Advanced Spinal Rehabilitation Center

"The leading Northwest center for non-surgical treatment of scoliosis."

PATIENT APPLICATION FORM
MOTOR VEHICLE (MINOR)

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their optimal level of health through our spinal and postural corrective programs. Our research based approach is very unique and advanced even from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

We only accept cases that we are confident we can help so please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you!

Date: _____

Patient Name: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____

PATIENT INFORMATION FOR PERSONAL INJURY

Name: _____Date_____ **Date of Accident**_____ Gender: ___ Marital Status: ____

Address: _____ City, State, Zip: _____

Home Phone: ( ) _____Work Phone: ( ) _____ Cell Phone: ( ) _____

Email Address: _____ Birth Date: _____ / _____ / _____ (Age) _____

Social Security #: _____ - _____ - _____ Driver's License # _____

# of Children _____ Names of Children: _____ Ages: _____

Emergency Contact: Name/Relationship_____ Phone: ( ) _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor **before**? ☐ Yes ☐ No Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

Did your previous chiropractor take **before** and **after** x-rays? ☐ Yes ☐ No

Did you know posture determines your health? ☐ Yes ☐ No

Are you aware of any of your poor posture habits? ☐ Yes ☐ No Explain: _____

_____

Are you aware of any poor posture habits in your ☐ Spouse or ☐ Children? ☐ Yes ☐ No

Explain: _____

The most common postural weakness is **Forward Head Syndrome** (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. **Have you ever been told or feel like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck?** ☐ Yes ☐ No

INSURANCE INFORMATION

Your Car Insurance Company: _____ Phone: _____

Do you have Personal Injury Protection (PIP)/Medical Coverage? Yes No

Policy #: _____PIP Claim# _____ Adjuster Name: _____

Insurance Company of **Responsible Person**: _____ Phone: _____

Claim #: _____ Adjuster Name: _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? Yes No

Do you have an attorney that has advised you in this case? Yes No

Attorney's Name: _____ Phone: _____ Address: _____

ACCIDENT INFORMATION

Date of Accident: _____

If Auto Accident, were you: Driver Passenger Pedestrian

Were you struck from: Behind Right Side Left Side Front Parked

Did **your** car strike the other involved: Yes No Did the **other** car strike yours: Yes No

As a result of the accident were traffic citations issued **to you**? Yes No

to the driver of the **other** car? Yes No to the driver of **your** car? Yes No

Did you see the car coming? Yes No In which direction was your head facing? Front Left Right Down Up Back

Did any part of your body strike any part of the car? _____

Did you have a safety belt on? Yes No Shoulder Strap? Yes No

Does your car have a head rest? Yes No How high is it adjusted? _____

Did you have loss of consciousness? Yes No Details: _____

Did you feel any popping, tearing, or ripping noise in your **neck** or **back**? Details: _____

_____

Were you stunned? Yes No How long? _____ Did you find any bruises? Yes No Where? _____

Did you feel any pain? Yes No When? _____ List the extent of the injuries as you know them: _____

_____

Did you require post-accident hospitalization? Yes No Name of Facility/Location: _____

Were you examined? Yes No X-rays taken? Yes No Any treatment given? Yes No Explain: _____

Any Medication given? Yes No List Medications: _____

Other Recommendations: _____

Have you lost any days of: [ ] **Work?** Yes No Dates: _____ [ ] **School?** Yes No Dates: _____

What are your **symptoms now**? _____

Were you treated **before** for any of these symptoms? Yes No If yes, which? _____

What are you now doing to treat these symptoms? _____

Dominant side: R L or Ambidextrous (equally able to use both left and right appendages)

