Welcome to our office!

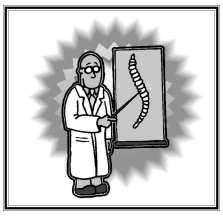
We hope your first visit with us is a pleasant one. These are the procedures you can expect over today's and your follow-up visit.

BAC TO HEALTH
CHIROPRACTIC GROUP
9730 Wilshire Boulevard
Suite 109
Beverly Hills, CA 90212
t: 310.888.8762
f: 310-888-0145

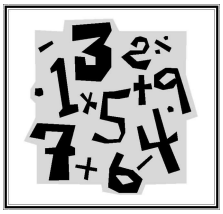
Paperwork
Complete this questionnaire to help us get to know you. The doctor will use this information to help formulate the recommendations for your care.

Consultation
You'll meet with the doctor who will discuss your case and determine if yours is a chiropractic condition.

Examination
Standard orthopedic, neurologic and chiropractic tests will be performed by the doctor to determine the cause of your problem. If necessary, X-Rays may be taken to further diagnose your condition.



Report of Findings
On your second visit, the doctor will explain what was uncovered by your examinations, if chiropractic can help, and how long it may take.



Treatment Plan
The doctor will outline a specific plan to address your problem including the frequency and duration of treatment.

Adjustments
The doctor will use carefully directed and controlled pressure to help restore bones to their proper position and motion- the key to reducing nervous system irritation.

Home Exercises
Once appropriate, the doctor will start you on a home stretching and strengthening plan.

Questions
We love questions, so ask anytime! Make sure you understand what we're doing and why.

BAC TO HEALTH
CHIROPRACTIC GROUP

OFFICE USE ONLY Doctor: Patient Number: Date:

Name _____ Address _____

City _____ State _____ Zip _____ Home ph _____ Cell ph _____

E-mail _____ SSN _____ Date of birth _____

Age _____ Height _____ Weight _____ Whom may we thank for referring you?_____

Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ # of children _____ Name of spouse (or parent) _____

Employer _____ Address _____

City _____ State _____ Zip _____ Wk ph _____ Occupation _____

Have you ever had Chiropractic care before? _____ If yes, when? _____

If you are experiencing any health problems, please list your chief complaints in order of severity (pain, symptoms, etc.)

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

Has this problem been getting worse or staying the same? _____

Currently or in the past have you ever experienced any of these complaints while working? _____ If yes, please describe what activities at work that may be causing you to experience these complaints: _____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? _____ If yes, please explain:

_____

Have you at any time in the past ever suffered a work injury? ____ If yes, what is the date of injury? _____ _____

Have you been involved in an auto accident in the last 12 months? __ yes __ No If yes, what is the date of the auto accident? _____

How many other passengers were in the car with you? _____

List other doctors consulted for these conditions: 1. _____ 2. _____

If due to an auto accident what is the name of your auto insurance company? _____ _____

Policy Holder Name _____ Claims address _____

Policy Number _____ Telephone Number _____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

Please list any injuries or illnesses that you have had that are not listed above: _____

Please indicate medications (over the counter) / prescriptions you are currently taking: ☐ Aspirin/Tylenol ☐Pain killers ☐Muscle Relaxers ☐Insulin ☐Tranquilizers ☐Birth Control Pills ☐Others _____

Health Insurance Co. Name _____ Policyholder _____

Name of Spouse's health insurance (If applicable) _____ Policyholder _____

Spouse's Health Insurance Claims address _____ Policy number _____

Confidential Information

Please check all present symptoms:

HEAD:

Headache
- ❑ Sinus (allergy)
- ❑ Entire head
- ❑ Back of head
- ❑ Forehead
- ❑ Temples
- ❑ Migraine

❑ Head feels heavy
❑ Loss of memory
❑ Light-headedness
❑ Fainting
❑ Light bothers eyes
❑ Blurred vision
❑ Double vision
❑ Loss of vision
❑ Loss of taste
❑ Loss of balance
❑ Dizziness
❑ Loss of hearing
❑ Pain in ears
❑ Ringing in ears
❑ Buzzing in ears

NECK:

❑ Pain in neck
❑ Neck pain with movement
- ❑ Forward
- ❑ Backward
- ❑ Turn to left
- ❑ Turn to right
- ❑ Bend to left
- ❑ Bend to right

❑ Pinched nerve in neck
❑ Neck feels out of place
❑ Muscle spasms in neck
❑ Grinding sounds in neck
❑ Popping sounds in neck
❑ Arthritis in neck

ARMS AND HANDS:

❑ Pain in upper arm
❑ Pain in elbow
❑ Movement aggravated
❑ Tennis elbow
❑ Pain in forearm
❑ Pain in hands
❑ Pain in fingers
❑ Sensation of pins and needles in arms
❑ Sensation of pins and needles in fingers
❑ Numbness in arms (R-L)
❑ Fingers go to sleep
❑ Hands cold
❑ Swollen joints in fingers
❑ Sore joints in fingers
❑ Arthritis in fingers
❑ Loss of grip strength

SHOULDERS:

❑ Pain in shoulder joint (R-L)
❑ Pain across shoulders
❑ Bursitis (R-L)
❑ Arthritis (R-L)
❑ Can't raise arm
- ❑ Above shoulder level
- ❑ Over head

❑ Tension in shoulders
❑ Pinched nerve in shoulder (R-L)
❑ Muscle spasms in shoulder

MIDBACK:

❑ Mid-back pain
❑ Location: _____
❑ Pain between shoulder blades
❑ Sharp stabbing
❑ Dull ache
❑ Pain from front to back
❑ Muscle spasms
❑ Pain in the kidney area

CHEST:

❑ Chest pains
❑ Shortness of breath
❑ Pain around ribs
❑ Breast pain
❑ Dimpled or orange peel breast
❑ Irregular heartbeat

ABDOMEN:

❑ Nervous stomach
❑ Foods can't eat _____
❑ Nausea
❑ Gas
❑ Constipation
❑ Diarrhea
❑ Hemorrhoids

LOWER BACK:

❑ Low back pain
❑ Sacroiliac
❑ Low back pain worse when:
- ❑ Working
- ❑ Lifting
- ❑ Stooping
- ❑ Standing
- ❑ Sitting
- ❑ Bending
- ❑ Coughing
- ❑ Lying down (sleeping)
- ❑ Walking

❑ Pain relieved when_____ _____
❑ Slipped disc
❑ Low back feels out of place
❑ Muscle spasms
❑ Arthritis

HIP, LEG, AND FEET:

❑ Pain in buttocks
❑ Pain in hip joint
❑ Pain down leg
❑ Pain down both legs
❑ Knee pain
- ❑ Inside
- ❑ Outside

❑ Leg cramps
❑ Cramps in feet
❑ Pins and needles in legs
❑ Numbness of legs
❑ Numbness of toes
❑ Feet feel cold
❑ Swollen ankles
❑ Swollen feet

WOMEN ONLY:

❑ Menstrual pain _____
❑ Cramping
❑ Irregularity
❑ Cycle _____days
❑ Birth control
❑ Hysterectomy
❑ Genital cancer
❑ Discharge
❑ Menopause
❑ Tumors
❑ Abortions
❑ Pregnant

MEN ONLY:

❑ Urinary frequency_____
❑ Difficulty in starting
❑ Night urination
❑ Prostate pain/swelling

GENERAL:

❑ Nervousness
❑ Irritable
❑ Depressed
❑ Fatigue
❑ Generally feel run-down
❑ Normal sleep hrs/night
❑ Loss of sleep hrs/night
❑ Loss of weight_____lbs.
❑ Gain of weight_____lbs.
❑ Coffee_____ cups/day
❑ Tea_____ cups/day
❑ Cigarettes_____pks/day
❑ Diabetes
❑ Hypoglycemia
❑ AIDS
❑ Other

REMARKS:

_____

_____

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.
0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

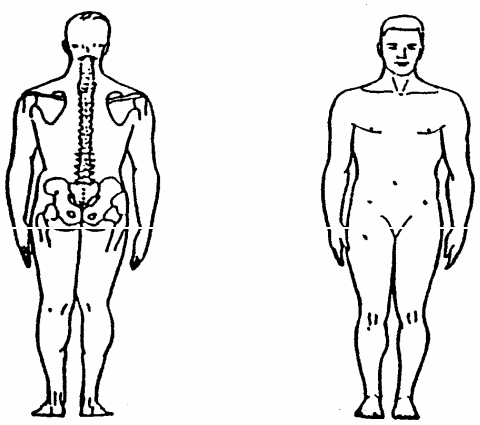
0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) _____
2. RECREATION: hobbies, sports, and other similar leisure time activities. _____
3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. _____
4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____
5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____
6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. _____

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking etc.

COMPLETE THESE DIAGRAMS



Whom may we contact in case of an emergency? _____ Phone: _____

Method of payment for today's charges: ☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ _____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. California State Law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.

