NEW PATIENT PERSONAL QUESTIONNAIRE (PIP)

Name:_____ Today's Date:_____
Street:_____
City:_____State:_____Zip:_____
SSI #:_____-_____-_____
Home Phone:_____Cell Phone:_____
Work Phone:_____Email:_____
Marital Status:_____Spouses Name:_____
Occupation(s):_____
Employer:_____
Date of Birth:_____Age:_____ Male/ Female/ Other (Circle)

Insurance Carrier:_____Policy Number:_____
Group/Claim Number:_____Name of Primary Insured:_____

Please describe your primary complaint. Use back of sheet if needed:
_____
_____
_____
_____

Is there anything else related to your health that you would like the Dr to know?
_____
_____
_____
_____

FILL OUT ONLY FOR INJURY RELATED TO CAR A ACCIDENT:
Insurance carrier for vehicle you were in:_____
Date of Accident:_____Policy No.:_____Claim No. if Reported:_____
Driver of Vehicle if you were a passenger:_____
Have you retained an attorney?_____
Name and phone of Insurance Adjuster:_____
Name and phone of Attorney:_____

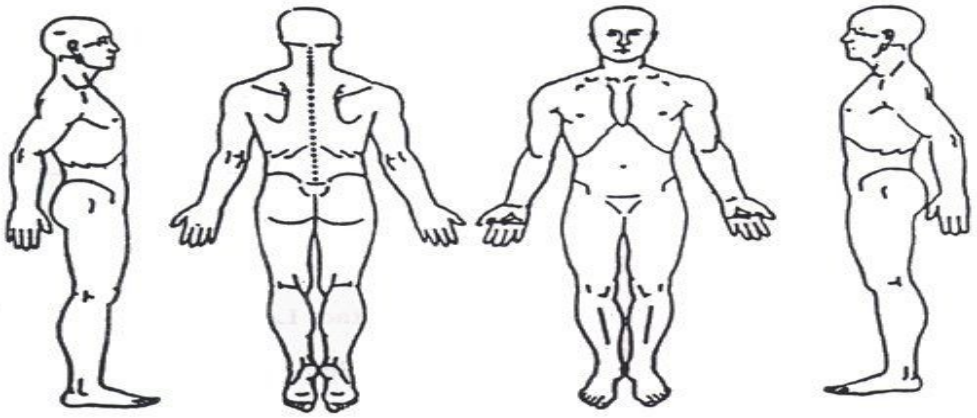
FILL OUT ONLY FOR WORK-RELATED INJURY:
Date of Accident:_____Was it reported? Yes/ No (Circle)
Name of Employer:_____
Did you stay at work? Yes/ No (Circle) If no, when did you return to work?_____
Name and Phone of Supervisor etc:_____
Did you consult a physician? Yes/ No (Circle) If yes, name and specialty of Doctor:
_____
Did you retain an attorney? Yes/ No (Circle) If yes, name and phone:_____
Have you ever had Worker's Comp. Claim before? Yes/ No (Circle) If so, when?_____

Patient Intake Form

Patient Name:_____Date:_____

1. Is today's problem caused by: Auto Accident or Worker's Compensation **(Circle)**

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



3. How often do you experience your symptoms? **(Circle)**

* Constantly(75-100% of the time)
* Occasionally(25-50% of the time)
* Frequently(50-75% of the time)
* Intermittently(0-25% of the time)

4. How would you describe the type of pain?

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

5. How are your symptoms changing with time **(Circle):**

* Getting Worse
* Staying the Same
* Getting Better

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

0 1 2 3 4 5 6 7 8 9 10

7. How much has the problem interfered with your work **(Circle)** ?

* 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 about this problem **(Circle)** ?