ACCIDENT INFORMATION CONTINUED

Any other problems **before** the accident? _____

Any **previous** accidents or fractures? _____

Are you experiencing any pain/problems? Yes No

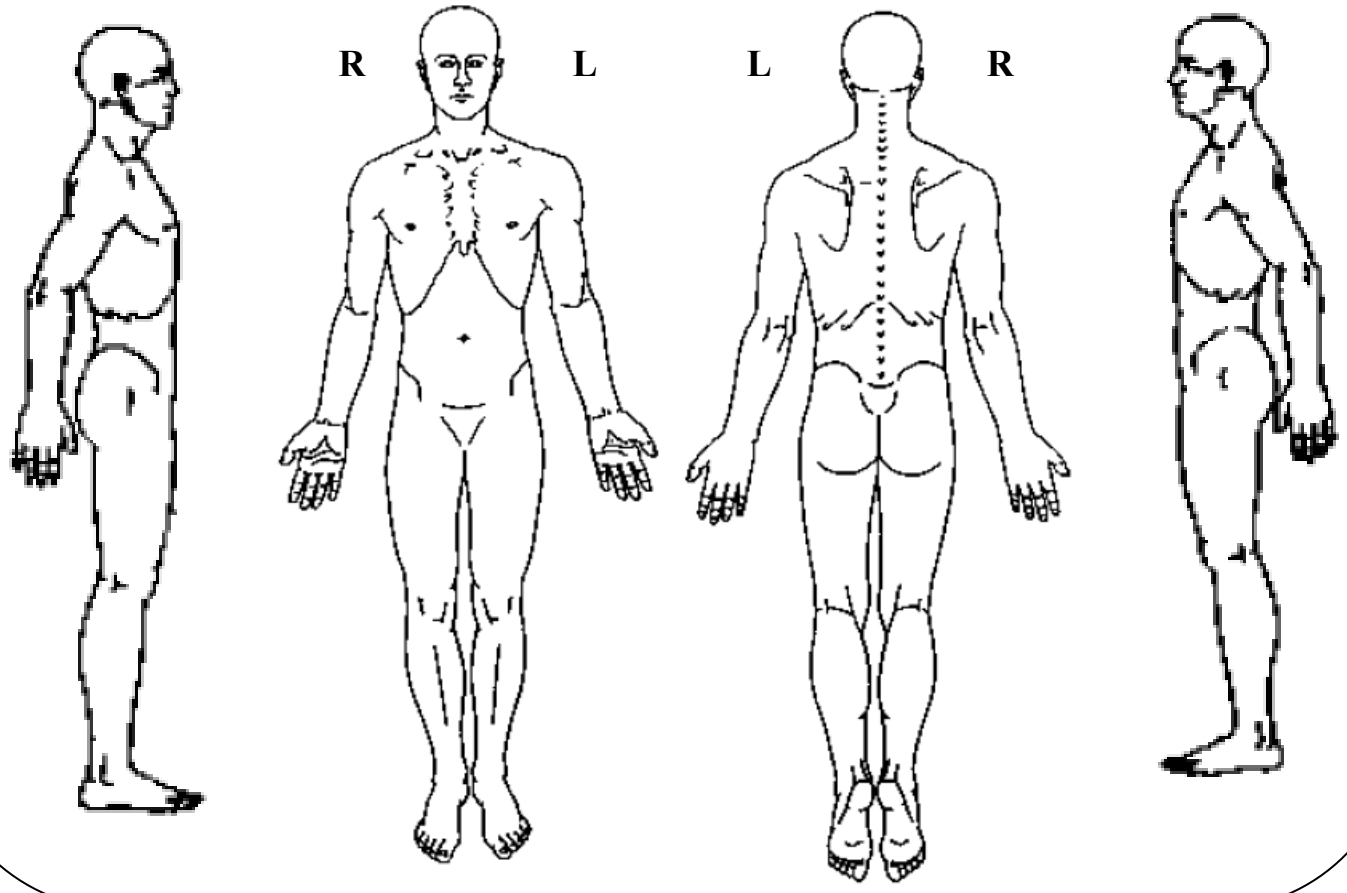
Please indicate below: R=Right L=Left

UPPER EXTREMITY	TRUNK/HEAD	LOWER EXTREMITY
Shoulder _____	Head _____	Hip _____
Arm (Upper) _____	Neck _____	Thigh _____
Elbow _____	Back _____	Knee _____
Arm (Lower) _____	Chest _____	Leg _____
Wrist _____	Abdomen _____	Ankle _____
Hand _____	Rib Cage _____	Foot _____

If it is pain you are experiencing, **where do you feel it**? Does the pain **radiate** (move in other directions from the pain site)?