Patient's Signature _____Date_____

PRIVACY PRACTICES

BAC TO HEALTH
CHIROPRACTIC GROUP

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.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that your medical information is personal and we are committed to protecting it. We create a record of the services you receive at our clinic. We need this to provide you with quality care and to comply with certain laws. This notice tells you about the ways we may use and share your information and your rights and certain duties regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law requires us to:
1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We have the right to:
1. Change our privacy practices and the terms of this notice at any time, provided that law permits the changes.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:
1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

This section describes different ways that we use and disclose medical information. We have listed all of the ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your written authorization. Any written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment and health care operations, we may use and disclose medical information for the following purposes.

Notification: Medical information to notify: a family member, your representative or other person responsible for your care. We will share information about your location, general condition or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, if you are not able to give permission, we will share only the information that is directly necessary for your care, according to our professional judgment. We will also use professional judgment to make decisions in your best interest about allowing someone to pick up medical supplies, x-ray or medical information for you.
Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.
Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director or an organ procurement organization.
Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.
Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.
Public Health Activities: We may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when law authorizes us to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.
Victims of Abuse, Neglect or Domestic Violence: We may disclose medical information to appropriate authorities if we believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share you information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.
Workers Compensation: We may disclose health information when authorized and necessary to comply with law relating to workers compensation or other similar programs.
Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative or criminal investigations or proceedings, inspections, license or disciplinary action, or other authorized activities.
Law Enforcement: We may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws, pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.
Sign-in Sheets: We use sign-in sheets that are visible to other patients. They will not have pertinent medical information listed on them (such as the reason for treatment). They will have only your name, name of doctor you are seeing and the time of the appointment.

4. YOUR INDIVIDUAL RIGHTS

You have a right to:
1. Look at or get copies of your medical information. You may request copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form by any office personnel. You may also request access by sending a letter to our office via mail or facsimile.
2. Receive a list of all the times we or our business associates shared your medical information for purposes not listed above.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request must be made in writing to our office.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others of the change and to include the changes in any future sharing of the information.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Date_____

Print Name_____

Birthdate_____

Signature_____

BAC TO HEALTH
CHIROPRACTIC GROUP

REQUEST FOR ALTERNATIVE COMMUNICATIONS

Patient Name:_____
Address:_____
Date of Birth:_____ Date of Request:_____

As allowed by the Privacy Regulation, I wish for this office to provide the following "Alternative" means of communication my Protected Health Information:
Please initial boxes:

☐ **Mailing Address**
If appropriate, please contact me at the following address:
_____

☐ I give BAC To Health approval to mail me postcards at the above address regarding birthdays, newsletters, special events and reminders.

☐ **Phone**
If appropriate, please contact me by telephone at the following number:
_____

☐ I give BAC To Health permission to call the above phone number to remind me of an appointment or to reschedule a missed appointment.

☐ **Fax**
If appropriate, please contact me by fax at the following number:
_____

☐ **E-Mail**
If appropriate, please contact me by e-mail at the following address:
_____

☐ **I have the following additional requests for confidential communications regarding my Protected Health Information:**

_____
_____

I understand that there may be additional costs associated with this request and I agree to reimburse this office for such costs.

_____ _____
Signature Date

☐ Accepted as requested ☐ Modified as noted:_____

_____ _____
Authorized Signature of Facility Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goals. Chiropractic does not diagnose or treat disease. Chiropractic has only one goal:

TO LOCATE, ANALYZE AND CORRECT
SPINAL INTERFERENCE TO THE NERVOUS SYSTEM.

The purpose of the nervous system is to control and coordinate all bodily functions. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference) in and of itself is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at it's optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain, and promote natural health.

WE DO NOT DIAGNOSE CONDITIONS OR DISEASES OTHER THAN VERTEBRAL SUBLUXATIONS.

WE OFFER NO TREATMENT OF CONDITIONS OR DISEASES OTHER THAN VERTEBRAL SUBLUXATIONS.

WE PROMISE NO CURE FROM ANY CONDITION OR DISEASE

THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO IT'S FULLEST POTENTIAL!!

I _____, having read the above statement, and

understanding it fully, do undertake chiropractic health care on this basis.

Signature _____ Date _____

Witness _____ Date _____

BAC TO HEALTH
CHIROPRACTIC GROUP

DEDICATED TO QUALITY CARE

OFFICE POLICIES

(Please initial at each paragraph)

_____Appointment Scheduling:

To save time, we ask you to pre-schedule all of your appointments. If you feel you need extra time with the Doctor, please let us know so that we may schedule extra time for your appointment.

_____Missing or Changing Appointments:

We will be setting up a specific course of treatment for you based on your needs to get well. A certain number of treatments in a set amount of time is required for us to get the results we both desire. Your results are obtained based on the number of visits per week, not per month. If you need to change the time of your appointment, plan to get adjusted at a different time on the same day. If the same day is not possible, be sure to make up the missed appointment at another time within the week. Repeatedly missing appointments will result in discharge from this office.

