Dunns Corners Chiropractic Center 259 Post Road Westerly, RI 02891
Robert C. Campbell, D.C., D.A.C.N.B. Phone 401-322-8822, Fax 401-322-9191

Personal Injury Insurance Information

Name _____ DOB: _____ Accident Date_____

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

Address_____ City_____ State_____ Zip _____

Employer: _____ Occupation: _____

Name of wife/husband/significant other: _____

Referred by:_____ Newspaper___ Yellow Pages_____ Internet_____ Self_____

Nearest relative not living with you:_____ Phone: _____

Preferred method of appointment reminder ____text____email Permission to leave messages: ____home____cell

Attorney Information

Name:_____Phone:_____

Address:_____

Auto Insurance Information

Company_____

Policy #:_____

Claim #:_____

Phone #: _____

Adjuster:_____

Address_____

_____

Other Party's Insurance Information

Company_____

Policy #:_____

Claim #: _____

Phone #:_____

Adjuster:_____

Address_____

_____

---

1. What was the date of the accident?_____
2. What time did the accident occur?_____
3. How many vehicles were involved in the accident?_____
4. What was the estimated damage to the vehicle you were in? _____
5. What state did the accident occur in? _____
6. What city did the accident occur in? _____
7. What street or intersection were you on when the accident occured?

_____

8. What direction were you traveling in?

_____

9. What type of impact was the auto accident? _____

10. Did your vehicle hit anything after the accident? if yes, please describe

_____

11. Where were you sitting in the vehicle during the accident?

_____

12. Did you know the accident was coming?_____

13. What type of vehicle were you in? _____

14. What type of vehicle impacted yours? _____

15. At the time of the impact, how fast was your vehicle moving? _____

16. At the time of impact, how fast was the other vehicle moving? _____

17. During and after the crash what happened to your vehicle? (circle all that apply)
- kept going straight
- kept going straight hitting a car in front
- was hit by another vehicle
- spun around
- spun around and hit a stationary object
- hit a stationary object

18. Did you lose consciousness during the accident? -yes - no

19. How was your head positioned during the accident? _____

20. How was your torso positioned during the accident? _____

21. How were your hands positioned during the accident? _____

22. Did your head hit anything during the accident? -no - yes, please describe_____

23. Did your face hit anything during the accident? -no - yes, please describe_____

24. Did your shoulders hit anything during the accident? -no - yes, please describe_____

25. Did your neck hit anything during the accident? -no - yes, please describe_____

26. Did your chest hit anything during the accident? -no - yes, please describe_____

27. Did your hips hit anything during the accident? -no - yes, please describe_____

28. Did your knees hit anything during the accident? -no - yes, please describe_____

29. Did your feet hit anything during the accident? -no - yes, please describe_____

30. What kind of headrest was in your vehicle?
- movable fixed headrest
- nonmovable fixed headrest
- no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? - yes -no

33. Did you slide out of your seatbelt during the accident? _____

34. What was damaged in your vehicle? (Circle all that apply)
- windshield - rear bumper - mirror
- steering wheel - front bumper - knee bolster
- dashboard - trunk - back right door
- seat frame - front left door - completely totalled
- side window - front right door
- rear window - back left door

35. Choose the items that dented inward
- floorboards - side door - dashboard

36. Choose the doors that would not open as a result of the accident
- front left - front right
- rear left - rear right

37. Did you go to the hospital? If no, why and do not answer 38-43
_____

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized over night? _____

41. Circle what you were prescribed at the hospital
- pain medication - muscle relaxors - neck brace

42. Did you recieve any stitches for any cuts at the hospital? _____

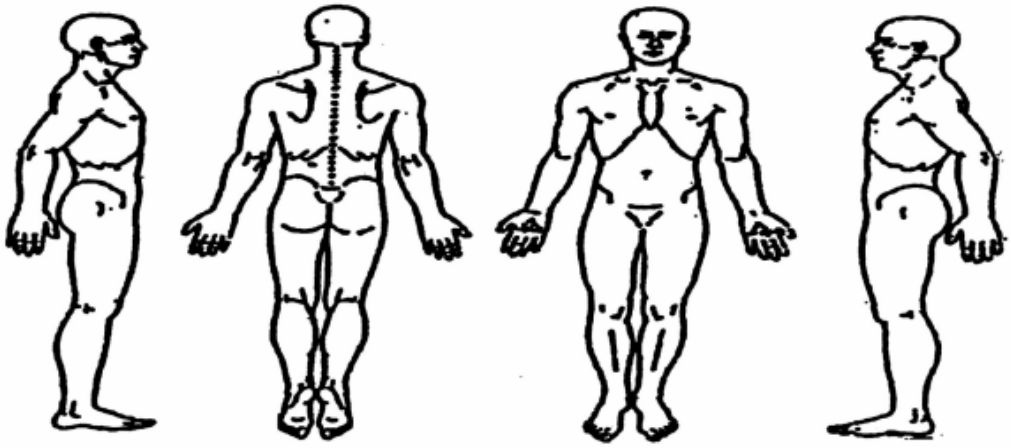
43. Were x rays taken at the hosiptal? If yes, which area was taken?
_____

Dunns Corners Chiropractic Center
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb □ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician □ Orthopedist
□ Other:_____ □ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ **Weight** _____ **Date of Birth** _____
Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain		□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite		**For Females Only**
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

The Oswestry Disability Index for Back Pain

This questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life activities. Please answer every section, and mark in each section the one box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your present day situation.