Describe and/or draw on body sketch: _____

_____



HEALTH HISTORY

Have **you (mark with *)** or any of your **family (mark with "F")** members ever been diagnosed with the following:

[] Diabetes –Type:_____
[] Rheumatic fever
[] High/Low blood pressure
[] Kidney disease
[] Liver disease
[] Broken bones/fractures
[] Pneumonia
[] Whooping Cough
[] Thyroid
[] Arthritis
[] Chest Pains
[] High Cholesterol
[] Varicose veins
[] Circulatory problems
[] Heart Disease
[] Epilepsy/seizures
[] Metal Implants
[] Appendectomy
[] Polio
[] Chicken Pox
[] Small Pox
[] Epilepsy
[] Heart Surgery/Pacemaker
[] Scoliosis
[] Neurological problems
[] Stroke
[] Cancer
[] Migraine Headaches
[] Infectious disease
[] Tonsillectomy
[] Tuberculosis
[] Mumps/Measles
[] Influenza
[] Lumbago
[] HIV/Aids
[] Other: _____
[] Lung Disease
[] Heart murmur
[] Osteoporosis
[] Arthritis
[] Gall bladder
[] Hernia
[] Anemia
[] Hepatitis
[] Pleurisy
[] Eczema
[] Shingles

Are you taking any of the following:

[] Nerve Pills
[] Muscle Relaxer
[] Insulin
[] Pain Killers
[] Blood Thinner
[] Statin
[] Cannabis
[] Tranquilizer
[] Chemotherapy
[] Aspirin
[] Stimulant
[] Birth Control

Please list any allergies: _____

HEALTH LIFESTYLE

How much do you value your Health on a scale of 1-10? _____

Do you exercise? □ Yes □ No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming other: _____

What time of day do you find yourself feeling tired or low energy? Morning Afternoon Evening I never feel tired

Do you smoke? Yes No How much? _____ Do you drink alcohol? Yes No How much / week? _____

Do you drink coffee? Yes No How many cups / day? _____

How many days a week do you eat fast food or frozen food 1-3 4-6 7

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

On a scale of 1-10, how open are you to learning more about natural (preventative) solutions to your health needs? _____

How much daily stress do you experience? Mild Average Severe

HEALTH LIFESTYLE (CONT.)

Are you involved with sports/activities outside of school? (Ex. Soccer, horseback riding, trampoline, tennis) Yes No
If yes, please list_____

Do you play an instrument(s)? Yes No If yes, please list _____

Do you carry a backpack? Yes or No Approximately how heavy? _____

Do you use a cell phone? Yes No Do you text? Yes No

Please circle if you use the following: Desktop computer Laptop ipad

Number of hours/day using computer/laptop/ipad_____

Please circle if you carry: Purse Laptop Bag ipad

Where do you do your homework? On my bed At a desk At a Kitchen/dining table Other location: _____

IN CASE OF EMERGENCY CALL

Name_____

Relationship to Minor: _____

Work Phone_____

Home Phone_____

Cell Phone_____

PREFERRED METHOD OF CONTACT

Circle all that apply and complete the information below: Phone Text Email

Home Phone_____

Cell Phone_____

Text: _____Preferred #: _____

Email:_____

****

I give permission to email statements as needed? Yes No

LIFE STRESSES EVALUATION

The following three areas of stress can cause the vertebrae to misalign (**subluxation**). Do you recognize any of these stresses? Please circle when you experienced these stresses: C (child), T (teenager), A (adult), or N (not at all).

I. PHYSICAL STRESS:					Explain
Birth Trauma	C	T	A	N	_____
Slips/Falls	C	T	A	N	_____
Car Accidents	C	T	A	N	_____
Sports Injuries	C	T	A	N	_____
Physical Abuse	C	T	A	N	_____
Work Injuries	C	T	A	N	_____
Poor Posture	C	T	A	N	_____
Sitting on a wallet for years	C	T	A	N	_____
Sleeping Position—Stomach	C	T	A	N	_____
Extensive Computer Work	C	T	A	N	_____
Carrying Heavy Purse/Bookbag/Child	C	T	A	N	_____
Repetitive Lifting/Bending	C	T	A	N	_____
Driving for many hours	C	T	A	N	_____
Continuous hours sitting/standing	C	T	A	N	_____

