BACK COUNTRY CHIROPRACTIC
"Individualized Chiropractic Care"

Dr. Jennifer M. Wells, D.C.
and Associates

PERSONAL INJURY FORM

PERSONAL INFORMATION

First Name:_____ **MI:**____ **Last Name:**_____ **Preferred Name:**_____

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

Birthdate:____/____/____ **Age:**_____ **Gender:** ☐ Male ☐ Female ☐ Unspecified **SSN:**_____-_____-_____

Primary Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Email:_____

By providing my email address, I authorize my doctor to contact me via the email address provided.

Preferred Contact Method: (check one) ☐ Primary Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Occupation:_____ **Employer:**_____

Status: (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated **Children?:** ☐ Yes ☐ No How Many:_____

Spouse's Name: (if applicable)_____

Emergency Contact: (Name, Relationship, Phone #)_____

Have you ever received chiropractic care?: ☐ Yes ☐ No If Yes, when?_____

Name of most recent chiropractor:_____

PATIENT HISTORY

1. Reasons for Seeking Chiropractic Care:

Primary Reason:_____

Secondary Reason:_____

2. Since the Motor Vehicle Collision, have you experienced any of the following:

A. Loss of Motion: ☐ Yes ☐ No **What body part(s):**_____

B. Visual Disturbance: ☐ Yes ☐ No

Blurring L / R	Floaters L / R	Vision Loss L / R	Hypersensitivity L / R
% of time_____	% of time_____	% of time_____	% of time_____

C. Dizziness: ☐ Yes ☐ No

D. Anxiety: ☐ Yes ☐ No

E. Depression: ☐ Yes ☐ No

F. Difficulty Sleeping: ☐ Yes ☐ No

3. Previous Interventions, Treatments, Medications, Surgery, or Care You've Sought for Your Complaint(s):

_____

_____

_____

4. Past Health History:

A. Please indicate if you have a history of any of the following:

☐ Anticoagulant Use ☐ Heart Problems/High Blood Pressure/Chest Pain ☐ Bleeding Problems
☐ Lung Problems/Shortness of Breath ☐ Cancer ☐ Diabetes ☐ Psychiatric Disorders
☐ Bipolar Disorder ☐ Major Depression ☐ Schizophrenia ☐ Stroke/TIA's ☐ Other:_____
☐ None of the Above

B. Previous Injury or Trauma:_____

Have you ever broken any bones? Which one(s)?:_____

C. Allergies:_____

D. Medications:

Medication(s): *Reason for Taking:*

_____

_____

_____

E. Surgeries:

Date: *Type of Surgery:*

_____

_____

_____

F. Females/Pregnancies and Outcomes:

Pregnancies/Date of Delivery: *Outcome:*

_____

_____

_____

4. Family Health History:

Do you have a family history of? (please indicate all that apply)

☐ Cancer ☐ Strokes/TIA's ☐ Headaches ☐ Cardiac Disease ☐ Neurological Diseases
☐ Adopted/Unknown ☐ Cardiac Disease below age 40 ☐ Psychiatric Disease ☐ Diabetes
☐ Other:_____ ☐ None of the Above

Deaths in Immediate Family:

Cause of Parent's or Sibling's Death: *Age at Death:*

_____

_____

5. Social and Occupational History:

A. Job Description:_____

B. Work Schedule:_____

C. Recreational Activities:_____

D. Lifestyle (Hobbies, Level of Exercise, Alcohol, Tobacco, and Drug Use, Diet, etc.):_____

_____

6. Accident Questionnaire: **Date of Accident:**_____

Name of your Auto Insurance Company:_____ **Claim #**_____

Auto Insurance Address for Billing:_____

Med Pay? ☐ Yes ☐ No **If Yes, what are the policy limits?**_____

3rd Party Auto Policy (other people's insurance):_____ **Claim #** _____

Adjuster Name:_____ **Phone:**_____

If you have retained an attorney, please provide the following information:

Attorney Name:_____ **Phone:**_____ **Fax:**_____

Attorney Address:_____

Patient Name (print):_____ **Date:**_____

REVIEW OF SYSTEMS

Have you had any of the following *Pulmonary (lung-related)* issues?