* 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 this problem began?_____

12. Do you consider this problem to be severe? **(Circle)**

* Yes * Yes, at times * No

13. What aggravates your and what alleviates your problem(s)?

Aggravates:_____

Alleviates:_____

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:_____

16. How would you rate your overall health**(Circle)** :

* Excellent * Very Good * Good * Fair * Poor

17. What type of exercise do you do? **(Circle)**

* Strenuous * Moderate * Light * None

18. Indicate if you have any immediate family members with any of the following **(Circle)** :

* Rheumatoid Arthritis * Diabetes * Lupus

* Heart Problems * Cancer * ALS

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

Past:	Present:	Past:	Present:	Past:	Present:
*	* Headaches	*	* High Blood Pressure	*	* Diabetes
*	* Neck Pain	*	* Heart Attack	*	* Allergies
*	* Upper Back Pain	*	* Chest Pain	*	* Smoking
*	* Mid Back Pain	*	* Stroke	*	* Drinking
*	* Lower Back Pain	*	* Angina	*	* Drug use
*	* Shoulder Pain	*	* Kidney Stones	*	* Depression
*	* Elbow/Upper Arm Pain	*	* Kidney Disorder	*	* Lupus
*	* Wrist Pain	*	* Bladder Infection	*	* Epilepsy
*	* Hand Pain	*	* Painful Urination	*	* HIV
*	* Hip Pain	*	* Loss of Bladder Control	*	* AIDS
*	* Upper Leg Pain	*	* Prostate Problems	*	* Pregnancy
*	* Knee Pain	*	* Abnormal Weight Gain/Loss	*	* Other:_____
*	* Ankle/Foot Pain	*	* Loss of Appetite		
*	* Jaw Pain	*	* Abdominal Pain		
*	* Joint Pain/Stiffness	*	* Ulcer		
*	* Arthritis	*	* Hepatitis		
*	* Rheumatoid Arthritis	*	* Liver/Gall Bladder Disorder		
*	* Cancer	*	* General Fatigue		
*	* Tumor	*	* Muscular Incoordination		
*	* Asthma	*	* Visual Disturbances		
*	* Chronic Sinusitis	*	* Dizziness		
*	* Birth Control Pills	*	* Hormonal Replacement		

20. Do you have a Pacemaker or any electrical device?_____

21. When was you last medical check up?_____

22. what activities do you do at work most days?

Sit:	* Most of the day	* Half of the day	* A little of the day
Stand:	* Most of the day	* Half of the day	* A little of the day
Computer Work:	* Most of the day	* Half of 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 had significant past trauma? Yes or No**(Circle)**

If yes, specify incident:_____

26. Anything else pertinent to your visit today?_____

27. Did you receive chiropractic care before?_____

Patient Signature_____Date:_____

Neck Index

Patient Name:_____Date:_____
Signature:_____

This questionnaire will give your provider information about how you neck condition affects your everyday life. Please answer every section by circling the one statement that applies to you. If two or more statements in one section apply, please circle the one statement that most clearly describes your problem.

Pain Intensity

0. I have pain at the moment.
1. The pain is very mild at the moment.
2. The pain comes and goes and it moderate.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment
5. The pain is the worst imaginable at the moment.

Sleeping

0. I have no trouble sleeping.
1. My sleep is slightly disturbed.
2. My sleep is mildly disturbed.
3. My sleep is moderately disturbed.
4. My sleep is greatly disturbed.
5. My sleep is completely disturbed.

Reading

0. I can read as much as I want without neck pain.
1. I can read as much as I want with slight neck pain.
2. I can read as much as I want with moderate neck pain.
3. I cannot read as much as I want because of moderate neck pain.
4. I can hardly read at all because of sever neck pain.
5. I cannot read at all because of neck pain.

Concentration

0. I can concentrate fully with no difficulty.
1. I can concentrate fully with slight difficulty.
2. I have fair degree of difficulty concentrating.
3. I have a lot of difficulty concentrating.
4. I have a great deal of difficulty concentrating.
5. I cannot concentrate at all.

Work

0. I can work as much as I want.
1. I can only do my usual work but no more.
2. I can only do most of my usual work.
3. I cannot do any of my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

Personal Care

0. I can look after myself without causing extra pain.
1. I can look after myself but it causes pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help but I manage most of my personal care.
4. I need help everyday in most aspects of self care.
5. I do not get dressed, I wash with difficulties and stay in bed.

Lifting

0. I can lift heavy weights without pain.
1. I can lift heavy weights but it causes pain.
2. Pain prevents me from lifting weights unless conveniently placed.
3. Pain prevents me from weights unless light conveniently placed.
4. I can only lift very light weights.
5. I cannot lift or carry anything at all.

Driving

0. I can drive without any neck pain.
1. I can drive my car as long as I want with slight neck pain.
2. I can drive my car as long as I want with moderate neck pain.
3. I cannot drive my car as long as I want because of moderate pain.
4. I can hardly drive at all because of sever neck pain.
5. I cannot drive my car at all because of neck pain.

Recreation

0. I am able to engage in all my recreation without pain.
1. I am able to engage in all my recreation with some pain.
2. I am able to engage in most but not all recreation because of pain.
3. I am able to engage in few of my usual activities because of pain.
4. I can hardly do any activities because of neck pain.
5. I cannot do any recreation activities at all.