PLEASE NOTE: You will be charged $25.00 if you miss an appointment without calling 24 hours in advance to reschedule!

_____Late Arrivals:

Late arrivals will back us up and cause others to wait. Please be courteous to the staff and other patients and arrive on time.

_____Upsets:

We are here to serve you. Please speak freely with the Doctor or staff about any upsetting matter. We see your comments as a way of helping us create a first-class facility for you, your family and your friends.

_____Payments:

Our office accepts payments by the week or month. Paying each visit will waste each other's time and money. We accept personal checks, Visa, MasterCard, and American Express.

_____Insurance:

If your insurance status changes, please let us know as soon as possible, otherwise we have no way of knowing. Please don't hesitate to ask if you have questions regarding your EOB's (Explanation of Benefits).

_____Cell Phone Use:

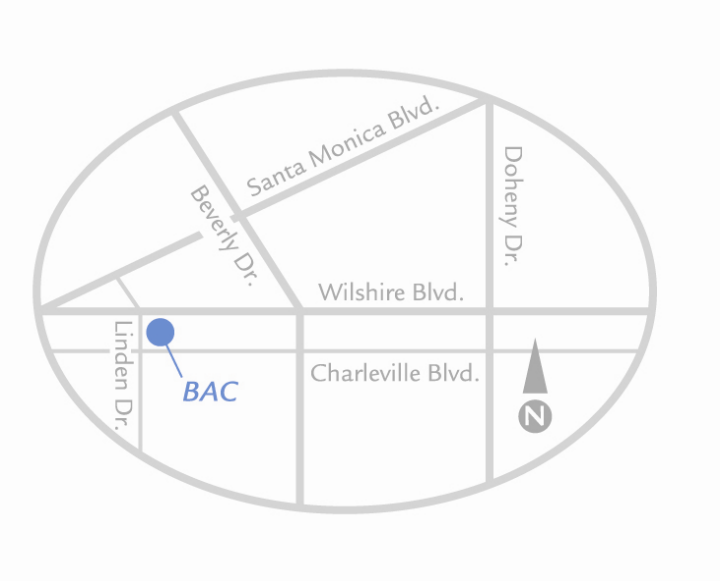
Please be courteous to others in this office. Please turn off your cell phone or ringer to avoid unnecessary interruptions. The Doctor's time is just as valuable as yours.

Patient Signature:_____ Date:_____

BAC TO HEALTH
CHIROPRACTIC GROUP

9730 Wilshire Blvd., Suite 109 ● Beverly Hills, California 90212
310-888-8762

DIRECTIONS



We are located on the Southeast corner of Wilshire and Linden, three blocks east of the Santa Monica-Wilshire intersection.

From the 405 freeway

Take the Santa Monica exit and head east. Make a right on Wilshire. Make a right on Linden and we are immediately on the left.

From the 10 freeway

Exit Robertson and head north. Make a left on Olympic. Make a right on Linden. We are on the right hand side just before you reach Wilshire.

PARKING

1. Lot available directly behind building. $1.75/15 minutes 8am-5pm. $3 after 5pm.
2. Meters on Linden, south of office. 1 Hour parking 8am-6pm. West side of street NO parking 9-12 Wednesdays for street cleaning. The rest of Linden is *PERMIT PARKING ONLY!*
3. Meters on Linden, north of office. Must enter from Little Santa Monica Blvd, Linden is one way going south at this point.
4. Metered lot on Linden and Little Santa Monica Blvd. Entrance is off of Roxbury Drive, one way street going north, just past Little S.M. The ramp is on your left before you reach Santa Monica Blvd.
5. Meters on Spalding Drive, one block west of Linden. 1 hour parking 8am-6pm. West side of the street NO parking 8am-10am Thursdays, East side NO Parking 8-10am Wednesdays for street cleaning. The rest of Spalding is *PERMIT PARKING ONLY!*
6. Street parking on McCarty Drive. West side of the street, 2 hour parking 8am-6pm. East side of the street, 1hour parking 8am-6pm, NO parking 9-12 Wednesdays.
7. Street parking on the north side of Charleville. 2 hour parking 8am-6pm.
8. Neiman Marcus Lot, entrance off Roxbury, south of Wilshire. 11/2 hours free with validation.

As always in Beverly Hills, parking regulations are subject to change at any time. Please make sure to read ALL posted signs.