☐ Asthma/Difficulty Breathing ☐ COPD ☐ Emphysema ☐ Other_____ ☐ None of the Above

Have you had any of the following *Cardiovascular (heart-related)* issues or procedures?

☐ Heart Surgeries ☐ Congestive Heart Failure ☐ Murmurs of Valvular Disease ☐ Heart Attacks/MIs ☐ Heart Disease/Problems

☐ Hypertension ☐ Pacemaker ☐ Angina/Chest Pain ☐ Irregular Heartbeat ☐ Other_____ ☐ None of the Above

Have you had any of the following *Neurological (nerve-related)* issues?

☐ Visual Changes/Loss of Vision ☐ One-sided Weakness of Face or Body ☐ One-sided Decreased Feeling in Face or Body

☐ History of Seizures ☐ Headaches ☐ Memory Loss ☐ Tremors ☐ Vertigo ☐ Loss of Sense of Smell ☐ Strokes/TIAs

☐ Other_____ ☐ None of the Above

Have you had any of the following *Endocrine (glandular/hormonal)* issues or procedures?

☐ Thyroid Disease ☐ Hormone Replacement Therapy ☐ Injectable Steroid Replacements ☐ Diabetes

☐ Other_____ ☐ None of the Above

Have you had any of the following *Renal (kidney-related)* issues or procedures?

☐ Renal Calculi/Stones ☐ Hematuria (blood in urine) ☐ Incontinence (can't control) ☐ Bladder Infections ☐ Difficulty Urinating

☐ Kidney Disease ☐ Dialysis ☐ Other_____ ☐ None of the Above

Have you had any of the following *Gastroenterological (stomach-related)* issues?

☐ Nausea ☐ Difficulty Swallowing ☐ Ulcerative Disease ☐ Frequent Abdominal Pain ☐ Hiatal Hernia ☐ Constipation

☐ Pancreatic Disease ☐ Irritable Bowel/Colitis ☐ Hepatitis or Liver Disease ☐ Bloody or Back Tarry Stools ☐ Vomiting Blood

☐ Bowel Incontinence ☐ Gastroesophageal Reflux/Heartburn ☐ Other_____ ☐ None of the Above

Have you had any of the following *Hematological (blood-related)* issues?

☐ Anemia ☐ Regular Anti-Inflammatory Use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) ☐ HIV Positive

☐ Abnormal Bleeding/Bruising ☐ Sickle-Cell Anemia ☐ Enlarged Lymph Nodes ☐ Hemophilia

☐ Hypercoagulation or Deep Venous Thrombosis/History of Blood Clots ☐ Anticoagulant Therapy ☐ Regular Aspirin Use

☐ Other_____ ☐ None of the Above

Have you had any of the following *Dermatological (skin-related)* issues?

☐ Significant Burns ☐ Significant Rashes ☐ Skin Grafts ☐ Psoriatic Disorders ☐ Other_____ ☐ None of the Above

Have you had any of the following *Musculoskeletal (bone/muscle-related)* issues?

☐ Rheumatoid Arthritis ☐ Gout ☐ Osteoarthritis ☐ Broken Bones ☐ Spinal Fracture ☐ Spinal Surgery ☐ Joint Surgery

☐ Arthritis (unknown type) ☐ Scoliosis ☐ Metal Implants ☐ Other_____ ☐ None of the Above

Have you had any of the following *Psychological* issues?

☐ Psychiatric Diagnosis ☐ Depression ☐ Suicidal Ideations ☐ Bipolar Disorder ☐ Homicidal Ideations ☐ Schizophrenia

☐ Psychiatric Hospitalizations ☐ Other_____ ☐ None of the Above

Is there anything else in your past medical history that you feel is important to your care?_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Back Country Chiropractic for services performed.