Headaches

0. I have no headaches at all.
1. I have slight headaches which come infrequently.
2. I have moderate headaches which come infrequently.
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently.
5. I have headaches almost all of the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score:_____

SIGN:_____

Back Index

Patient Name:_____Date:_____
Signature:_____

This questionnaire will give your provider information about how you back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please circle the one statement that most clearly describes your problem.

Pain Intensity

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain comes and goes and is moderate.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

Sleeping

0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is completely disturbed (5-7 hours sleepless).

Sitting

0. I can sit in any chair as long as I like.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minuets.
5. I avoid sitting because it increases pain immediately.

Standing

0. I can stand as long as I want without pain.
1. I have pain while standing but it doesn't increase with time.
2. I cannot stand for longer than 1 hour without pain.
3. I cannot stand for longer than ½ hour without pain.
4. I cannot stand for longer than 10 minuets without pain.
5. I avoid standing because it increases pain immediately.

Walking

0. I have no pain while walking.
1. I have pain while walking but it doesn't increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Personal Care

0. I do not have to change my way of personal care in order to avoid pain.
1. I do not normally change my personal care even though it causes pain.
2. Personal care increases the pain but I manage not to change my routine.
3. Personal care increases pain and it is necessary to change my routine.
4. Because of pain I am unable to do some personal care without help.
5. Because of pain I am unable to do any personal care without help.

Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it causes pain.
2. Pain prevents me from lifting heavy weights from floor.
3. Pain prevents me from lifting unless light or conveniently placed.
4. I can only lift very light weights.
5. I cannot lift or carry anything at all.

Traveling

0. I get no pain while traveling.
1. I get pain while traveling but it doesn't make any of my travels worse.
2. I get pain while traveling but it doesn't prevent me from travel.
3. I get pain while traveling which causes me to seek other forms of travel.
4. Pain restricts all form of travel except that done while lying down.
5. Pain restricts all from of travel.

Social Life

0. My social life is normal and gives me no extra pain.
1. My social life is normal but increases my pain.
2. Pain has no affect on my life apart from limiting more active interests.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of my pain.

Changing Degree of Pain

0. My pain is getting better.
1. My pain fluctuated but overall is definitively getting better,
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score:_____

SIGN:_____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays and/or other tests on me (or the patient named below, for whom I am legally responsible) by the doctor or chiropractor named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back up for the doctor or chiropractor named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatments of my condition.

Dr. Michael Spinelli Dr. Vimarelis Rivera Contes

_____ _____

Patient Signature-or signature of Patient's Representative Date

Print Patient Name _____

ACKNOWLEDGMENT OF RECEIPT
NOTICES OF PRIVATE PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders by:
Mail:_____;
Email:_____; at email address
_____;
Telephone numbers:_____;
_____;
By voice mail:_____;
By text message:_____;
By Facebook address:_____;

By checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by:
Mail:_____;
Email:_____; at email address
_____;
Telephone numbers:_____;
_____;
By voice mail:_____;
By text message:_____;
By Facebook address:_____;

By checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition.

Date:_____

Patient Name(Print):_____

Name of Parent, Guardian or Patients Legal Representative:

_____

Signature of Patient, Parent, Guardian or Patients Legal Representative:

_____

<u>This Form Will Be Placed In The Patient's Chart And Maintained For Six Years.</u>

List below the names and relationship of people to whom you authorize the practice to release PHI.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature:_____

Print Name:_____

Date:_____ **Date of Birth:**_____

Open Room Policy Patient Acknowledgment

Open Room: We utilize an open therapy room. We make good faith attempts to keep conversations at a low level. We offer every patient the opportunity to be treated in a private room if requested.

Signature:_____

Date:_____

Medication List

Name:_____Date of Birth:_____Date:_____

Please list all medications and what they are used for:
Medications/ Vitamins:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

List all surgeries or procedures with date it was completed:

1._____
2._____
3._____
4._____
5._____

List any current or past health conditions:

1._____
2._____
3._____
4._____
5._____

Did you have any of the following? If yes, please state when?