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient: _____

Employer: _____

Claim/Group # _____

SSN/ID# _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

BAC To Health Chiropractic Group
9730 Wilshire Boulevard, Suite 109
Beverly Hills, CA 90212

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

BAC To Health Chiropractic Group
9730 Wilshire Boulevard, Suite 109
Beverly Hills, CA 90212

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Additionally, I authorize the Doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at 9730 Wilshire Blvd., Ste. 109, Beverly Hills, CA 90212 this _____ day of _____ 20_____

Signature of Policyholder _____ Witness _____

INJURY INFORMATION

Name _____ **Date** _____

Date of Accident _____ **Time of Accident** _____

❑ *Driver* ❑ *Passenger (Front / Back)* ❑ *Pedestrian* ❑ *Slip & Fall* ❑ *Other:* _____

Location of Accident & Cross Street _____ **City** _____

How did the accident occur? _____

_____

_____

Where was your vehicle damaged? _____

Damage made to vehicle: ❑ *Slight* ❑ *Moderate* ❑ *Severe* *Total:* _____

Where you wearing your seatbelt? ❑ *Yes* ❑ *No* **Child Restraint?** ❑ *Yes* ❑ *No*

Did any part of your body strike anything, if so describe? _____

_____

Were you: ❑ *Pitched back & forward* ❑ *Thrown side to side* ❑ *Thrown around abruptly* ❑ *Other:* _____

Injuries at time of accident, began? ❑ *Immediately after* ❑ *Hour* ❑ *Days after accident*

Immediately after the accident, did you feel?

❑ *Nervous* ❑ *Scared* ❑ *Stunned* ❑ *Panicky* ❑ *Shock*
❑ *Confused* ❑ *Dazed* ❑ *Dizzy* ❑ *Nausea* ❑ *Vomit*

Immediately after the accident, did you? ❑ *Lose consciousness* ❑ *Faint* ❑ *Black Out*

Did you receive Emergency Treatment? ❑ *Yes* ❑ *No*

Treatment Received: _____

Where did you go following the accident?

❑ *Home* ❑ *Work* ❑ *Doctor / Hospital & City:* _____

Treatment Received: _____

Previous Injuries (Auto /Work /Other) Date: _____ Treated by _____

Areas injured _____ Residuals _____ Case: Open / Closed

(Surgeries/Fractures) _____ Disability from: _____ to: _____

Previous Injuries (Auto /Work /Other) Date: _____ Treated by _____

Areas injured _____ Residuals _____ Case: Open / Closed

(Surgeries/Fractures) _____ Disability from: _____ to: _____

Complaints at this time: _____

_____

_____

AUTHORIZATION OF DIRECT PAYMENT AND DOCTOR'S LIEN

Attorney: _____

_____

_____

_____

Doctor:
BAC To Health Chiropractic
9730 Wilshire Blvd., St. 109
Beverly Hills, CA 90212
310.888.8762

RE: _____

DOI: _____

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 in 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 serviced rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And 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 for injuries in connection herewith.

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

Dated _____ Patient's signature _____

Witness _____ Address: 9730 Wilshire Blvd. Ste 109 Beverly Hills, CA 90212

The undersigned being 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 names.

Dated _____ Attorney's Signature _____

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

* Reply envelope attached.
* Keep one copy for your records.

POWER OF ATTORNEY TO ENDORSE CHECKS

KNOWN ALL MEN BY THESE PRESENT: That the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint the BAC To Health Chiropractic Group and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful Attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said BAC To Health Chiropractic Group which checks, drafts or money or orders are to pay for **Chiropractic services** or the like which have been made by BAC To Health Chiropractic Group at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

The undersigned by these presents does thus give and grant unto the said BAC To Health Chiropractic Group as attorney the full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power of attorney and which the said attorney shall do or cause to be done by virtue of these presents.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this

_____ day of _____, 20 _____.

_____ _____

Witness of Patient's Signature Patient's Full Name

_____

Signature of Patient

SUBSTITUTION OF ATTORNEY / PRO PER

I _____, agree that if I replace my current-of-record attorney with any subsequent attorney prior to settlement of my case, it is my sole responsibility to have my new attorney-of-record sign a doctor's lien agreement with BAC To Health Chiropractic Group to assure proper payment to BAC To Health Chiropractic Group Should I fail to obtain any subsequent attorneys signature who represents my interest in this case on the aforementioned lien agreement. I will be personally responsible to pay all monies due to BAC To Health Chiropractic Group for treatment I received should my new Attorney-of-record fail to do so.

Also, should I decide to waive my privilege of representation by an attorney and represent myself (i.e. pro per), I am solely responsible to pay BAC To Health Chiropractic Group for treatment rendered have read the above contract and understand it, and I agree to fulfill ALL of the provisions therein.

Signed _____Date _____