Patient Name (print):_____

Signature of Patient, Parent, or Legal Guardian: X_____ **Date:**_____

SYMPTOMS

PLEASE START AT THE TOP OF YOUR BODY AND WORK YOUR WAY DOWN, LISTING ALL YOUR SYMPTOMS FROM THE TOP TO BOTTOM: i.e. Headache, Neck Pain, Shoulders/Arms, Mid-Back, Lower Back, Hips, Knees, and Feet last.
Be complete with every complaint individually

Symptom #1 *(Starting from the top of your head down):*_____

On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time.
1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity?
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin?_____

Did the symptom begin: ☐ Suddenly ☐ Gradually

How did the symptom begin?_____

Was this symptom a result of a motor vehicle collision? ☐ Yes ☐ No

Did you have this symptom before this motor vehicle accident? ☐ Yes ☐ No

If so, what was the intensity (1-10, with 10 being the worst)_____ and frequency?_____

What makes the symptom worse? (circle all that apply)
*Bending Neck Forward / Bending Neck Backward / Tilting Head to Left / Tilting Head to Right / Turning Head to Left / Turning Head to Right / Bending Forward at Waist / Bending Backward at Waist / Tilting Left at Waist / Tilting Right at Waist / Twisting Left at Waist / Twisting Right at Waist / Sitting / Standing / Getting Up from Sitting / Lifting / Any Movement / Driving / Walking / Running / Nothing / Other:*_____

What makes the symptom better? (circle all that apply)
*Rest / Ice / Heat / Stretching / Exercise / Massage / Pain Medication / Muscle Relaxers / Nothing / Other:*_____

Describe the quality of the symptom: (circle all that apply)
*Sharp / Dull / Achy / Burning / Throbbing / Piercing / Stabbing / Deep / Nagging / Shooting / Stinging / Other:*_____

Does the symptom radiate to another part of your body? ☐ Yes ☐ No
If yes, where does the symptom radiate?_____

Is the symptom worse at certain times of the day or night? (circle one)
Morning / Afternoon / Evening / Night / Unaffected by time of day

Symptom #2 *(Next symptom below Symptom #1):*_____

On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time.
1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity?
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin?_____

Did the symptom begin: ☐ Suddenly ☐ Gradually

How did the symptom begin?_____

Was this symptom a result of a motor vehicle collision? ☐ Yes ☐ No

Did you have this symptom before this motor vehicle accident? ☐ Yes ☐ No

If so, what was the intensity (1-10, with 10 being the worst)_____ and frequency?_____

What makes the symptom worse? (circle all that apply)
*Bending Neck Forward / Bending Neck Backward / Tilting Head to Left / Tilting Head to Right / Turning Head to Left / Turning Head to Right / Bending Forward at Waist / Bending Backward at Waist / Tilting Left at Waist / Tilting Right at Waist / Twisting Left at Waist / Twisting Right at Waist / Sitting / Standing / Getting Up from Sitting / Lifting / Any Movement / Driving / Walking / Running / Nothing / Other:*_____

What makes the symptom better? (circle all that apply)
*Rest / Ice / Heat / Stretching / Exercise / Massage / Pain Medication / Muscle Relaxers / Nothing / Other:*_____

Describe the quality of the symptom: (circle all that apply)
*Sharp / Dull / Achy / Burning / Throbbing / Piercing / Stabbing / Deep / Nagging / Shooting / Stinging / Other:*_____

Does the symptom radiate to another part of your body? ☐ Yes ☐ No
If yes, where does the symptom radiate?_____

Is the symptom worse at certain times of the day or night? (circle one)
Morning / Afternoon / Evening / Night / Unaffected by time of day

Patient Name (print):_____ **Date:**_____

Symptom #3 *(Next symptom below Symptom #2):*_____

On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time.