- Medical exam_____
- Colonoscopy_____
- Cardiac exam_____
- Pacemaker_____
- GYN (Female)_____
- Bone density_____
- Prostate(Male)_____
- Spinal Xrays_____
- MRI'S_____
- Chiropractic adjustment_____

Name:_____Date of Birth:_____Date:_____

Signature:
X._____

Motor Vehicle Collision Form

Patient's Name:_____ Date:____/_____/_____

1) **Date of the Auto Accident: _____/_____/_____**

2) **Time of the Accident: _____:_____ am / pm**

3) **Number of vehicles involved in the accident: _____**

4) **What road/City/State were you traveling? _____**

5) **What direction were you traveling in? _____**

6) **As a result of the accident were traffic citations issued to you/other car? _____**

7) **Please choose the primary type of impact (circle all that apply):**
   Behind Left Side Right Side Front

8) **Where were you sitting in the vehicle?**
   Driver Passenger Pedestrian

9) **Did you know the accident was coming? _____**

10) **At the time of impact, your vehicle was (circle all that apply):**
    Slowing down Gaining speed Stopped Moving at a steady speed

11) **During and after the crash, what happened to your vehicle: _____**

12) **Did you lose consciousness during the accident? Yes No**

13) **How was your head positioned during the accident? _____**

14) **How was your torso positioned during the accident? _____**

15) **How were your hands positioned during the accident? _____**

16) **Did your head or any other bodily part hit any of the following (circle all that apply)?**
    Windshield Steering wheel Side door Dashboard Ceiling
    Seat Other:_____

17) **Did you have your seat belt on? Yes No**

17A) **Was your airbag deployed? Yes No**

18) Were Police/EMT's on scene of the accident? Yes No

19) Did you go to the hospital? Yes No

20) Name of hospital: _____

21) How did you go to the hospital? _____

22) Were you hospitalized overnight? Yes No

23) At the hospital, were you prescribed pain medication? Yes No

24) At the hospital, were you prescribed muscle relaxers? Yes No

25) Did you receive stitches for any cuts? Yes No

26) Did you receive any of the following (circle all that apply)?
Cervical Collar Back Brace

27) Were x-rays taken at the hospital? Yes No

28) Was an MRI performed? Yes No

29) Did you receive any other special imaging? Yes No

30) Have you lost any days from work? Yes No If so how many? _____

31) Since the accident have you noticed any of the following symptoms (circle all that apply)?

Headaches	Neck Pain	Neck Stiff
Tension	Back Pain	Sleeping problem
Shortness of breath	Irritability	Dizziness
Head feels heavy	Ears ring	Fainting
Pins & Needles in arms	Nervousness	Hands cold
Pins & Needles in legs	Feet cold	Numbness
Light bothers eyes	Face flushed	Fatigue
Buzzing in ears	Constipation	Cold sweats
Loss of smell	Diarrhea	Fever
Loss of balance	Stomach upset	Loss of memory

Other Symptoms:_____

Patient Signature: _____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS, LIEN, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally irrevocably assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (hereinafter PIP), Uninsured Motorist and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. This assignment of benefits includes transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I as he named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Lien: I, the undersigned patient guarantee full payment to Butterfly Family Chiropractic and agree that I will remain personally responsible for unpaid charges as a result of any deductible, co-payment, and treatment after benefits are exhausted and/or for any other treatment/service that remains unpaid. Furthermore, I grant Butterfly Family Chiropractic a lien against any recovery, which I may have against any tortfeasor, responsible party, or any responsible insurance carrier. I direct my attorney to withhold any funds I receive from any settlement to pay for any outstanding balance to Butterfly Family Chiropractic. I agree to and instruct my attorney to promptly advise Butterfly Family Chiropractic of any settlement as a result of the injuries sustained in the _____(Date) motor vehicle accident, slip-n-fall, or motorcycle accident. Additionally, I agree and instruct my attorney that I will not accept any settlement check until the remaining balance is resolved with Butterfly Family Chiropractic.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of the Medicare Fee Schedule or any other fee schedule contained within F.S. 627.736 then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office/billing manager and mailed to the attention of the office/billing manager. *See Fla. Stat. §673.3111*.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; and for my insurance carrier to **send insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically to the above-named provider**; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission. **PLEASE NOTE: The insurer is not authorized to release protected health information (PHI) to third party vendors that schedule independent medical examinations or independent medical examination physicians**.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet, and the insurance policy to the above provider within 15 days, as well as notify the provider pursuant to F.S. 627.736(6)(f) when benefits have been exhausted. The insurer is directed to pay the bills in the order they

are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. The insurer is instructed to inform, in writing, the provider of any dispute.

Caution: Please read before signing. **If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above. I certify that I have read and agree to all of the above and was not solicited or promised anything in exchange for receiving health care. I agree that the prices for the medical care is reasonable.**

Patient's Name _____ Patient's Signature _____
(Please Print) (If patient is a minor, signature of parent/guardian)

Date _____