Section 1. Pain Intensity

_____A. My pain is mild to moderate. I do not need pain killers
_____B. The pain is bad, but I manage without taking painkillers
_____C. Pain killers give me complete relief from pain
_____D. Pain killers give me moderate relief from pain
_____E. Pain killers give me very little relief form pain.
_____F. Pain killers have no effect on the pain.

Section 2 Personal Care

_____A. I can look after myself normally without causing extra pain.
_____B. I can look after myself normally but it causes extra pain.
_____C. It is painful to look after myself and I am slow and careful.
_____D. I need some help but manage most of my personal care.
_____E. I need help every day in most aspects of self-care.
_____F. I do not get dressed, I wash with difficulty and stay in bed.

Section 3. Lifting

_____A. I can lift heavy weights without causing extra pain.
_____B. I can lift heavy weights but it gives me extra pain.
_____C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
_____D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
_____E. I can lift very light weights.
_____F. I cannot lift or carry anything at all.

Section 4. Walking

_____A. I can walk as far as I wish.
_____B. Pain prevents me from walking more than 1 mile.
_____C. Pain prevents me from walking more than ½ mile.
_____D. Pain prevents me from walking more than 1/4 mile.
_____E. I can walk only if I use a cane or crutches.
_____F. I am in bed or in a chair for most of the day.

Section 5. Sitting

_____A. I can sit in any chair for as long as I like.
_____B. I can sit in my favorite chair only, but for as long as I like
_____C. Pain prevents me from sitting for more than 1 hour.
_____D. Pain prevents me from sitting for than ½ hour.
_____E. Pain prevents me from sitting for more than 10 minutes.
_____F. Pain prevents me from sitting at all.

Section 6. Standing

_____ A. I can stand as long as I want without extra pain.
_____ B. I can stand as long as I want but it gives me extra pain.
_____ C. Pain prevents me from standing for more than 1 hour.
_____ D. Pain prevents me from standing for more than ½ hour.
_____ E. Pain prevents me from standing for more than 10 minutes.
_____ F. Pain prevents me from standing at all.

Section 7. Sleeping

_____ A. Pain does not prevent me from sleeping well.
_____ B. I sleep well but only when taking medicine.
_____ C. Even when I take medication, I sleep less than 6 hours.
_____ D. Even when I take medication, I sleep less than 4 hours.
_____ E. Even when I take medication, I sleep less than 2 hours.
_____ F. Pain prevents me from sleeping at all.

Section 8. Social Life

_____ A. My social life is normal and causes me no extra pain.
_____ B. My social life is normal, but increases the degree of pain.
_____ C. Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
_____ D. Pain has restricted my social life and I do not go out as often.
_____E. Pain has restricted my social life to my home.
_____F. I have no social life because of pain.

Section 9. Sexual Activity

_____A. My sexual activity is normal and causes no extra pain.
_____B. My sexual activity is normal, but causes some extra pain.
_____C. My sexual activity is nearly normal, but it is very painful.
_____D. My sexual activity is severely restricted by pain.
_____E. My sexual activity is nearly absent because of pain.
_____F. Pain prevents any sexual activity at all.

Secrion 10. Traveling

_____A. I can travel anywhere without extra pain.
_____B. I can travel anywhere, but it gives me extra pain.
_____C. Pain is bad, but I manage journeys over 2 hours.
_____D. Pain restricts me to journeys of less than 1 hour.
_____E. Pain restricts me to necessary journeys under ½ hour.
_____F. Pain prevents traveling except to the doctor/hospital.

Patient Name:_____

Date:_____ Score_____ _____

Signature

NECK DISABILITY INDEX

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 – Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – Reading

- ☐ I can read as much as I want with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all due to pain.

SECTION 5 – Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

Date:_____

File #:_____

_____

Name

SECTION 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7 – Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can not do any work at all.

SECTION 8 – Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car at all.

SECTION 9 – Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Dunns Corners Chiropractic Center

Robert C. Campbell, D.C., D.A.C.N.B.
259 Post Road
Westerly, Rhode Island 02891

Phone: (401)322-8822
Fax: (401)322-9191
www.dunnscornerschiro.com

Privacy Policy

1. All patient information is confidential.

2. Every attempt will be made to respect confidentiality when communicating with patients.

3. Patients will be informed of this policy upon entering the practice, and then yearly thereafter.

4. It is our policy to release patient information to other providers only with written Patient consent.

5. Only patients themselves may call for test results unless they have authorized us to give information to family members.