1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin?_____

Did the symptom begin: ☐ Suddenly ☐ Gradually

How did the symptom begin?_____

Was this symptom a result of a motor vehicle collision? ☐ Yes ☐ No

Did you have this symptom before this motor vehicle accident? ☐ Yes ☐ No

If so, what was the intensity (1-10, with 10 being the worst)_____ **and frequency?**_____

What makes the symptom worse? (circle all that apply)

*Bending Neck Forward / Bending Neck Backward / Tilting Head to Left / Tilting Head to Right / Turning Head to Left / Turning Head to Right / Bending Forward at Waist / Bending Backward at Waist / Tilting Left at Waist / Tilting Right at Waist / Twisting Left at Waist / Twisting Right at Waist / Sitting / Standing / Getting Up from Sitting / Lifting / Any Movement / Driving / Walking / Running / Nothing / Other:*_____

What makes the symptom better? (circle all that apply)

*Rest / Ice / Heat / Stretching / Exercise / Massage / Pain Medication / Muscle Relaxers / Nothing / Other:*_____

Describe the quality of the symptom: (circle all that apply)

*Sharp / Dull / Achy / Burning / Throbbing / Piercing / Stabbing / Deep / Nagging / Shooting / Stinging / Other:*_____

Does the symptom radiate to another part of your body? ☐ Yes ☐ No

If yes, where does the symptom radiate?_____

Is the symptom worse at certain times of the day or night? (circle one)

Morning / Afternoon / Evening / Night / Unaffected by time of day

Symptom #4 *(Next symptom below Symptom #3):*_____

On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time.

1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin?_____

Did the symptom begin: ☐ Suddenly ☐ Gradually

How did the symptom begin?_____

Was this symptom a result of a motor vehicle collision? ☐ Yes ☐ No

Did you have this symptom before this motor vehicle accident? ☐ Yes ☐ No

If so, what was the intensity (1-10, with 10 being the worst)_____ **and frequency?**_____

What makes the symptom worse? (circle all that apply)

*Bending Neck Forward / Bending Neck Backward / Tilting Head to Left / Tilting Head to Right / Turning Head to Left / Turning Head to Right / Bending Forward at Waist / Bending Backward at Waist / Tilting Left at Waist / Tilting Right at Waist / Twisting Left at Waist / Twisting Right at Waist / Sitting / Standing / Getting Up from Sitting / Lifting / Any Movement / Driving / Walking / Running / Nothing / Other:*_____

What makes the symptom better? (circle all that apply)

*Rest / Ice / Heat / Stretching / Exercise / Massage / Pain Medication / Muscle Relaxers / Nothing / Other:*_____

Describe the quality of the symptom: (circle all that apply)

*Sharp / Dull / Achy / Burning / Throbbing / Piercing / Stabbing / Deep / Nagging / Shooting / Stinging / Other:*_____

Does the symptom radiate to another part of your body? ☐ Yes ☐ No

If yes, where does the symptom radiate?_____

Is the symptom worse at certain times of the day or night? (circle one)

Morning / Afternoon / Evening / Night / Unaffected by time of day

Patient Name (print):_____ **Date:**_____

Symptom #5 *(Next symptom below Symptom #4):*_____

On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time.

1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin?_____

Did the symptom begin: ☐ Suddenly ☐ Gradually

How did the symptom begin?_____

Was this symptom a result of a motor vehicle collision? ☐ Yes ☐ No

Did you have this symptom before this motor vehicle accident? ☐ Yes ☐ No

If so, what was the intensity (1-10, with 10 being the worst)_____ **and frequency?**_____

What makes the symptom worse? (circle all that apply)

*Bending Neck Forward / Bending Neck Backward / Tilting Head to Left / Tilting Head to Right / Turning Head to Left / Turning Head to Right / Bending Forward at Waist / Bending Backward at Waist / Tilting Left at Waist / Tilting Right at Waist / Twisting Left at Waist / Twisting Right at Waist / Sitting / Standing / Getting Up from Sitting / Lifting / Any Movement / Driving / Walking / Running / Nothing / Other:*_____

