ more than 5 caffeinated beverages per day

Tobacco Use?

Years of Tobacco Use?
- ❑ _____

Cigarettes
- ❑ does not smoke
- ❑ < 1/4 pack per day
- ❑ 1/4 pack per day
- ❑ 1/2 pack per day
- ❑ 1 pack per day
- ❑ 2 packs per day
- ❑ 3 packs or > per day
- ❑ in the past

Chewing tobbaco
- ❑ never used
- ❑ occasionally
- ❑ often
- ❑ in the past

Cigars
- ❑ never used
- ❑ occasionally
- ❑ often
- ❑ in the past

Served in the Military?
- ❑ yes
- ❑ No

Serve during Wartime?
- ❑ yes
- ❑ no

Suffer trauma from War?
- ❑ yes
- ❑ no

Branch of Service?
- ❑ Army
- ❑ Navy
- ❑ Air Force
- ❑ Marines

Health History

Please select all choices that apply to you, either currently or in the past.

- ❑ Abdominal Pain
- ❑ Allergies
- ❑ Angina
- ❑ Anorexia
- ❑ Aortic Aneurysm
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood Disorder
- ❑ Breast Soreness
- ❑ Bulemia
- ❑ Cancer
- ❑ Colitis
- ❑ Convulsions
- ❑ Diabetes
- ❑ Dislocated Joints
- ❑ Dizziness
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting
- ❑ Hay Fever
- ❑ Headaches
- ❑ Heart Attacks
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Irregular Bowel Habits
- ❑ Irregular Menstrual
- ❑ Irritable Colon
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Multiple Sclerosis
- ❑ Osteoporosis
- ❑ Painful Urination
- ❑ PMS
- ❑ Polio
- ❑ Profuse Menstrual
- ❑ Prostate Disease
- ❑ Rapid Heart Rate
- ❑ Rheumatic Fever
- ❑ Scoliosis
- ❑ Sexually Transmitted Diseases
- ❑ Sickle Cell Anemia
- ❑ Sinus Trouble
- ❑ Spinal Disc Disorder
- ❑ Stroke
- ❑ Thyroid Disorder
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Vaginal Discharge
- ❑ _____

Are you presently taking any medications? If so, please list. _____

Have you had any surgeries? If so, please list. _____

Family History

	Mother	*Father*	*Siblings*	*Cousins*	*Maternal Grandmother*	*Maternal Grandfather*	*Paternal Grandmother*	*Paternal Grandfather*
Angina	❑	❑	❑	❑	❑	❑	❑	❑
Arthritis or Rheumatism	❑	❑	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑	❑	❑
Blindness*	❑	❑	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑	❑	❑
Chronic Bronchitis	❑	❑	❑	❑	❑	❑	❑	❑
Congestive Heart Failure	❑	❑	❑	❑	❑	❑	❑	❑
Deafness*	❑	❑	❑	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes Mellitus Type II	❑	❑	❑	❑	❑	❑	❑	❑
Emphysema	❑	❑	❑	❑	❑	❑	❑	❑
Heart Attack	❑	❑	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑	❑	❑
Sciatica/Chronic Low Back Pain	❑	❑	❑	❑	❑	❑	❑	❑
Seizures	❑	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑	❑	❑
Ulcers or GI Bleeding	❑	❑	❑	❑	❑	❑	❑	❑
OTHER:	❑	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑	❑

❑ Relatives Still Living
❑ Relatives In Good Health

***Blindness was caused by:**
- ❑ Cataracts
- ❑ Conginital absence of ability
- ❑ Glaucoma
- ❑ Trauma

***Deafness was caused by:**
- ❑ Conginital absence of ability
- ❑ Meniere's Disease
- ❑ Otic Cancer
- ❑ Trauma

Family history negative for:
- ❑ Cancer
- ❑ Diabetes
- ❑ Thyroid Disorders
- ❑ Heart Disease
- ❑ Stroke
- ❑ High Blood Pressure
- ❑ Asthma
- ❑ Seizures
- ❑ Liver Dysfunction
- ❑ Kidney Pathologies
- ❑ **All Of The Above**

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of ***Wilmington Family Chiropractic's Notice of Privacy Practices for Protected Health Information.***

_____
Patient or Guardian Name Printed

_____ _____
Patient or Guardian Signature Date

CONSENT TO TREAT

I understand that all records established by this office are the sole property of Dr. Jensen. Copies, however, will be made upon 72 hours notice to the doctor, and I understand and agree to pay all costs involved in their reproduction.