6. Employees will review this policy upon hiring, and then yearly thereafter.

Dear Patient,
Our sign in sheet is in open site, allowing the possibility for others entering the office to see your name. If you do not want to sign in, please let the receptionist know so we can make other arrangements.

At times the office may need to contact you regarding exam results, insurance claims, or appointment confirmation. If we call you and you are not available.

May we leave a message on an answering machine at home? Yes____ No____

May we leave a message on an answering machine at work? Yes____ No____

May we leave a message with a family member? Yes____ No____

May we leave a message with a co-worker? Yes____ No____

If yes, name of person_____

Please indicate the best telephone number for us to reach you:_____

Patient Signature:_____

Please Print Name:_____Date:_____

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov
We have adopted the following policies:

1. Patient information will be kept confidential except as in necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-Mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date:_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in the policy. I understand that this consent shall remain in force from this time forward.

Dunns Corners Chiropractic Center

Robert C. Campbell, D.C., D.A.C.N.B.
259 Post Road
Westerly, Rhode Island 02891

Phone: (401)322-8822
Fax: (401)322-9191
www.dunnscornerschiro.com

BLANKET AUTHORIZATION/RELEASE FORM

___ **Insurance Assignment –** I authorize payment of medical benefits from _____ insurance company to be paid directly to: Robert C. Campbell, D.C., D.A.C.N.B., for services rendered to me. If my current policy prohibits the direct payment to the doctor, then I also instruct and direct you to make out the check to me and mail it to our office. I also acknowledge that all services rendered to me are ultimately my financial responsibility. I agree to pay any balance that remains after my insurance company has made payment, and any unpaid balance that remains 60 days after services are rendered.

____ **Cash Policy** – I do not have insurance benefits available and agree to pay for all services rendered to me, at the time they incur, unless otherwise agreed to in the form of a financial payment contract.

____ **Records Release** – I hereby authorize the release of my x-rays and medical records from any medical provider, hospital, attorney or insurance company upon receipt of a copy of this form, to Dunn's Corners Chiropractic Center. SPECIFIC REQUEST FOR RECORDS FROM_____

____ **Authorize to Release Information** – I authorize your office to release any information you deem appropriate concerning my condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me in this chiropractic office. I hereby release you from any consequences thereof.

____ **Pregnancy Release** – To the best of my knowledge I am not pregnant. I understand that x-ray radiation may pose risks to an unborn child. I consent to having x-rays taken, and I release Dr. Robert Campbell, and the office from any responsibility that could in any way associate damage to an unborn child with the x-ray examination. If you have any concerns, please consult the doctor.

____ **Termination of Care Waiver** – I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my attending chiropractor, I cannot expect maximum chiropractic results and the doctor has full and complete right to terminate my case and discharge me from care.

____ **Consent to Treat a Minor** – I hereby give my consent for Dr. Robert Campbell to examine and render treatment to my son/daughter_____
who is a minor.

I have read the above blanket authorization/release form and agree to the _____ items checked off.

_____ _____
Patient Name (print) Patient/Guardian Signature

Date: _____ Witness:_____

Dunn's Corners Chiropractic Center

Robert C. Campbell, D.C., D.A.C.N.B.
259 Post Road
Westerly, Rhode Island 02891

Phone: (401)322-8822
Fax: (401)322-9191
www.dunnscornerschiro.com

Notice of Doctor's Lien

To:_____

Patient;_____

Date of Accident:_____

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself with regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office to withhold such sum from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. I hereby further give a Lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and that said payment is not contingent upon any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the protecting the doctors interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated:_____ Patient's Signature_____

The undersigned being the attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named.

Dated:_____ Attorney's Signature_____

Attorney: Please date, sign and return one copy to doctor's office.

Dunn's Corners Chiropractic Center

Robert C. Campbell, D.C., D.A.C.N.B.
259 Post Road
Westerly, Rhode Island 02891

Phone: (401)322-8822
Fax: (401)322-9191
www.dunnscornerschiro.com

3rd Party Medical Lien and Assignment

Patient:_____
Claim #:_____
Date of Injury:_____

I hereby authorize and direct _____Insurance Company, to pay to Dr. _____ such sums as may be due and owing him/her for medical/chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and full compensate said doctor. And I hereby further request that payment be made directly to said doctor which would otherwise be paid to myself, as the result of the treatment charges incurred for injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for services rendered me and that this agreement is made solely for said doctor's protection and in consideration of his/her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if you do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable by me.

_____ _____
Date Patient's Signature

The undersigned insurance company does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said doctor above and below named and make payment payable directly to said doctor.

_____ _____
Date Signature of Insurance Company Representative

_____
Print First and Last Name

_____
Insurance Company Name

Please date, sign and return one copy to the doctor's office below. Also, keep one copy for your records.

Dunn's Corners Chiropractic Center_____

259 Post Road_____
Address
Westerly, Rhode Island 02891_____