What makes the symptom better? (circle all that apply)

*Rest / Ice / Heat / Stretching / Exercise / Massage / Pain Medication / Muscle Relaxers / Nothing / Other:*_____

Describe the quality of the symptom: (circle all that apply)

*Sharp / Dull / Achy / Burning / Throbbing / Piercing / Stabbing / Deep / Nagging / Shooting / Stinging / Other:*_____

Does the symptom radiate to another part of your body? ☐ Yes ☐ No

If yes, where does the symptom radiate?_____

Is the symptom worse at certain times of the day or night? (circle one)

Morning / Afternoon / Evening / Night / Unaffected by time of day

Any other symptoms? *(add here and describe as above in area below):*_____

Patient Name (print):_____ **Date:**_____

AUTO ACCIDENT MECHANISM OF INJURY FORM

Date of Collision:_____ **Hour of Accident:**_____ **AM / PM**

Please describe how the collision happened:_____

_____

_____

_____

What was your position in the car? (check one) ☐ Driver ☐ Front Passenger ☐ Left Rear ☐ Right Rear

If "Driver", were your hands on the steering wheel? (check one) ☐ Both ☐ Left ☐ Right

Did the airbags deploy? ☐ Yes ☐ No

Did you strike another vehicle? ☐ Yes ☐ No **Did another vehicle strike your vehicle?** ☐ Yes ☐ No

Angle of Impact: ☐ Front ☐ Back ☐ Left ☐ Right ☐ Other:_____

If Second Collision – Angle of 2nd impact: ☐ Front ☐ Back ☐ Left ☐ Right ☐ Other:_____

In relation to the back of your head, was your headrest set: ☐ Low ☐ Middle ☐ High

Were you surprised by the impact? ☐ Yes ☐ No

If No, how did you brace? ☐ With Hands ☐ With Feet

Where was your head facing at the time of impact? ☐ Straight Ahead ☐ Left ☐ Right ☐ Behind

Were you leaning forward at the time of impact? ☐ Yes ☐ No

Year, make, and model of the vehicle were you in?_____

What was the approximate speed of your vehicle when the accident occurred?_____**mph**

Year, make, and model of the vehicle that struck yours?_____

What was the approximate speed of the other vehicle when the accident occurred?_____**mph**

Were you wearing a seatbelt? ☐ Yes ☐ No **What type:** ☐ Lap Belt ☐ Shoulder Belt ☐ Both

Did you feel pain immediately after the accident? ☐ Yes ☐ No **If so, where?**_____

Were you rendered unconscious as a result of the accident? ☐ Yes ☐ No

Did you strike anything in the vehicle at the time of impact? ☐ Yes ☐ No

If Yes, specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

Steering Wheel_____ **Windshield**_____

Dashboard_____ **Roof**_____

Left Side Door_____ **Right Side Door**_____

Left Window_____ **Left Side Door**_____

Other_____

Did your seat break or bend? ☐ Yes ☐ No

Immediately following the accident, how did you feel? (Circle all that apply)

*Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other:*_____

Patient Name (print):_____

Signature of Patient, Parent, or Legal Guardian: X_____ **Date:**_____

AUTO ACCIDENT POLICE AND AMBULANCE FORM

Was the accident reported to the police? ☐ Yes ☐ No

Were traffic citations issued? ☐ Yes ☐ No **If Yes, to whom?**_____

Did you go to the hospital? ☐ Yes ☐ No **If Yes, when?**_____

If "YES", how did you get there? ☐ Ambulance ☐ Police Car ☐ Private Transportation

Were you admitted? ☐ Yes ☐ No **If Yes, how long?**_____

Name of Hospital?_____ **Attended by Dr.**_____

What treatment given? (Circle all that apply) *None / X-rays / Pain Medication / Stitches / Muscle Relaxants / Bandaged / Cervical Collar / Physical Therapy / Instructed Regarding Concussion / Instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist / Instructed to Call a Private Physician / Referred to This Office / Other:*_____