I hereby give Wilmington Family Chiropractic and Dr. Jensen CONSENT TO TREAT me and/or my minor child, and I understand that Wilmington Family Chiropractic requires personal p

I, the undersigned, hereby authorize Dr. Jensen (and whom he may designate his assistants) to administer any examination and/or treatment as is necessary and to perform appropriate diagnostic and therapeutic procedures as are considered necessary on the basis of findings during the course of said examination and/or treatment. I also authorize the release of any information or records from this office to other past, present or future health care professionals, facilities, attorneys or agencies for the purpose of continuity of my health care and for the purpose of collection for services rendered.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Wilmington Family Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Wilmington Family Chiropractic and Dr. Jensen will be credited to my account on receipt. I also give Wilmington Family Chiropractic and Dr. Jensen limited power of attorney to endorse checks received from my insurance company relating only for my treatment, to be credited to my account. However, I clearly understand and agree that all services rendered to me and/or my minor child are charged directly to me and that I am personally responsible for payment, regardless of my insurance coverage. I also understand that if I suspend or terminate my care and treatment and/or if in the event that my insurance benefits are terminated or exhausted, any fees for professional services rendered to me and/or my minor child will be immediately due and payable.

I also certify that no guarantee has been made as to the results that may be obtained from any treatment given.

By signing below, I affirm that I have read the above and that it has been clearly explained to my as well by Wilmington Family Chiropractic.

Patient (or Guardian) Signature _____ Date _____

FEMALE PATIENT X-RAY PREGNANCY VERIFICATION

I, _____, a patient of Wilmington Family Chiropractic, certify that to the best of my knowledge that I am not pregnant. By my signature below, I authorize Wilmington Family Chiropractic and Dr. Jensen to take all appropriate diagnostic x-rays. If there is even a remote chance of pregnancy, I will notify Dr. Jensen immediately.

Signed: _____ Date: _____

Doctor's Signature: _____ Date: _____

ASSIGNMENT, LIEN AND AUTHORIZATION TO RELEASE MEDICAL RECORDS AND INFORMATION

Patient Name: _____

For good and valuable consideration received, I, _____, being the undersigned, authorize and direct you, _____ my insurance carrier and _____, my attorney, to pay directly to WILMINGTON FAMILY CHIROPRACTIC any sums as may be due and owing this office for services rendered me, both by reason of accident, or illness and/or by reason of any other bills, medical payments, no-fault benefits, health and/or accident benefits, workers' compensation benefits, or any other insurance benefits or reimbursement for which you may be obligated to reimburse me, or from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect WILMINGTON FAMILY CHIROPRACTIC and Dr. Stephen Jensen who provided these services.

I hereby give a lien to said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgement or verdict, which may be owed me as a result of the injuries or illness for which I have been treated by said office. This contract is to act as an assignment of my rights and benefits to the extent of the office's charges for services provided herein.

In further consideration of the treatment rendered herein, I do hereby authorize WILMINGTON FAMILY CHIROPRACTIC to furnish you, the above-indicated party, a full report of my examination, diagnosis, treatment, prognosis, chiropractic bills and any other relevant information pertaining to my treatment.

I, the undersigned, further hereby authorize and direct my attorney, _____, when settlement or judgment is reached, to pay in full the chiropractic bills rendered for all treatment and services as a result of the injuries or illness for which I have been treated by said office and any other amounts which I may owe said office at that time.

In further consideration of the treatment rendered herein, I do hereby authorize WILMINGTON FAMILY CHIROPRACTIC to furnish you, the above-indicated party, a full report of my examination, diagnosis, treatment, prognosis, chiropractic bills and any other relevant information pertaining to my treatment.

I understand that by signing this document, I am authorizing release of reports and information to the above-indicated party, which could include the responsible party's insurance company.

Furthermore, I authorize WILMINGTON FAMILY CHIROPRACTIC to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment, lien and medical authorization.

In the event that the insurance company is obligated to make payments to me for charges made by this office for services rendered and refuses to make such payments, I hereby assign and transfer to this office any and all cause of action, claims, whether in law or equity, that I might have or that I might exist in my favor against such company, and authorize this office to compromise, settle or otherwise resolve any claim or cause of action in its sole discretion herein as it relates to amounts owed the doctor.

I understand that I am directly and fully responsible to said office for all medical bills submitted by them for services rendered to me and this agreement is made solely for said office's additional protection while awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fees.

This agreement is irrevocable and is binding upon the heirs, executors and legal representatives of the undersigned.

_____

Patient Signature and Date

ATTORNEY ACKNOWLEDGEMENT OF ASSIGNMENT, LIEN AND AUTHORIZATION AND RELEASE OF MEDICAL RECORDS AND INFORMATION.

I, _____, attorney for the above-named patient, hereby acknowledge receipt of the above assignment and lien and agree to protect WILMINGTON FAMILY CHIROPRACTIC and Dr. Stephen A. Jensen pursuant to the

Date: _____ Attorney: _____