II. EMOTIONAL STRESS:					Explain
Relationships	C	T	A	N	_____
Career	C	T	A	N	_____
Children	C	T	A	N	_____
Fast-Paced Life	C	T	A	N	_____
Hold in Feelings	C	T	A	N	_____
Quick Tempered	C	T	A	N	_____
Verbal Abuse	C	T	A	N	_____
Perfectionist	C	T	A	N	_____
Procrastinator	C	T	A	N	_____
Loss of a Loved One	C	T	A	N	_____
Shoveling, Painting, Gardening, Cleaning	C	T	A	N	_____

III. CHEMICAL STRESS					Explain
Smoker—Amount?	C	T	A	N	_____
Second-hand Smoke	C	T	A	N	_____
Poor Diet	C	T	A	N	_____
Caffeine —Amount?	C	T	A	N	_____
Excessive Sugar	C	T	A	N	_____
Artificial Sweeteners	C	T	A	N	_____
Prescription Drugs	C	T	A	N	_____
Over-The-Counter Drugs	C	T	A	N	_____
(Example: Tylenol, Motrin)					

IV. Which do you feel are primary stresses? _____

_____

INSURANCE INFORMATION & POLICY

For Parent/Legal Guardian: I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an **arrangement between my insurance carrier and myself.** If this office chooses to bill any services to my insurance carrier that they are performing these services are **strictly as a convenience to me. Staying informed at all times of my account status is my responsibility.** The Doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

Understand there could be some services that your insurance company does not cover, if this is the case are you willing to pay for these services? [ ] YES [ ] NO

Patient/Legal Guardian Name _____ Date_____

Parent/Legal Guardian Signature Authorizing Care_____ Date_____

I hereby authorize Advanced Spinal Rehabilitation Center to administer care as deemed necessary to my child, a minor under the age of 18 years old.

You are considered to be a cash patient until our office qualifies your coverage to determine the extent of benefits under your policy.

All patients under Maintenance Care will not be eligible for insurance assignment, unless otherwise stated. Charges for services rendered will be due at the time of service.

Name of Insurance Co. _____ Policy#_____

Address_____ Phone # _____

Insured's Name_____ Insured's SS# _____

For Automobile Accidents, include Policy Claim No._____

Relationship to Insured _____ Birthdate _____/_____/_____

Employer_____

Who should receive charges on this account?

☐ Patient ☐ Spouse ☐ Parent/Guardian ☐ Workers Comp ☐ Auto Insurance ☐ Medicare ☐ Personal Health Insurance

RADIOGRAPH CONSENT

I, (Parent/Legal Guardian Name) _____ do hereby give my consent to allow Advanced Spinal Rehabilitation Center and its representatives, as deemed by the examining physician to **take radiographs of (Minor Name)_____ spine and/or extremities.**

Female: I also hereby declare that to the best of my knowledge that **I am not pregnant** _____ (Initial) I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signature of **Patient/or Guardian of said Minor** _____ Date _____

FINANCIAL POLICY

We believe that a clear definition of our office policies will allow you, the patient, and us, the doctor, to concentrate on the big issue – **REGAINING AND MAINTAINING YOUR HEALTH.**

Cell Phone Usage: HIPAA RULES: **No cell phones in treatment areas. It is prohibited to take pictures.** Please help us keep a peaceful, relaxing environment by putting your phone on silent mode or off. **Please take your phone calls outside.**

It is our Financial Policy that patients whose monthly payments are not paid on or before the 21st of each month, will incur a one-time service charge/late fee of $20.00 per late or missed monthly payment.

As a patient in our office, it will be your responsibility to keep scheduled appointments. If you need to cancel or reschedule an appointment we **require at least 24-hours notice**. If at least 24-hours notice is not received you will be charged a **$25.00 no-show fee**.

It is our policy that **ALL services rendered in this office are charged directly to you, the patient, and that you are personally responsible for all payments,** regardless of whether or not this office accepts insurance assignment. It is also your patient responsibility to ask any and all questions regarding your account balance, payments and charges and to know at all times where your account stands.