What other doctor have you seen as a result of this injury?_____

Do you have difficulty in excessive: ☐ Standing ☐ Walking ☐ Riding ☐ Bending ☐ Twisting

Do you have difficulty in excessive lifting: ☐ Light ☐ Moderate ☐ Heavy ☐ Repetitive

Symptoms other than above:_____

Patient Name (print):_____

Signature of Patient, Parent, or Legal Guardian: X_____ **Date:**_____

LITIGATION AND LIEN AGREEMENT

1. IDENTIFICATION OF PARTIES: This agreement is entered into among Dr. Jennifer M. Wells, D.C. @ 911 6th St. Norco CA 92860 and: _____ (hereinafter "Patient-Client") and _____ ("Attorney"), in consideration of the mutual obligation set forth herein, to make certain their responsibilities to each other during the pendency of patient-client's litigation arising from the accident on _____ (hereinafter "Litigation").

2. CREATION OF LIEN: Patient-Client hereby gives a lien to physician against all proceeds derived from this litigation whether by settlement, arbitration award, Court judgment, or otherwise. This lien will secure payment of all amounts now or hereafter owed to Physician by Patient-Client for health care services provided to Patient-Client as of the time such proceeds are received.

3. DEFERRAL OF PAYMENT: Payment of amount owed to Physician may be deferred until resolution of Patient-Client's claim, except to the extent that any amounts are paid to Patient-Client by any insurer, benefit program, or other third party for amounts owed to Physician.

4. INSURANCE BILLING: All parties agree that Physician will not bill Patient-Client's private health insurance, if applicable, for treatment received for Litigation. Patient-Client may submit bills to their own insurance company. Whether to bill Patient-Client's insurance is entirely at the discretion of Physician and Physician's staff. If requested in special circumstances, Physician may agree to bill private insurance but under no circumstances will Physician bill Medicare or Medi-Cal. And, any payment received by Patient or by Physician as a result of an insurance claim will be accepted by Physician as partial payment on the lien and not as full and final payment on the lien. Contracted fee schedules of health insurance companies do not apply to services rendered under this agreement. By accepting medical reports drafted and other services provided solely for the purpose of Litigation and not covered by private health insurance, Physician is relieved of his contractual obligation to accept the predetermined insurance fee schedule.

5. PATIENT'S RESPONSIBILITY OF PAYMENT: Notwithstanding any other provisions of this agreement, Patient-Client fully understands that he/she is directly, fully, and personally responsible for physician for all fees incurred for services rendered and that by signing below is agreeing to pay said amounts. The obligation to pay physician is not contingent on any settlement, judgment or verdict by which patient/client may eventually recover said fee. To the extent that amounts owed are not paid out of any recovery, or if there is no recovery, they must be paid by Patient-Client. Patient-Client agrees that the statute of limitations is tolled during the pendency of this proceeding.

6. DIRECTION TO ATTORNEY: Patient-Client hereby authorizes and directs Attorney to honor the lien and pay physician the accumulated amount due and owing to Physician for medical services rendered to Patient-Client by reason of this accident. Patient-Client further directs Attorney to pay Physician with the funds secured directly to Physician as soon as possible after the proceeds of any recovery are received by Attorney and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect physician.

7. ATTORNEY'S RESONSIBILITY: Attorney acknowledges notice of the lien granted herein by Patient-Client to Physician and will honor the lien by paying the funds secured directly to Physician as soon as possible after the proceeds of any recovery are received by Attorney and by withholding such sums from any settlement, judgment, or verdict as may be necessary to adequately protect the physician. In the event of a dispute between patient-Client and Physician, the parties direct Attorney to hold the disputed amount of fund in trust until the dispute is resolved. Attorney further agrees to provide Physician status reports at least every 6 months and within 30 days of request by physician.

8. REPORTS: Patient-Client hereby authorizes physician to provide attorney, at intervals determined by physician, with reports of patient-client's medical condition and care and cost of treatment and associated services. Physician agrees to furnish these reports within a reasonable time and cost.

9. CONSULTATIONS, DEPOSITIONS, COURT APPEARANCES: Physician agrees to make himself available for consultations, depositions, and court appearances upon reasonable notice and for reasonable compensation. Fees for these services, as well as cancellation policy are determined per our current fee schedule, are due and payable at time of scheduling and not subject to deferral of payment (paragraph 3).

10. CHANGE OF ATTORNEY: Patient-Client is represented by Attorney with respect to any claims and causes of action arising out of the aforementioned Litigation. Attorney and Patient-Client hereby agree to notify Physician immediately should Patient-Client retain new legal counsel and to furnish Physician with the name, address and phone number of the new attorney. Patient-Client agrees to direct new legal counsel to honor this agreement and to execute another copy of this Litigation and Lien Agreement. New legal counsel will be bound by the terms of this agreement, unless superceded by another agreement executed by all parties.

11. DISPUTES AND ATTORNEY FEES: If any action at law or in equity, including an action for declaratory relief or interpleader, or any processing in arbitration, is brought to enforce or interpret the provisions of this Agreement, the prevailing party shall be entitled to reasonable attorney's fees, which may be set by the court or the arbitration panel in the same action or any separate action brought for that purpose, in addition to any other relief to which such party may be entitled.

12. EFFECTIVE DATE OF AGREEMENT: The effective date of this agreement with be the date of its execution by the last of the parties to do so.

In witness of these mutual obligations and responsibilities, this PHYSICIAN/PATIENT-CLIENT/ATTORNEY LITIGATION AND LIEN AGREEMENT is entered into by:

Physician's Name:_____ **Signature: X**_____ **Date:**_____

Patient's Name:_____ **Signature: X**_____ **Date:**_____

Attorney's Name:_____ **Signature: X**_____ **Date:**_____

3RD PARTY LIEN AND ATTORNEY ACKNOWLEDGEMENT AND UNDERSTANDING

I hereby acknowledge that I am receiving (or about to receive) health care services from Dr. Jennifer Wells or Associate Doctor @ Back Country Chiropractic "The Office". I have been advised that the doctor providing services to me is willing to wait for the full and final payment for these services as a courtesy, provided that there continues to be a reasonable chance that payment will be made either by insurance reimbursement or out of the settlement of a liability claim or law suit.

I understand that if it is determined:

1. That there is no insurance company obligated to pay for these services, or if the insurance company involved refuses to acknowledge an assignment to the doctor or make other provisions for the protection of the doctor's charges, OR

2. If a liability claim exists, and my current attorney or any new attorney I may retain at a later date refuses to agree to protest the interest of the doctor by signing a lien agreement, OR

3. If I do not engage the services of an attorney, OR

4. I have made or will make a settlement with the third party for a set amount of treatment and "The Office" can send the bills directly to the 3rd Party carrier.

I agree to pay for all services rendered to me on a current basis and any remaining balance owing on my account will be paid in full as soon as my liability claim is settled or within three months of the date of my last treatment, whichever occurs first. I may be asked to make partial payments on each visit during the course of my care towards my balance due.

If I settle my case with a Third Party, the check for my treatment made by the 3rd Party will have both my name AND "Dr. Jennifer M. Wells" or "Back Country Chiropractic" printed as the recipients OR a check made directly to the office will be made OR the third party will pay the office directly.