Should you discontinue care for any reason other than being discharged by the doctor, all balances will become due immediately, payable in full. All payments are expected at the time of service; including co-pays, co-insurance, deductibles, and/or time of service fees. Failure to pay any coupon or promotional special fees will result in being charged full retail fees.

Returned checks will be charged a $35.00 NSF fee per transaction. All balances for services rendered that are over 60 days will be charged 1% simple interest on that balance each month on the first of the month.

All accounts not paid within ninety (90) days will automatically be sent to an outside collection agency.

Phone and Skype Consultations:
We continue to work towards providing our patients the best possible healthcare which includes personal consultations outside the clinic. Due to the increased demand and frequency of extended consultations by phone and Skype interactions, Advanced Spinal Rehab is incorporating a charge for these types of consultations. There is a corresponding code that you will be able to submit to insurance which you will see on your attached itemized billing statement. Note that simple email questions will continue to be answered at no charge.

Insurance Reports/Updates/Referrals:
The first 2 **brief** reports, updates, or referrals which Advanced Spinal Rehab provides to you or your insurance company are no charge. Each additional basic reports, updates, or referrals will be provided at a charge of $40.00. More in-depth reports will be charged based on the complexity and you will be advised of the charge prior to the report being written. Please email us with the details of what you need included in the report, the name of the insurance company, patient name and number, and date the report is needed. **We require the information 2 week's prior**.

PARENT/LEGAL GUARDIAN RESPONSIBILITY:

I certify that I have read and understand all of the above information. I understand that I am personally **financially responsible** for all services rendered whether or not paid for by my insurance. I am also responsible for any **annual deductibles applicable, co-payments, or non-covered services as may be required by my insurance plan.** I also agree to and understand that any balance over 60 days will incur 1% simple interest on the first of each month until paid in full.

x _____ _____

Signature of Patient or Person acting on Patient's behalf Date

PARENT/LEGAL GUARDIAN AUHTORIZATION:

I authorize the **release** of any **medical or other information necessary to process my claims**. This is a permanent authorization that I may revoke at any time by written notice.

x _____ _____

Signature of Patient or Person acting on Patient's behalf Date

HEALTHCARE AUTHORIZATION FORM

_____(Initial) I authorize and agree to allow the doctors to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

_____(Initial) The doctors will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

_____(Initial) I also clearly understand that if I do not follow the doctors specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

THE FOLLOWING AUTHORIZES ADVANCED SPINAL REHABILITATION CENTER TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

_____(Initial) I give permission to Advanced Spinal Rehabilitation Center to **treat (Minor Name) _____in an open room** where other patients are also being treated. I am aware that **other persons in the office may overhear some of his/her protective health care information** during the course of treatment. Should the patient or parent/legal guardian need to speak with a doctor in private, the doctor will provide a private room for these conversations.

We may contact you to give you information about workshops or services related to your treatment, case management, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We may put your picture, written or video testimonial up in our office or on our website. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices for Advanced Spinal Rehabilitation Center that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent
* The right to object to the use of my health care information for directory purpose
* The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

I further acknowledge that a copy of the current notice is **posted in the reception area** and that any amended Notice of Privacy Practices will be made available at my next appointment.

Signed:_____ Date:_____

Print Name: _____ Telephone:_____

If not signed by the patient, please indicate:

Relationship: ☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient

Name of Patient:_____

ASSIGNMENT, LIEN, AND AUTHORIZATION FOR DIRECT PAYMENTS BY MY PAYERS TO ADVANCED SPINAL REBHABILITATION, INC.