Patient's Name:_____ **Date of Injury:**_____

Patient's Signature: X_____ **Date:**_____

Witness Name:_____ **Date:**_____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement binds all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present, or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as to back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.
All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgement for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here **X**_____. Effective as of the date of first professional services.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name:_____ **Signature: X**_____ **Date:**_____

Parent or Guardian:_____ **Signature: X**_____ **Date:**_____

Witness Name:_____ **Signature: X**_____ **Date:**_____

INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use, as a Doctor of Chiropractic, is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Spinal Manipulative Therapy
- Palpatation
- Vital Signs
- Range of Motion Testing
- Orthopedic Testing
- Basic Neurological Testing
- Laser Treatment
- Postural Analysis
- EMS
- Ultrasound
- Hot/Cold Therapy
- Radiographic Studies
- Other (please explain)_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatments. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

1. Self-administered, over-the-counter analgesics and rest
2. Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
3. Hospitalization
4. Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW:

☐ **I have read** or ☐ **have had read to me** the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor of Chiropractic at Back Country Chiropractic and have had my questions answered to my satisfaction. I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at Back Country Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name:_____ **Signature: X**_____ **Date:**_____

Physician's Name:_____ **Signature: X**_____ **Date:**_____

HIPAA NOTICE OF PRIVACY PRACTICES

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 describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our 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, pay your health care bills, to support the operations 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 health care 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 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, marketing, and fund raising activities, and conduction 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 included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you 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.

May we phone, email or send you a text to confirm appointments? ☐ Yes ☐ No

May we leave a message on phone numbers or with any family members? ☐ Yes ☐ No

May we discuss medical condition with any member of your family? ☐ Yes ☐ No

If so, list name(s) of member(s) allowed?_____

_____

Patient Name (print):_____

Signature of Patient, Parent, or Legal Guardian: X_____ **Date:**_____

DUTIES UNDER DURESS SUMMARY

Complete the following summary as it relates to your living and work duties and how the injury(s) are affecting your performance. List the day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. Include those duties/responsibilities which require that you reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your performance.

WORK	**Reason for Difficutly:**	**Duration:**
Job Description:_____		
Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Other:_____	Increased Pain	_____

STUDIES/SCHOOL	**Reason for Difficutly:**	**Duration:**
Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Studying	Increased Anxiety/Pain	_____
Other:_____	Increased Pain	_____

DOMESTIC DUTIES	**Reason for Difficutly:**	**Duration:**
Cleaning	Increased Pain	_____
Vacuuming	Increased Pain	_____
Child Care	Increased Anxiety	_____
Preparing Meals	Increased Pain	_____
Other:_____	Increased Pain	_____

HOUSEHOLD DUTIES	**Reason for Difficutly:**	**Duration:**
Yardwork	Increased Pain	_____
Transportation	Increased Anxiety	_____
Shopping	Increased Pain	_____
Taking Out Trash	Increased Pain	_____
Other:_____	Increased Pain	_____

Patient Name (print):_____ **Date:**_____

LOSS OF ENJOYMENT SUMMARY

Complete the following summary as it relates to your lifestyle, work environment and activities which you normally would be enjoying, but are currently not enjoying, as a result of the motor vehicle collision. Include all areas which you have had to reduce the time you are capable of experiencing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your participation in any of the following areas:

WORK	**Reason for Difficutly:**	**Duration:**
Job Description:_____		
Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Other:_____	Increased Pain	_____

STUDIES/SCHOOL	**Reason for Difficutly:**	**Duration:**
Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Studying	Increased Anxiety/Pain	_____
Other:_____	Increased Pain	_____

DOMESTIC DUTIES	**Reason for Difficutly:**	**Duration:**
Cleaning	Increased Pain	_____
Vacuuming	Increased Pain	_____
Child Care	Increased Anxiety	_____
Preparing Meals	Increased Pain	_____
Other:_____	Increased Pain	_____

HOUSEHOLD DUTIES	**Reason for Difficutly:**	**Duration:**
Yardwork	Increased Pain	_____
Transportation	Increased Anxiety	_____
Shopping	Increased Pain	_____
Taking Out Trash	Increased Pain	_____
Other:_____	Increased Pain	_____

SPORTS	**Reason for Difficutly:**	**Duration:**
Social	_____	_____
Competitive	_____	_____
Regional	_____	_____
Other:_____	_____	_____

Patient Name (print):_____ **Date:**_____