Purpose. The purpose of this Assignment & Lien is to assist the Office in obtaining Proceeds from various Payers for the payment of my Charges. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment & Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to Advanced Spinal Rehabilitation, Inc/Advanced Spinal Rehab located at 1331 118th Ave. SE, Suite 200, Bellevue, WA 98005; "Assignment & Lien Document," Assignment & Lien," and "Assignment" shall refer to this document. "Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, adjuster, claims handler, medical examiner, individual reviewer or review entity, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds, either now or in the future, or which may be involved directly or indirectly in determining the obligation to pay or disburse Proceeds, either nor or in the future; "Proceeds" shall include without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, the proceeds relating to "health-care-benefits, plans or coverages: individual and group health benefits, Medicare and Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, errors & omissions, and malpractice; "Charges" shall include without limit the full fees for the Office's goods and services (including without limit treatment, diagnostic services, medical equipment, supplies, supplements, narrative reports, photocopies, pre-authorization requests, no-shows, depositions, and testimony, whether rendered before or after the date of this Assignment & Lien), any Collection Costs incurred by the Office, delinquency penalties and interest to the maximum extent permitted under law or at the annual rate of eighteen percent (18%), whichever is greater, and any other charges incurred by me at the Office; "Collection Costs" shall include without limit any pre– and post judgment court costs, filing fees, service of process charges, attorneys fees, fees or costs associated with requests for reconsideration, independent review, appeals, mediation, arbitration, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Assignment and Lien Terms. I hereby assign to the Office to the extent permitted by law, but only to the extent of my Charges, all of my claims to, rights to, and interest in, Proceeds, whether resolved or unresolved, including without limit ownership rights, which I may have now or in the future relating directly or indirectly to my Charges, condition, or causes of my condition ("Claims to Proceeds"), including without limit any and all causes of action, receivables, payment intangibles, and remedies that I might have against or with respect to any Payer now or in the future, and the right to prosecute, seek, settle, or otherwise resolve such Claims to Proceeds either in my name or in the Office's name and as the Office otherwise sees fit. I agree that this assignment shall be effective as of the date and time the initial cause of my condition occurred. I further intend for this Assignment & Lien to create a security interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to the Office a primary, non-contingent security interest in all of my Claims to Proceeds to the extent permitted by law for the purpose of securing payment of my Charges, the attachment and perfection of which shall relate back to, and be effective as of, the date and time that the initial cause of my condition occurred. I further authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency relating to such security interests, and to make such filings in all relevant jurisdictions as the Office sees fit in its sole discretion. I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my agreement with the Office, such security interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Service Certified Mail. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the full extent of my Charges. To the extent that any law, including without limit a lien statute, purports to limit, reduce, or modify the distribution of Proceeds in any manner inconstant with this Assignment & Lien including without limit through the reservation of a portion of the Proceeds exclusively to me, I hereby waive such limits, reductions, or modifications. Such waiver shall not adversely affect or prejudice any rights which the Office may have and elect to exercise under said law.

ASSIGNMENT, LIEN, AND AUTHORIZATION FOR DIRECT PAYMENTS BY MY PAYERS TO ADVANCED SPINAL REBHABILITATION, INC. (Cont.)

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys who receive(s) Proceeds from one or more Payers, I hereby direct (and the Office herby requests) each attorney to provide immediate notice to the Office regarding such Proceeds, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of such Proceeds shall be primarily to pay my Charges. If I have a dispute regarding the Charges, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the Office. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney's fees and costs, or other expenses of obtaining Proceeds.

Disclosure Directives. I hereby direct each and every Payer to immediately release to the Office any Pertinent Information relating to (a) any coverage I may have and (b) any Proceeds Determination by the Payer relating to the Office's Charges. "Pertinent Information" shall include without limit the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information": shall also include without limit copies of all documents, records, and other information (a) relied upon by the Payer in make a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny, or delay payment of any Proceeds relating to the Office's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or for me by the Office to all Payers, including without limit a copy of my Charges and a copy of this Assignment & Lien, unless otherwise agreed to in writing.

Miscellaneous. Except as provided in this paragraph, this Assignment & Lien shall not be modified or revoked with out the expressed, written consent of the Office. I herby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment & Lien. I agree that each and every provision of the Assignment & Lien is reasonably necessary. However, should any provision of this Assignment & Lien be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this assignment & Lien shall, nevertheless, remain in full force and effect. This assignment & Lien shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment & Lien, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment & Lien.

I have read, understood, and agree to the terms of this Assignment & Lien.

Patient Name (print):_____Patient Signature_____Date:_____/ _____/ _____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature_____ Date:_____/ _____ / _____